

WEST VIRGINIA

SECRETARY OF STATE

KEN HECHLER

ADMINISTRATIVE LAW DIVISION

Form #3

FILED

AUG 16 5 12 PM '93

OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

NOTICE OF AGENCY APPROVAL OF A PROPOSED RULE AND FILING WITH THE LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

AGENCY: Insurance Commissioner TITLE NUMBER: 114

CITE AUTHORITY West Virginia Code §§ 33-2-10 and 33-16-3(f)

AMENDMENT TO AN EXISTING RULE: YES ___ NO X

IF YES, SERIES NUMBER OF RULE BEING AMENDED: _____

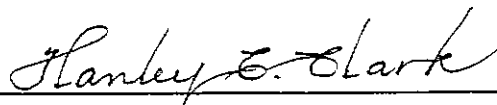
TITLE OF RULE BEING AMENDED: _____

IF NO, SERIES NUMBER OF NEW RULE BEING PROPOSED: Series 39

TITLE OF RULE BEING PROPOSED: Group Accident and Sickness

Insurance Minimum Policy Coverage Standards

THE ABOVE PROPOSED LEGISLATIVE RULE HAVING GONE TO A PUBLIC HEARING OR A PUBLIC COMMENT PERIOD IS HEREBY APPROVED BY THE PROMULGATING AGENCY FOR FILING WITH THE SECRETARY OF STATE AND THE LEGISLATIVE RULE MAKING REVIEW COMMITTEE FOR THEIR REVIEW.



Hanley C. Clark
Insurance Commissioner

14.40



STATE OF WEST VIRGINIA
Offices of the Insurance Commissioner

Legal Division

GASTON CAPERTON
Governor

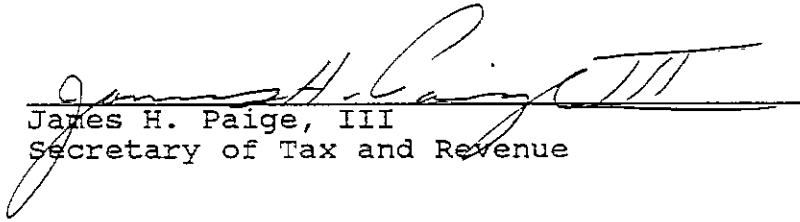
HANLEY C. CLARK
Insurance Commissioner

CONSENT TO PROPOSAL OF RULE

To Whom It May Concern:

Pursuant to West Virginia Code § 5F-2-2(a)(12), the undersigned hereby grants consent to the proposal of the following rule proposed by the Insurance Commissioner of the State of West Virginia: Title 114, Series 39, relating to Group Accident and Sickness Insurance Minimum Policy Coverage Standards.

Signed this 14 day of July, 1993.


James H. Paige, III
Secretary of Tax and Revenue

Insurance Commissioner
Legislative Rule
Title 114, Series 39

FILED
Aug 16 5 12 PM '93

**GROUP ACCIDENT AND SICKNESS INSURANCE
MINIMUM POLICY COVERAGE STANDARDS**

OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

Title 114, Series 39

**BRIEF SUMMARY OF RULE AND
DETAILED STATEMENT OF CIRCUMSTANCES
REQUIRING PROPOSED LEGISLATIVE RULE**

During its 1993 Regular Session, the West Virginia Legislature passed Senate Bill 326 relating to group accident and sickness insurance. The bill amended West Virginia Code § 33-16-3 by adding new subsection (f), which mandates that the Insurance Commissioner promulgate this proposed legislative rule to establish minimum policy coverage standards for group health insurance policies. S.B. 326 also amended other provisions of existing insurance statutes to require that the minimum standards established by this rule apply not only to licensed insurance companies, but also to: hospital, medical, dental and health service corporations; health care corporations; and health maintenance organizations.

