WEST VIRGINIA
SECRETARY OF STATE
JOE MANCHIN, III
ADMINISTRATIVE LAW DIVISION

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Form #6

NOTICE OF FINAL FILING AND ADOPTION OF A LEGISLATIVE RULE AUTHORIZED BY THE WEST VIRGINIA LEGISLATURE

AGENCY Insurance Commission NUMBER: 114

AMENDMENT TO AN EXISTING RULE: YES X NO ___

IF YES, SERIES NUMBER OF RULE BEING AMENDED: 39

TITLE OF RULE BEING AMENDED: Group Accident and Sickness Insurance Minimum Policy Coverage Standards

IF NO, SERIES NUMBER OF RULE BEING PROPOSED: ___

TITLE OF RULE BEING PROPOSED: ___

THE ABOVE RULE HAS BEEN AUTHORIZED BY THE WEST VIRGINIA LEGISLATURE.

AUTHORIZATION IS CITED IN (house or senate bill number) S.B. 287

SECTION 64-7-1(g), PASSED ON March 7, 2003

THIS RULE IS FILED WITH THE SECRETARY OF STATE. THIS RULE BECOMES EFFECTIVE ON THE FOLLOWING DATE: April 3, 2003

Authorized Signature

PROMULGATION HISTORY

WEST VIRGINIA INSURANCE COMMISSION

TITLE

GROUP ACCIDENT AND SICKNESS INSURANCE MINIMUM POLICY COVERAGE STANDARDS

TITLE 114, SERIES 39

5/29/02	Notice of Comment Period Filed
7/01/02	Last Date Comments Were Received
7/26/02	Agency Approved Legislative Rule Filed
11/20/02	Date Reviewed by Legislative Rule-Making Review Committee
4/03/03	Filing Date
4/03/03	Effective Date

114CSR39
WEST VIRGINIA LEGISLATIVE RULE
INSURANCE COMMISSIONER

SERIES 39
GROUP ACCIDENT AND SICKNESS INSURANCE MINIMUM POLICY COVERAGE STANDARDS

Section

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114CSR39
WEST VIRGINIA LEGISLATIVE RULE
INSURANCE COMMISSIONER

SERIES 39
GROUP ACCIDENT AND SICKNESS INSURANCE MINIMUM POLICY COVERAGE STANDARDS

§114-39-1. General.

1.1. Scope and Applicability. -- This rule applies to all group accident and sickness insurance policies, all group subscriber contracts of hospital, medical, dental and health service corporations, health care corporations and fraternal benefit societies and all enrollee agreements or contracts of health maintenance organizations, issued in connection with a group health plan and delivered or issued for delivery in this state on and after the effective date hereof, except that it does not apply to:

a. Individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group insurance;

b. Individual policies or contracts issued to eligible individuals.

c. Credit accident and sickness insurance subject to WV 114CSR6 "Regulation of Credit Life Insurance and Credit Accident and Sickness Insurance;"

d. Medicare supplement insurance policies subject to WV 114CSR24 "Medicare Supplement Insurance; "

e. Long-term care insurance policies subject to WV 114CSR32 "Long-Term Care Insurance; "

f. Coverage under the West Virginia Public Employees Insurance Act (W. Va. Code §§5-16-1 et seq.): Provided, That this rule applies to a health benefit plan issued by a health insurer to provide medical care under the West Virginia Public Employees Insurance Act;

g. Coverage under Medicare or Medicaid: Provided, That this rule applies to a health benefit plan issued by a health insurer to provide medical care under Medicare or Medicaid;

h. Coverage under any automobile no-fault, workers' compensation, employer's liability, occupational disease or similar law;

i. Basic Hospital and Medical-Surgical Expense Coverage; and

j. Individual limited benefits. "Limited benefits policy" means any individual or

group accident and sickness insurance policy, including all riders thereto (and certificates in the case of a group policy), that covers one or more residents of this state and that is not required to offer or provide all benefits mandated by any other applicable provision of this chapter. Such policies include, but are not limited to, accident only, sickness only disability, sickness only, accident only disability, hospital indemnity, specified disease and travel accident insurance policies:

Provided, that the following types of policies and certificates are excluded from the definition of "limited benefits policy:"

1. Credit accident and sickness insurance;

2. Long-term care insurance;

3. Medicare supplement insurance;

4. Minimum benefits accident and sickness insurance issued pursuant to section fifteen, article fifteen of this chapter or article sixteen-c of this chapter;

5. Accident and sickness policies which provide benefits for loss of income due to disability;

6. Major medical policies;

7. Dental policies; and

8. Vision policies.

k. Disability income insurance

1.2. Sections 7, 8 and 9 of this rule apply only to group major medical expense coverage.

The requirements contained in this rule are in addition to WV 114CSR54 "Group Accident and Sickness Insurance Issuance, Portability and Marketing Requirements" and any other applicable rules previously adopted.