This proposed rule establishes minimum policy coverage standards for group accident and sickness insurance. It applies to group accident and sickness insurance policyholders; to subscribers to health care plans sold by hospital, medical, dental and health service corporations and health care corporations; and to enrollees in health maintenance organizations. The rule defines terms used in group health insurance policies, subscriber contracts and health care plans. It also prohibits the use of certain provisions in such insurance policies, subscriber contracts and plans. The rule establishes minimum standards for benefits and requires disclosure of specified provisions in such insurance policies, contracts and plans. The rule is needed to standardize minimum coverage provisions required to be included in group health insurance policies or plans, and to provide specific guidelines for use by the Insurance Commissioner in approving group accident and sickness policy forms and certificate forms.

APPENDIX B

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Group Accident and Sickness Insurance Minimum Policy Coverage Standards (Title 114, Series 39)

Type of Rule: X Legislative Interpretive Procedural

Agency Insurance Commissioner

Address 2019 Washington Street, East

P. O. Box 50540

Charleston, WV 25305-0540

1. Effect of Proposed Rule

	ANNUAL FISCAL YEAR				
	INCREASE	DECREASE	CURRENT	NEXT	THEREAFTER
<u>ESTIMATED TOTAL COST</u>	\$ NONE	\$ NONE	\$ NONE	\$ NONE	\$ NONE
PERSONAL SERVICES					
CURRENT EXPENSE					
REPAIRS & ALTERNATIONS					
EQUIPMENT					
OTHER					

2. Explanation of above estimates:

The proposed rule will have no cost impact on state, local or federal government.

3. Objectives of these rules:

The objectives of this rule are to establish minimum policy coverage standards for group accident and sickness insurance. The rule applies to group health insurance policies sold by insurance companies; to subscriber contracts marketed by health care corporations and hospital, medical, dental and health service corporations; and to enrollment agreements entered into by persons using the services of health maintenance organizations.

Rule Title: Group Accident and Sickness Insurance Minimum
Policy Coverage Standards (Title 114, Series 39)

4. Explanation of Overall Economic Impact of Proposed Rule.

A. Economic Impact on State Government.

The rule will have no economic impact on state government.

B. Economic Impact on Political Subdivisions; Specific Industries; Specific groups of Citizens.

The rule will have no economic impact on political subdivisions or specific groups of citizens. It may increase administrative costs for sellers of group health insurance policies, health care plans or services provided by health maintenance organiza-

C. Economic Impact on Citizens/Public at Large. tions.

Depending upon coverages currently being sold by health care insurers and the other insuring entities subject to this rule, the public at large may receive greater benefits in return for the dollars they spend on health insurance, health care plans and services provided by health maintenance organizations

Date: July 8, 1993

Signature of Agency Head or Authorized Representative

Hanley C. Clark

Hanley C. Clark
Insurance Commissioner

DATE: AUGUST 16, 1993

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

FROM: OFFICE OF THE INSURANCE COMMISSIONER

Group Accident and Sickness Insurance Minimum
LEGISLATIVE RULE TITLE: Policy Coverage Standards (Title 114, Series 39)

1. Authorizing statute(s) citation West Virginia Code
§§ 33-2-10 and 33-16-3(f)

2. a. Date filed in State Register with Notice of Hearing
July 16, 1993

b. What other notice, including advertising, did you give
of the hearing?

None

c. Date of Hearing(s) The public comment period, held in lieu
of a hearing, ended on August 16, 1993 at 8:00 a.m. EDT.

d. Attach list of persons who appeared at hearing,
comments received, amendments, reasons for amendments.

Attached xx No comments received

e. Date you filed in State Register the agency approved
proposed Legislative Rule following public hearing:
(be exact)

August 16, 1993

f. Name and phone number(s) of agency person(s) to
contact for additional information:

Linda Gay

Associate Counsel, Office of the Insurance Commissioner

(304) 558-0401

3. If the statute under which you promulgated the submitted rules requires certain findings and determinations to be made as a condition precedent to their promulgation:

a. Give the date upon which you filed in the State Register a notice of the time and place of a hearing for the taking of evidence and a general description of the issues to be decided.

Not applicable

b. Date of hearing: Not applicable

c. On what date did you file in the State Register the findings and determinations required together with the reasons therefor?

Not applicable

d. Attach findings and determinations and reasons:

Attached Not applicable

114CSR39

TITLE 114
LEGISLATIVE RULE
INSURANCE COMMISSIONER

SERIES 39
GROUP ACCIDENT AND SICKNESS INSURANCE
MINIMUM POLICY COVERAGE STANDARDS

Section

- 114-39-1. General
- 114-39-2. Definitions
- 114-39-3. Policy Definitions
- 114-39-4. Prohibited Policy Provisions
- 114-39-5. Minimum Standards for Benefits
- 114-39-6. Required Disclosure Provisions
- 114-39-7. Severability

FILED

114CSR39

AUG 16 5 12 PM '93

TITLE 114
LEGISLATIVE RULE
INSURANCE COMMISSIONER

OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

SERIES 39
GROUP ACCIDENT AND SICKNESS INSURANCE
MINIMUM POLICY COVERAGE STANDARDS

§ 114-39-1. General

1.1. 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 and health care corporations, and enrollee agreements and contracts of health maintenance organizations; 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; and to provide for full disclosure in the sale of such policies, contracts and agreements.

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

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

1.2.b. Accident and sickness insurance contracts covering members of fraternal benefit societies organized pursuant to West Virginia Code Chapter 33, Article 23;

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

1.2.d. Medicare supplement insurance policies subject to WV 114CSR24 "Permanent Regulations on Medicare Supplement Insurance";

Insurance Commissioner
Legislative Rule
Title 114, Series 39

1.2.e. Group minimum benefits accident and sickness insurance policies subject to WV 114CSR33 "Individual and Employer Group Minimum Benefits Accident and Sickness Insurance Policies";

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

1.2.g. Coverage under the West Virginia Public Employees Insurance Act (West Virginia Code Chapter 5, Article 16);

1.2.h. Coverage under Medicare or Medicaid; and

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

The requirements contained in this rule are in addition to any other applicable rules previously adopted.

1.3. Authority. -- West Virginia Code §§ 33-2-10 and 33-16-3(f).

1.4. Filing Date. --

1.5. Effective Date. --

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

2.3. "Commissioner" means the Insurance Commissioner of the State of West Virginia.

2.4. "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 hospital, medical, dental or health service corporation organized pursuant to West Virginia Code Chapter 33,

Insurance Commissioner
Legislative Rule
Title 114, Series 39

Article 24; a health care corporation organized pursuant to West Virginia Code Chapter 33, Article 25; or a health maintenance organization organized pursuant to West Virginia Code Chapter 33, Article 25A.

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

2.6. "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.

2.7. "Policy" means any policy, plan, contract, agreement, provision, rider or endorsement delivered or issued for delivery in this State by an insurer subject to this rule.

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

§ 114-39-3. Policy Definitions

3.1. Except as provided hereafter, no policy or certificate subject to this rule may be advertised, solicited, delivered or issued for delivery in this State unless such policy or certificate contains definitions or terms which conform to the requirements of this section.

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.

3.2.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

Insurance Commissioner
Legislative Rule
Title 114, Series 39

disease or bodily infirmity or any other cause, and occurs while the insurance coverage is in force.

3.2.b. Such 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.

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

3.3.a.A. Be operated pursuant to law;

3.3.a.B. Be approved for payment of Medicare benefits or be qualified to receive such approval if so requested;

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

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

3.3.a.E. Maintain a daily medical record of each patient.

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

3.3.b.A. Any home, facility, or part thereof used primarily for rest;

3.3.b.B. A home or facility for the aged or for the care of drug addicts or alcoholics; or

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

Insurance Commissioner
Legislative Rule
Title 114, Series 39

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.