1.3. Authority. -- W. Va. Code §§33-2-10, 33-16-3(f), 33-16-17 and 33-16D-6.

1.4. Filing Date. -- April 3, 2003.

1.5. Effective Date. -- April 3, 2003.

1.6. Purpose. -- The purpose of this legislative rule is to provide reasonable standardization of coverage and simplification of terms and benefits of group accident and sickness insurance policies, subscriber contracts of hospital, medical, dental and health service corporations, health care corporations, fraternal benefit societies and enrollee agreements and

contracts of health maintenance organizations, which are issued in connection with a group health plan; to facilitate public understanding and comparison of such policies, contracts and agreements, to eliminate provisions contained in such policies, contracts and agreements which may be misleading or confusing in connection with either their purchase or the settlement of claims; to provide for full disclosure in the sale of such policies, contracts and agreements; and to implement standards set forth in 1997 W. Va. Acts 109 and the federal Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), as amended by the Newborns' and Mothers' Health Protection Act of 1996 and the Mental Health Parity Act of 1996 (P.L. 104-204).

§114-39-2. Definitions.

As used in this legislative rule:

2.1. "Applicant" means a person who seeks to contract for insurance coverage.

2.2. "Basic Hospital and Medical Surgical Expense Coverage" means policies designed to provide coverage for hospital and medical surgical expenses only incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, hospital out-patient services, surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for unlimited hospital or medical surgical expenses.

2.3. "Bona Fide Association" means an association which:

a. Has been organized in good faith for purposes other than that of obtaining or providing insurance;

b. Has a minimum of one hundred members;

c. Has been actively in existence for at least five years;

d. Has a constitution and bylaws providing that:

1. The association holds annual meetings to further purposes of its members;

2. Except in the case of credit unions, the association collects dues or solicits contributions from members; and

3. The members have voting privileges and representation on the governing board and committees that exist under the authority of the association;

e. Does not condition membership in the association on any health status-related factor relating to an individual;

f. Makes accident and sickness insurance offered through the association available to all members regardless of any health status-related factor relating to members or individuals eligible for coverage through a member;

g. Does not make accident and sickness insurance coverage offered through the association available other than in connection with a member of the association; and

h. Meets any additional requirements as may be set forth in chapter thirty-three of the W. Va. Code or by rule.

2.4. "Certificate" means any certificate delivered or issued for delivery in this state under a policy subject to this rule.

2.5. "Commissioner" means the Insurance Commissioner of the state of West Virginia.

2.6. "Eligible individual" means an individual:

a. For whom, as of the date on which the individual seeks coverage, the aggregate period of creditable coverage is eighteen months or more and whose most recent prior creditable coverage was under a group health plan, governmental plan (as defined in section 3(32) of the Employee Retirement Income Security Act of 1974), church plan (as defined in section 3(33) of the Employee Retirement Income Security Act of 1974) or accident and sickness insurance coverage offered in connection with any such plan;

b. Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act, or state plan under Title XIX of such act (or any successor program), and does not have other accident and sickness insurance coverage;

c. With respect to whom the most recent prior creditable coverage was not terminated as a result of fraud, intentional misrepresentation of material fact under the terms of the coverage, or nonpayment of premium;

d. Who did not turn down an offer of continuation of coverage under a COBRA continuation provision or under a similar state program if it was offered; and

e. Who, if the individual elected such continuation coverage, has exhausted that coverage under the COBRA continuation provision or similar state program.

2.7. "Enrollment date" means the first day of an individual's coverage under a policy, or if there is a waiting period for coverage, the first day of the waiting period.

2.8. "Excepted benefits" means:

a. Any policy of liability insurance or contract supplemental thereto; coverage only for accident or disability income insurance or any combination thereof; automobile medical

payment insurance; credit-only insurance; coverage for on-site medical clinics, workers' compensation insurance; or other similar insurance under which benefits for medical care are secondary or incidental to other insurance benefits; or

b. If offered separately, a policy providing benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof, dental or vision benefits, or other similar, limited benefits; or

c. If offered as independent, noncoordinated benefits under separate policies or certificates, specified disease or illness coverage, hospital indemnity or other fixed indemnity insurance, or coverage, such as medicare supplement insurance, supplemental to a group health plan; or

d. A policy of accident and sickness insurance covering a period of less than one year.

2.9. "Group health plan" means an employee welfare benefit plan, including a church plan or a governmental plan, all as defined in section three of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1003, to the extent that the plan provides medical care. For purposes of this rule, "group health plan" includes any plan, fund or program which would not (but for this subsection) be a group health plan and which is established or maintained by a partnership, to the extent that such plan, fund or program provides medical care to present or former partners or their dependents (as defined under terms of the plan, fund or program).

2.10. "Health benefit plan" means benefits consisting of medical care provided, directly through insurance or reimbursement, or indirectly, including items and services paid for as medical care, under any hospital or medical expense incurred policy or certificate; hospital; medical or health service corporation contract; health maintenance organization contract; or plan provided by a multiple-employer trust or a multiple-employer welfare arrangement. "Health benefit plan" does not include a policy consisting solely of excepted benefits.

2.11. "Health Insurer" means any of the following entities that holds a valid certificate of authority from the commissioner: An insurance company authorized to transact accident and sickness insurance; a fraternal benefit society organized pursuant to W. Va. Code §§33-23-1 et seq.; a hospital, medical, dental or health service corporation organized pursuant to W. Va. Code §§33-24-1 et seq., a health care corporation organized pursuant to W. Va. Code §§33-25-1 et seq.; or a health maintenance organization organized pursuant to W. Va. Code §§33-25A-1 et seq.

2.12. A "home health care agency" is:

a. An agency approved under Title XVIII of the Social Security Act (42 U.S.C. §1395 et seq.) (Medicare); or

b. An agency certified to provide home health care in this state.

2.13. "Individual" means any private or natural person as distinguished from a

partnership, corporation, limited liability company or other legal entity.

2.14. "Insurance producer" means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance.

2.15. "Limited benefits insurance coverage," for purposes of this rule, is any policy, other than a policy, covering only a specified disease or diseases, which provides benefits that are less than the minimum standards for benefits required under subsections 5.2, 5.3, 5.5 and 5.6 of this rule.

2.16. "Medical care" means amounts paid for, or paid for insurance covering, the diagnosis, cure, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body, including amounts paid for transportation primarily for and essential to such care.

2.17. "Medical care provider" means an individual licensed or similarly authorized to provide medical care and operating within the scope of services authorized for the individual.

2.18. "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

2.19. "Medicare supplement policy" means a policy of accident and sickness insurance, a subscriber contract of a hospital, medical, dental or health service corporation or health care corporation, or an enrollee agreement or contract of a health maintenance organization, other than a policy issued pursuant to a contract under section 1876 or 1833 of the federal Social Security Act, 42 U.S.C. section 1395 et seq., or an issued policy under a demonstration project authorized pursuant to amendments to the federal Social Security Act, which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare.

2.20. "Mental health benefits" means benefits with respect to mental health services, as defined under the terms of a group health plan or a health benefit plan offered in connection with the group health plan.

2.21. "Policy" means any health benefit plan, policy, plan, contract, agreement, provision, rider or endorsement delivered or issued for delivery in this state by a health insurer subject to this rule.

2.22. "Premium" means the consideration for insurance, by whatever name called.

2.23. "Small employer" means any person, firm, corporation, partnership or bona fide association actively engaged in business in the state of West Virginia who during the preceding calendar year, employed an average of no more than fifty but not fewer than two eligible employees and employs at least two employees on the first day of its group health plan year. A new employer, not in existence for all of the preceding calendar year, shall be considered a small employer if it is reasonably expected to employ an average of no more than fifty but not fewer

than two eligible employees on business days in the current calendar year. Companies which are affiliated companies or which are eligible to file a combined tax return for state tax purposes shall be considered one employer.

2.24. "Specified accident coverage" is an accident insurance policy which provides coverage for a specifically identified kind of accident (or accidents) for each person insured under the policy for accidental death or accidental death and dismemberment combined, with a benefit amount not less than one thousand dollars ($1,000) for accidental death, one thousand dollars ($1,000) for double dismemberment, and five hundred dollars ($500) for single dismemberment.

§114-39-3. Policy Definitions.

3.1. Except as provided in this rule, no policy subject to this rule may be advertised, solicited, delivered or issued for delivery in this state unless the policy contains definitions or terms which conform to the requirements of this section. Certificates issued under a policy subject to this rule and the terms used therein shall be consistent with this section. However, only this subsection and subsection 3.10 apply to a policy issued to an employer of fifty-one (51) or more employees, under which the coverage is negotiated by the policyholder.

3.2. "Accident," "accidental injury," or "accidental means" shall be defined to employ "result" language and may not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

a. The definition may not be more restrictive than the following: "Injury or injuries, for which benefits are provided" means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while the insurance coverage is in force.

b. The definition may provide that the term "injuries" excludes injuries for which benefits are provided or available under any motor vehicle no-fault, workers' compensation, employer's liability, occupational disease or similar law, unless prohibited by law.

3.3. "Convalescent nursing home," "extended care facility," "intermediate care facility" or "skilled nursing facility" shall be defined in relation to its status, facilities and available services.

a. A definition of the home or facility may not be more restrictive than one requiring that it:

1. Be operated pursuant to law;

2. Be approved for payment of Medicare benefits or be qualified to receive such approval if requested;

3. Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;

4. Provide continuous twenty-four-hour-a-day nursing services by or under the supervision of a registered graduate professional nurse (R.N.); and

5. Maintain a daily medical record of each patient.

b. The definition of the home or facility may provide that the term excludes:

1. Any home, facility, or part thereof used primarily for rest;

2. A home or facility for the aged or for the care of drug addicts or alcoholics; or

3. A home or facility primarily used for the care and treatment of mental diseases or disorders, or custodial or educational care.

3.4. "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals.

a. The definition of "hospital" may not be more restrictive than one requiring that the hospital:

1. Be an institution operated pursuant to law;

2. Be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an in-patient basis for which a charge is made; and

3. Provide twenty-four-hour (24-hour) nursing services by or under the supervision of registered graduate professional nurses (R.N.'s).

b. The definition of "hospital" may state that the term excludes:

1. Convalescent homes, or convalescent, rest or nursing facilities;

2. Facilities primarily affording custodial, educational or rehabilitory care;

3. Facilities for the aged, drug addicts or alcoholics; or

4. Any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or agency thereof for the treatment of

members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability exists for charges made to the individual for the services: Provided, That no policy providing hospital indemnity coverage may exclude coverage because of confinement in a hospital operated by the federal or state government.

3.5. "Medicare" shall be substantially defined as "the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I Of Public Law 89-97 as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

3.6. "Mental or nervous disorder" may not be defined more restrictively than a definition including neurosis, psycho-neurosis, psychosis, or mental or emotional disease or disorder of any kind.