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

3.4.a.A. Be an institution operated pursuant to law;

3.4.a.B. 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

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

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

3.4.b.A. Convalescent homes, convalescent, rest or nursing facilities;

3.4.b.B. Facilities primarily affording custodial, educational or rehabilitory care;

3.4.b.C. Facilities for the aged, drug addicts or alcoholics; or

3.4.b.D. 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 such 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

Insurance Commissioner
Legislative Rule
Title 114, Series 39

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 such terms requires the insurer to recognize the services of any individual who qualifies under such 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 such terms requires an insurer to recognize and to accept, to the extent of its obligation under the policy, all providers of medical care and treatment when such 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

Insurance Commissioner
Legislative Rule
Title 114, Series 39

the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within a two-year (2-year) period preceding the effective date of the coverage of the insured person under the policy, or a condition for which medical advice or treatment was recommended by a physician or received from a physician within a two-year (2-year) period preceding the effective date of the coverage of the insured person 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 insurer may use "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 requiring that the individual who is totally disabled not be 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 not be engaged in any employment or occupation for wage or profit.

3.14.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:

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

3.14.a.B. Engage in any training or rehabilitation program.

3.14.b. An 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. An 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 utilize an initial premium which is less than a pro rata portion of the applicable annual premium.~~

~~4.2.~~ 4.1. No policy may exclude coverage for a loss due to a preexisting condition for a period greater than twelve (12) months following policy issue.

~~4.3.~~ 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.

~~4.4.~~ 4.3. 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.~~ 4.4. 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 deemed 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. The following minimum standards for benefits are prescribed for the categories of coverage noted in the following

subsections. No policy or certificate may be delivered or issued for delivery in this State which does not meet the required minimum standards for the specified categories, unless the Commissioner finds that policies or certificates 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 West Virginia Code § 33-6-9.

5.1.a. 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.

5.1.b. In the event the insurer cancels or refuses to renew, policies providing pregnancy benefits 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.

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

5.1.d. 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 such date, the insurer receive due proof of such 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.

5.1.e. 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.

5.1.f. 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 such disability.

5.1.g. 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 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.

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

5.1.i. Termination of the policy by the insurer 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 insured or limited to the duration of the policy benefit period, if any.

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 per cent (5%) of the aggregate maximum limit under the policy, unless the policy is written to complement underlying hospital and medical insurance in which case such deductible may be increased by the amount of the benefits provided by such underlying insurance, for each covered person for at least:

5.3.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;

5.3.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;

5.3.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 such surgical procedure.

5.3.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 therein for anesthesia services at the same unit value as used for the surgical schedule;

5.3.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 call, one (1) call per day, for at least twenty-one (21) such calls during one period of confinement.

5.3.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

5.3.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.

5.4.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 thereof that:

5.4.a.A. 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).

5.4.a.B. Contains an elimination period no greater than:

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

5.4.a.B.(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

5.4.a.B.(c). Three hundred sixty-five (365) days in all other cases during the continuance of disability resulting from sickness or injury.

5.4.a.C. 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.

5.4.b. Subsection 5.4 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.

5.6.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 subparagraphs 5.6.a.C, 5.6.a.D, and 5.6.a.E

herein. Insurance covering specified disease(s) other than cancer shall meet the standards of subparagraphs 5.6.a.B or 5.6.a.E.

5.6.a.A. 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 shall 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 ones shall govern:

5.6.a.A.(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.

5.6.a.A.(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.

5.6.a.A.(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 condition(s) or disease(s) directly caused or aggravated by the specified diseases(s) or the treatment of the specified disease(s).

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

5.6.a.A.(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. Such statement may be combined with any other statement for which the insurer may require the applicant's signature.

5.6.a.A.(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.

5.6.a.A.(g). Except for the uniform provision regarding other insurance with this insurer, benefits

for specified disease coverage shall be paid regardless of other coverage available through other individual health insurance.

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

5.6.a.B. The following minimum benefits standards apply to noncancer coverages:

5.6.a.B.(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:

5.6.a.B.(a)(A). Hospital room and board and any other hospital-furnished medical services or supplies;

5.6.a.B.(a)(B). Treatment by a legally qualified physician or surgeon;

5.6.a.B.(a)(C). Private duty services of a registered nurse (R.N.);

5.6.a.B.(a)(D). X-ray, radium and other therapy procedures used in diagnosis and treatment;

5.6.a.B.(a)(E). Professional ambulance for local service to or from a local hospital;

5.6.a.B.(a)(F). Blood transfusions, including expenses incurred for blood donors;

5.6.a.B.(a)(G). Drugs and medicines prescribed by a physician;

5.6.a.B.(a)(H). Rental of a mechanical ventilator or similar mechanical apparatus;

5.6.a.B.(a)(I). Braces, crutches and wheelchairs as are deemed necessary by the attending physician for the treatment of the disease;

5.6.a.B.(a)(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; and

5.6.a.B.(a)(K). Any other expenses necessarily incurred in the treatment of the disease.

5.6.a.B.(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.

5.6.a.C. 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:

5.6.a.C.(a). Treatment by, or under the direction of, a legally qualified physician or surgeon;

5.6.a.C.(b). X-ray, radium, chemotherapy and other therapy procedures used in diagnosis and treatment;

5.6.a.C.(c). Hospital room and board and any other hospital-furnished medical services or supplies;

5.6.a.C.(d). Blood transfusions, and the administration thereof, including expenses incurred for blood donors;

5.6.a.C.(e). Drugs and medicines prescribed by a physician;

5.6.a.C.(f). Professional ambulance for local service to or from a local hospital;

Insurance Commissioner
Legislative Rule
Title 114, Series 39

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

5.6.a.C.(h). Any other expenses necessarily incurred in the treatment of the disease: **Provided**, That subdivisions 5.6.a.C.(a), 5.6.a.C.(b), 5.6.a.C.(d), 5.6.a.C.(e), and 5.6.a.C.(g), 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:

5.6.a.C.(i). Braces, crutches and wheelchairs as are deemed necessary by the attending physician for the treatment of the disease;

5.6.a.C.(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; and

5.6.a.C.(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.

5.6.a.C.(k)(A). A "home health care agency" is (1) an agency approved under Title XVIII of the Social Security Act (42 U.S.C. § 1395 et seq.) (Medicare), or (2) an agency certified to provide home health care in this State.

5.6.a.C.(k)(B). Home health care coverages shall include:

5.6.a.C.(k)(B)1. Services provided by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.);

5.6.a.C.(k)(B)2. Home health aide services to the extent that such services would be covered if provided to the insured on an in-patient basis;

5.6.a.C.(k)(B)3. Health services provided by physical, occupational, respiratory, or speech and hearing therapists; and

Insurance Commissioner
Legislative Rule
Title 114, Series 39

5.6.a.C.(k)(B)4. Medical supplies, drugs and medicines prescribed by a physician and related pharmaceutical services, and laboratory services to the extent such charges or costs would be covered under the policy if provided to the insured on an in-patient basis.

5.6.a.C.(l). Physical, respiratory, speech, hearing and occupational therapy;

5.6.a.C.(m). Special equipment including hospital beds, toilettes, pulleys, wheelchairs, aspirators, chux, oxygen, surgical dressings, rubber shields, colostomy and ileostomy appliances;

5.6.a.C.(n). Prosthetic devices including wigs and artificial breasts; and

5.6.a.C.(o). Nursing home care for noncustodial services.

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

5.6.a.D.(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.

5.6.a.D.(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.

5.6.a.D.(c) 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:

5.6.a.D.(c)(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.

5.6.a.D.(c)(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.