3.7. "Nurse" may be defined so that the description of "nurse" is restricted to a type of nurse, such as registered graduate professional nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.).If the words "nurse," "trained nurse," "registered nurse" or "nurse-midwife" are used without specific instruction, then the use of those terms requires the health insurer to recognize the services of any individual who qualifies under that terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of this state.

3.8. "One (1) period of confinement" means consecutive days of in-hospital service received as an in-patient or successive confinements when discharge from and readmission to the hospital occur within a period of time not more than ninety (90) days or three times the maximum number of days of in-hospital coverage provided by the policy to a maximum of one hundred eighty (180) days.

3.9. "Partial disability" shall be defined in relation to the individual's inability to perform one or more but not all of the "major," "important," or "essential" duties of employment or occupation, or may be related to a percentage of time worked or to a specified number of hours or to compensation. Where a policy provides total disability benefits and partial disability benefits, only one (1) elimination period may be required.

3.10. "Physician" may be defined by including words such as "duly qualified physician" or "duly licensed physician." The use of these terms requires a health insurer to recognize and to accept, to the extent of its obligation under the policy, all providers of medical care and treatment when the services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.

3.11. "Preexisting condition" may not be defined to be more restrictive than the following: "Preexisting condition" means a condition (whether physical or mental and regardless of its cause) for which medical advice diagnosis, care or treatment was recommended by or received from a medical care provider prior to the enrollment date of the individual covered under the policy.

3.12. "Residual disability" shall be defined in relation to the individual's reduction in earnings and may be related either to the inability to perform some part of the "major," "important" or "essential duties" of employment or occupation, or to the inability to perform all usual business duties for as long as is usually required. A policy which provides for residual disability benefits may require a qualification period, during which the insured shall be continuously totally disabled before residual disability benefits are payable. The qualification period for residual benefits may be longer than the elimination period for total disability. In lieu of the term "residual disability," the health insurer may use the term "proportionate disability" or other term of similar import which, in the opinion of the commissioner, adequately and fairly describes the benefit.

3.13. "Sickness" may not be defined to be more restrictive than the following: "Sickness" means illness or disease of an insured person which first manifests itself after the effective date of the policy and while the policy is in force. The definition may be further modified to exclude sickness or disease for which benefits are provided or available under any workers' compensation, occupational disease, employer's liability or similar law.

3.14. "Total disability" may not be defined more restrictively than a disability which prohibits the individual from being engaged in any employment or occupation for which he or she is or becomes qualified by reason of education, training or experience, and in fact prohibits the individual from being engaged in any employment or occupation for wage or profit.

a. Total disability may be defined in relation to the inability of the person to perform duties but may not be based solely upon an individual's inability to:

1. Perform "any occupation whatsoever," "any occupational duty," or "any and every duty of his or her occupation"; or

2. Engage in any training or rehabilitation program.

b. A health insurer may specify the requirement of the complete inability of the person to perform all of the substantial and material duties of his or her regular occupation, or words of similar import. A health insurer may require care by a physician (other than the insured or a member of the insured's immediate family).

§114-39-4. Prohibited Policy Provisions.

4.1. No policy may exclude coverage for a loss due to a preexisting condition for a period greater than twelve (12) months following an individual's enrollment date. For a health benefit plan issued in connection with a group health plan, a waiting period or affiliation period elected by a health maintenance organization pursuant to WV 114CSR54 "Group Accident and Sickness Insurance Issuance, Portability and Marketing Requirements," prior to an insured's eligibility for benefits must run concurrently with a preexisting condition exclusion period.

4.2. Policies providing hospital confinement indemnity coverage may not contain

provisions excluding coverage because of confinement in a hospital operated by the federal or state government.

4.3. For a health benefit plan issued in connection with a group health plan, a health insurer may impose a preexisting condition exclusion only as provided in WV 114CSR54 "Group Accident and Sickness Insurance Issuance, Portability and Marketing Requirements."

4.4. For policies other than a health benefit plan issued in connection with a group health plan, this rule does not impair or limit the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases, physical conditions or extra-hazardous activity. Where waivers are required as a condition of policy issuance, renewal or reinstatement, signed acceptance by the insured is required unless on initial issuance of the policy, the full text of the waiver is contained either on the first page or the specification page.

4.5. Policy provisions expressly precluded in this section shall in no way be construed as a limitation on the authority of the commissioner to disapprove other policy provisions including, but not limited to, provisions respecting limitations, exceptions, reductions or eliminations of coverage, not otherwise specifically authorized by statute or rule, which policy provisions are determined by the commissioner to be unjust, unfair, unreasonable or unfairly discriminatory either to the policyholder, subscriber, beneficiary or any person insured under the policy.

§114-39-5. Minimum Standards for Benefits.

5.1. General. -- The following minimum standards for benefits are prescribed for the categories of coverage noted in the following subdivisions. No health insurer may deliver or issue for delivery in this state a policy which does not meet the required minimum standards of subdivisions a and b of this subsection, if applicable. Except for coverage under policies issued to employers of fifty-one (51) or more employees, under which the coverage is negotiated by the policyholder, no health insurer may deliver or issue for delivery in this state a policy which does not meet the required minimum standards of subdivisions c through k of this subsection unless the commissioner finds that policies containing less than the prescribed minimum standards for benefits, which are filed for approval, will be in the public interest and otherwise meet the requirements set forth in W. Va. Code §33-6-9. The benefits described in a certificate issued under a policy subject to this rule shall be consistent with the benefits contained in the policy and shall be no less than those required under this section.

a. A health benefit plan issued in connection with a group health plan and providing inpatient benefits in connection with childbirth must meet all requirements of W. Va. Code §33-16-3j with respect to both the mother and her newborn.

b. A health benefit plan issued in connection with a group health plan and providing mental health benefits must meet all requirements of W. Va. Code §33-16-3a: Provided, That W. Va. Code §33-16-3a(d) does not apply to any health benefit plan for any group health plan year of a small employer.

c. If a policy contains a status-type military service exclusion which suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to an insured in military service on a pro rata basis.

d. If a health insurer terminates coverage under a policy providing pregnancy coverage, such policy shall provide for an extension of benefits as to pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force, provided that this subsection shall not apply when termination of coverage is due to fraud, nonpayment of premium or any breach of the terms of the policy for which termination is authorized under chapter 33 of the W. Va. Code.

e. Policies providing convalescent or extended care benefits following hospitalization may not condition the benefits upon admission to the convalescent or extended care facility within a period of less than fourteen (14) days after discharge from the hospital.

f. Any policy which provides coverage of a dependent child may not terminate coverage for the dependent child if upon attainment of any limiting age set forth in the policy, the child is and continues to be both: (1) incapable of self-sustaining employment due to mental retardation or physical handicap on the date that the child's coverage would otherwise terminate under the policy due to the attainment of the specified limiting age; and (2) chiefly dependent on the policyholder for support and maintenance. The policy may require that within thirty-one (31) days of the termination date, the health insurer must receive due proof of the incapacity in order for the insured to elect to continue the policy in force with respect to the dependent child. As an alternative to this requirement, a separate converted policy may be issued to the child at the option of the insured or policyholder.

g. Any policy providing coverage for the recipient in a transplant operation shall also provide for the reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy, after benefits for the recipient's own expenses have been paid provided such benefits may be limited to those expenses directly relating to the organ donation.

h. A policy may contain a provision relating to recurrent disabilities: Provided, That no such provision may specify that a recurrent disability be separated by a period greater than six (6) months from the last previous occurrence of the disability.

i. Accidental death and dismemberment benefits shall be payable if the loss occurs within ninety (90) days from the date of the accident, irrespective of total disability. Disability income benefits, if provided, may not require the loss to commence less than thirty (30) days after the date of accident, nor may any policy which the health insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the policy was in force.

j. Specific dismemberment benefits may not be in lieu of other benefits unless the specific benefit exceeds the other benefits.

k. Termination of coverage under a policy shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period the policy was in force may be predicated upon the continuous disability of the individual covered under the policy or limited to the duration of the policy benefit period if any: Provided, That this subdivision shall not apply when termination of coverage is due to fraud, nonpayment of premium or any breach of the terms of the policy for which refusal to renew the policy is authorized under W. Va. Code, chapter thirty-three.

5.2. Hospital Confinement Indemnity Coverage. -- "Hospital confinement indemnity coverage" is a policy which provides daily benefits for hospital confinement on an indemnity basis in an amount not less than thirty dollars ($30) per day and for a period of not less than thirty-one (31) days during any one (1) period of confinement for each person insured under the policy.

5.3. Major Medical Expense Coverage. -- "Major medical expense coverage" is a policy which provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than ten thousand dollars ($10,000); copayment by the covered person not to exceed twenty-five percent (25%) of covered charges; and a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of such bases not to exceed five percent (5%) of the aggregate maximum limit under the policy, unless the policy is written to complement underlying hospital and medical insurance in which case the deductible may be increased by the amount of the benefits provided by the underlying insurance, for each covered person for at least:

a. Daily hospital room and board expenses for not less than fifty dollars ($50) daily (or in lieu thereof the average daily cost of the semi-private room rate in the area where the insured resides) for a period of not less than thirty-one (31) days during continuous hospital confinement;

b. Miscellaneous hospital services for an aggregate maximum of not less than four thousand five hundred dollars ($4,500) or fifteen (15) times the daily room and board rate if specified in dollar amounts;

c. Surgical services to a maximum of not less than six hundred dollars ($600) for the most expensive surgical procedure when two or more medically necessary surgical procedures are performed during the course of a single operation. Amounts paid for the second and each additional surgical procedure during such single operation shall be reasonably related to the above-stated maximum amount for the first surgical procedure.

d. Anesthesia services for a maximum of not less than fifteen (15%) percent of the covered surgical fees or, alternatively, if the surgical schedule is based on relative values, not less than the amount provided in the surgical schedule for anesthesia services at the same unit value as used for the surgical schedule;

e. In-hospital medical services, consisting of physicians' services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than that for

which surgical care is required, in an amount not less than eighty percent (80%) of the reasonable charges, or five dollars ($5) per hospital call, one (1) call per day, for at least twenty-one (21) calls during one period of confinement.

f. Out-of-hospital care, consisting of physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, and diagnostic X-ray, laboratory services, radiation therapy and hemodialysis order by a physician; and

g. Prosthetic appliances, meaning artificial limbs or other prosthetic appliances (except replacements thereof) and rental of durable medical equipment required for therapeutic use.

5.4. Disability Income Protection Coverage.

a. "Disability income protection coverage" is a policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination of sickness or injury that:

1. Provides that periodic payments which are payable at ages after sixty-two (62) and reduced solely on the basis of age are at least fifty percent (50%) of amounts payable immediately prior to age sixty-two (62).

2. Contains an elimination period no greater than:

A. Ninety (90) days in the case of coverage providing a benefit of one (1) year or less;

B. One hundred eighty (180) days in the case of coverage providing a benefit of more than one year but not greater than two (2) years; or

C. Three hundred sixty-five (365) days in all other cases during the continuance of disability resulting from sickness or injury; and

3. Has a maximum period of time for which it is payable during disability of at least six (6) months. No reduction in benefits may be put into effect because of an increase in Social Security or similar benefits during a benefit period.

b. Subsection 5.4 of this rule does not apply to those disability income protection policies providing business buy-out coverage.

5.5. Accident-Only Coverage. -- "Accident-only coverage" is a policy of accident insurance which provides coverage, singly or in combination, for death, dismemberment, disability or hospital and medical care caused by accident. Accidental death and double dismemberment amounts under an accident-only policy shall be at least one thousand dollars ($1,000), and a single dismemberment amount shall be at least five hundred dollars ($500).

5.6. Specified Disease and Specified Accident Coverage.

a. "Specified disease coverage" pays benefits for the diagnosis and treatment of a specifically named disease or diseases. Any such policy shall meet the following rules and one of the following sets of minimum standards for benefits. Such insurance covering cancer -- whether cancer only, or in conjunction with other conditions(s) or disease(s) -- shall meet the standards of paragraphs 3, 4 and 5 of this subdivision. Insurance covering specified disease(s) other than cancer shall meet the standards of paragraph 2 of this subdivision.

1. Except for cancer coverage provided on an expense-incurred basis, either as cancer-only coverage or in combination with one or more other specified diseases, the following provisions apply to specified disease coverages in addition to all other requirements imposed by this rule. In cases of conflict between the following and other provisions, the following provisions shall govern:

A. Policies covering a single specified disease or combination of specified diseases may not be sold or offered for sale other than as specified disease coverage under this section.

B. Any policy issued pursuant to this section which conditions payment upon pathological diagnosis of a covered disease shall also provide that if such a pathological diagnosis is medically inappropriate, a clinical diagnosis will be accepted in lieu thereof.

C. Notwithstanding any other provision of this rule, specified disease policies shall provide benefits to any covered person not only for the specified disease(s) but also for any other conditions(s) or disease(s) directly caused or aggravated by the specified diseases(s) or the treatment of the specified disease(s).

D. No policy issued pursuant to this section may contain a waiting or probationary period greater than thirty (30) days.

E. Any application for specified disease coverage shall contain a statement above the signature of the applicant that no person to be covered for specified disease is also covered by any Title XIX program such as Medicaid. The statement may be combined with any other statement for which the health insurer may require the applicant's signature.

F. Payments may be conditioned upon a covered person receiving medically necessary care, given in a medically appropriate location, under a medically accepted course of diagnosis or treatment.

G. Except for the uniform provision regarding other insurance with this health insurer, benefits for specified disease coverage shall be paid regardless of other coverage available through other individual health insurance.

H. After the effective date of the coverage or applicable waiting period, benefits shall begin with the first day of care or confinement if the care or confinement is for a covered disease even though the diagnosis is made at some later date. The retroactive application of the coverage may not be less than ninety (90) days prior to the diagnosis.

2. The following minimum benefits standards apply to non-cancer coverages:

A. Coverage for each person insured under the policy for a specifically named disease or diseases with a deductible amount not in excess of two hundred fifty dollars ($250) and an overall aggregate benefit limit of not less than five thousand dollars ($5,000) and a benefit period of not less than two (2) years for at least the following incurred expenses:

1. Hospital room and board and any other hospital-furnished medical services or supplies;

2. Treatment by a legally qualified physician or surgeon;

3. Private duty services of a registered nurse (R.N.);

4. X-ray, radium and other therapy procedures used in diagnosis and treatment;

5. Professional ambulance for local service to or from a local hospital;

6. Blood transfusions, including expenses incurred for blood donors;

7. Drugs and medicines prescribed by a physician;

8. Rental of a mechanical ventilator or similar mechanical apparatus;

9. Braces, crutches and wheelchairs as are deemed necessary by the attending physician for the treatment of the disease;

10. Emergency transportation if, in the opinion of the attending physician, it is necessary to transport the insured to another locality for treatment of the disease; and

11. Any other expenses necessarily incurred in the treatment of the disease; and

B. Coverage for each person insured under the policy for a

specifically named disease or diseases with no deductible amount, and an overall aggregate benefit limit of not less than twenty-five thousand dollars ($25,000) payable at the rate of not less than fifty dollars ($50) a day while confined in a hospital and a benefit period of not less than five hundred (500) days.

3. A policy which provides coverage for each person insured under the policy for cancer-only coverage or in combination with one or more other specified diseases on an expense-incurred basis for services, supplies, care and treatment of cancer, in amounts not in excess of the usual and customary charges, with a deductible amount not in excess of two hundred fifty dollars ($250), and an overall aggregate benefit limit of not less than ten thousand dollars ($10,000) and a benefit period of not less than three (3) years for at least the following:

A. Treatment by, or under the direction of, a properly licensed and/or certified physician or surgeon;

B. X-ray, radium, chemotherapy and other therapy procedures used in diagnosis and treatment;

C. Hospital room and board and any other hospital-furnished medical services or supplies;

D. Blood transfusions, and the administration thereof, including expenses incurred for blood donors;

E. Drugs and medicines prescribed by a physician;

F. Professional ambulance for local service to or from a local hospital;

G. Private duty services of a registered nurse (R.N.) provided in a hospital;

H. Any other expenses necessarily incurred in the treatment of the disease: Provided, That subparagraphs A, B, D, E and G of this paragraph, plus at least the following shall also be included, but may be subject to copayment by the covered person not to exceed twenty percent (20%) of covered charges when rendered on an out-patient basis:

I. Braces, crutches and wheelchairs as are considered necessary by the attending physician for the treatment of the disease;

J. Emergency transportation if, in the opinion of the attending physician, it is necessary to transport the insured to another locality for treatment of the disease;

K. Home health care that is necessary care and treatment provided at the covered person's residence by a home health care agency or by others under arrangements made with a home health care agency. The program of care and treatment shall be ordered in

writing by the covered person's attending physician, who shall approve the program prior to its start and renew the order for such care and treatment at least every sixty (60) days. The physician shall certify that hospital confinement would be otherwise required.

1. Home health care coverages shall include:

(a) Services provided by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.);

(b) Home health aide services to the extent that the services would be covered if provided to the insured on an in-patient basis;

(c) Health services provided by physical, occupational, respiratory, or speech and hearing therapists; and

(d) Medical supplies, drugs and medicines prescribed by a physician and related pharmaceutical services, and laboratory services to the extent the charges or costs would be covered under the policy if provided to the insured on an in-patient basis.

L. Physical, respiratory, speech, hearing and occupational therapy;

M. Special equipment including hospital beds, toilettes, pulleys, wheelchairs, aspirators, chux, oxygen, surgical dressings, rubber shields, and colostomy and ileostomy appliances;

N. Prosthetic devices including wigs and artificial breasts; and

O. Nursing home care for noncustodial services.

4. The following minimum benefits standards apply to cancer coverages written on a per diem indemnity basis. The coverages shall offer covered persons:

A. A fixed-sum payment of at least one hundred dollars ($100) for each day of hospital confinement for at least three hundred sixty-five (365) days.

B. A fixed-sum payment equal to one half of the hospital in-patient benefit for each day of hospital or non-hospital out-patient surgery, chemotherapy and radiation therapy, for at least three hundred sixty-five (365) days of treatment.

5. The following minimum benefits standards apply to cancer coverages written on a per diem indemnity basis. Benefits tied to confinement in a skilled nursing home or to receipt of home health care are optional. If a policy offers these benefits, they must equal the following:

A. A fixed-sum payment equal to one-fourth of the hospital

in-patient benefit for each day of skilled nursing home confinement for at least one hundred (100) days;

B. A fixed-sum payment equal to one-fourth of the hospital in-patient benefit for each day of home health care for at least one hundred (100) days;

C. Benefit payments shall begin with the first day of care or confinement after the effective date of coverage if the care or confinement is for a covered disease, even though the diagnosis of a covered disease is made at some later date (but not retroactive more than thirty (30) days from the date of diagnosis) if the initial care or confinement was for diagnosis or treatment of the covered disease;

D. Notwithstanding any other provision of this rule, any restriction or limitation applied to the benefits in subparagraphs A and B of this paragraph, whether by definition or otherwise, shall be no more restrictive than those under Medicare.

6. The following minimum benefits standards apply to lump-sum indemnity coverage of any specified disease(s):

A. The coverages shall pay indemnity benefits on behalf of covered persons for a specifically named disease or diseases. The benefits are payable as a fixed, one-time payment made within thirty (30) days of submission to the health insurer of proof of diagnosis of the specified disease(s). Dollar benefits shall be offered for sale only in even increments of one thousand dollars ($1,000); and

B. Where coverage is advertised or otherwise represented to offer generic coverage of a disease or diseases, the same dollar amounts shall be payable regardless of the particular subtype of the disease with one exception. In the case of clearly identifiable subtypes with significantly lower treatment costs, lesser amounts may be payable so long as the policy clearly differentiates that subtype and its benefits.

5.7. Specified disease coverage. -- A policy covering a single specified disease or combination of diseases shall meet the requirements of subsection 5.6 of this rule and shall not be offered for sale as a policy that limits benefits in a manner contrary to subsection 5.6 of this rule.

§114-39-6. Required Disclosure Provisions.

6.1. Each policy subject to this rule shall include a renewal, continuation or nonrenewal provision. The language or specifications of such provision shall be consistent with the type of policy to be issued. The provision shall be appropriately captioned, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

6.2. Except for riders or endorsements by which the health insurer effectuates a request made in writing by the policyholder or certificate holder, or exercises a specifically reserved

right under the policy, all riders or endorsements added to a policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy require signed acceptance by the policyholder or certificate holder, as appropriate. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the policyholder or certificate holder, as appropriate, except if the increased coverage or benefits are required by law.

6.3. Where a separate additional premium is paid for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy.

6.4. A policy which provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import shall include a definition of those terms within the policy.

6.5. Any provisions limiting or excluding coverage of preexisting conditions shall appear in a separate paragraph of the policy and shall be labeled as "Preexisting Condition Limitations."

6.6. All accident-only policies shall contain on the first page of the policy or attached thereto in either contrasting color or in boldface type at least equal to the size of type used for policy captions, a prominent statement as follows: "This is an accident-only policy, and it does not pay benefits for loss from sickness."

6.7. Any accident-only policy providing benefits which vary according to the type of accidental cause shall prominently set forth the circumstances under which benefits are payable which are less than the maximum amount payable under the policy.

6.8. All specified disease policies shall contain on the first page of the policy or attached thereto, in either contrasting color or in boldface type at least equal to the size of type used for policy captions, a prominent statement as follows: "Caution: This is a limited benefits policy. Read it carefully."

6.9. All policies shall have a notice prominently printed on the first page of the policy or attached thereto, stating in substance that the group policyholder shall have the right to return the policy within ten (10) days of its delivery and to have the premium refunded if, after examination of the policy, the group policyholder is not satisfied for any reason. The notice shall also state that in the event the policyholder exercises this right, the health insurer shall not be obligated to pay any benefits under the policy for claims submitted to the health insurer during such ten (10) day period.

6.10. If age is to be used as a determining factor for reducing the maximum aggregate benefits made available in the policy as originally issued, that fact shall be prominently set forth in the policy and certificate.

6.11. If a policy contains a conversion privilege, it shall comply, in substance, with the

following: The caption of the provision shall be "Conversion Privilege," or words of similar import. The provision shall indicate the persons eligible for conversion; the circumstances applicable to the conversion privilege, including any limitations on the conversion; and the person by whom the conversion privilege may be exercised. The provision shall specify the benefits to be provided on conversion, or may state that the converted coverage will be as provided on a policy form then being used by the health insurer for that purpose.

§114-39-7. Association Group Policy Disclosure, Affiliation of Association and Insurer.

7.1. Each insurer offering coverage under a group accident and sickness policy which is issued to a non bona fide association shall be required to make full disclosure to each applicant who is not already a member of the association on a form approved by the Commissioner. Such disclosure shall be provided at the time the application for coverage is completed.

7.2. Full disclosure under 7.1 above shall state:

a. That the individual must already be or become a member of the association to be eligible for coverage under the group policy;

b. All costs related to association membership, including but not limited to initial association membership fee and the amount of the annual association dues;

c. That membership fees and/or dues are in addition to the policy premium;

d. That the association holds the master policy;

e. That the premium charged and the terms and conditions of coverage are determined between the association and the insurer; and

f. That the premium, terms and conditions of coverage may be changed by agreement of the association group policyholder and the insurer, without the consent of the individual certificate holder.

7.3. In the event the premium, terms and/or conditions of coverage change, a notice of the changes shall be provided to the certificate holders as follows:

a. If the master policyholder is not a bona fide association, the insurer shall notify the certificate holders no later than thirty (30) days prior to a change in the premium, terms and/or conditions of the coverage.

b. If the master policyholder is a bona fide association, the insurer shall notify the group certificate holder of changes in premium, terms and/or conditions of the coverage.

c. If the master policyholder is a bona fide association and there is not a group certificate holder, the insurer shall notify the individual certificate holder of changes in premium, terms and/or conditions of the coverage.

7.4. An insurer may not provide group accident and sickness insurance to an association or other eligible group in which the insurer has an affiliation. "Affiliation" includes but is not limited to:

a. Common board members, officers, executives or employees;

b. Common ownership or control of the insurer, association or other eligible group; or

c. Common use of the same office space or equipment utilized by the insurer to transact insurance.

7.5. An insurer offering group accident and sickness insurance may not make any false, deceptive or misleading statement regarding the insurer's endorsement by the association or other eligible group.

§114-39-8. Billing of Association Dues by an Insurer.

8.1. An insurer which bills association member ship dues shall provide the certificate holders a statement at least annually disclosing the amount of the premium billed by the insurer.

8.2. An insurer which bills association fees and/or dues may not include the cost of the billing for the association in the determination of the premium rate.

§114-39-9. Eligibility of Associations.

9.1. Prior to offering a group accident and sickness insurance policy to an association, an insurer must submit evidence to the commissioner that the association meets the requirements under W. Va. Code §§33-16-1a(a) or 33-16-2(b). The commissioner shall review the evidence and may request additional evidence as needed.

9.2. An insurer shall submit to the commissioner within thirty (30) days any changes in the evidence submitted under subsection 9.1 of this section.

9.3. The commissioner may order an insurer to cease offering accident and sickness insurance to an association if the commissioner determines that the association does not satisfy the requirements under W.Va. Code §§33-16-1 et seq.

§114-39-10. Severability.

If any provision of this legislative rule or the application thereof to any person or circumstance is for any reason held invalid, the remainder of the rule and the application of the provision to other persons or circumstances shall not be affected by the holding.