Insurance Commissioner
Legislative Rule
Title 114, Series 39

5.6.a.D.(c)(C). Benefit payments shall begin with the first day of care or confinement after the effective date of coverage if such 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 such covered disease.

5.6.a.D.(c)(D). Notwithstanding any other provision of this rule, any restriction or limitation applied to the benefits in 5.6.a.D.(c)(A) and 5.6.a.D.(c)(B), whether by definition or otherwise, shall be no more restrictive than those under Medicare.

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

5.6.a.E.(a). Such coverages shall pay indemnity benefits on behalf of covered persons for a specifically named disease or diseases. Such benefits are payable as a fixed, one-time payment made within thirty (30) days of submission to the 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).

5.6.a.E.(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.

5.6.b. Specified Accident Coverage. -- "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.

5.7. Limited Benefits Insurance Coverage. -- "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. A policy covering a single specified disease or combination of diseases shall meet the requirements of subsection 5.6 and shall not be offered for sale as a limited benefits policy.

§ 114-39-6. Required Disclosure Provisions

6.1. Each policy or certificate 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 or certificate to be issued. Such 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 or certificate is issued and for which it may be renewed.

6.2. Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder or certificateholder, 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 shall require signed acceptance by the policyholder or certificateholder, as appropriate. After 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 certificateholder, 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, such 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 such 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.

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, such 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 insurer for that purpose.

§ 114-39-7. Severability

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

ATTACHMENT TO QUESTION 2(d):

Richard W. Adkins, Associate Corporate Counsel for Mountain State Blue Cross & Blue Shield, Inc., ("MSBCBS") of Parkersburg, West Virginia, submitted comments to the Insurance Commissioner ("Commissioner") regarding this proposed new Series 39 rule on minimum policy coverage standards for group accident and sickness insurance. A copy of Mr. Adkins' comments, contained in an August 13, 1993 letter to Associate Counsel Linda Gay of the Commissioner's office, is attached hereto and incorporated herein by reference.

Prior to setting forth his responses to the section-by-section comments of MSBCBS regarding this proposed rule, the Commissioner wishes to note at the outset that many of the rule provisions criticized by MSBCBS have been in effect for eighteen years as part of his existing Series 12 rule on individual health insurance that took effect April 1, 1975 ("the existing Series 12 rule"). Other provisions of this new agency-approved group health insurance rule are based upon portions of the National Association of Insurance Commissioners' (NAIC) "Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act" adopted by the NAIC in July 1989 ("the Model Regulation"). Where appropriate, the Commissioner has either used verbatim or adapted certain provisions of the existing Series 12 rule on individual health insurance or the Model Regulation in drafting this new agency-approved rule establishing minimum standards for group health insurance.

The Commissioner's response to the comments filed on behalf

of MSBCBS are set forth below, in the same section order in which the comments appear in Mr. Adkins' aforementioned August 13, 1993 letter.

Section 1.2.g excepts the West Virginia Public Employees Insurance Agency (PEIA) from the provisions of this rule. This section merely recognizes that, as a matter of law, the Commissioner has no jurisdiction or authority over the PEIA, which is governed by the provisions of West Virginia Code Chapter 5, Article 16 and not by the state's insurance statutes contained in West Virginia Code Chapter 33. Therefore, the Commissioner declines to delete **Section 1.2.g** from this agency-approved rule.

Sections 3.2 and 3.2.a of this rule define "accident," "accidental injury," "accidental means" and "injury or injuries, for which benefits are payable." These definitions are based on Section 5D of the Model Regulation, and similar definitions are contained in the existing Series 12 rule. They have been modified somewhat in the instant agency-approved rule, in accordance with updated language used in parallel definitions in the July 1991 model regulation of the NAIC relating to Medicare supplement insurance. (This model rule is the basis for the Commissioner's existing "Permanent Regulations on Medicare Supplement Insurance" at 114CSR24.) Therefore, the Commissioner declines to change these definitions in this agency-approved rule governing group health insurance.

Section 3.4.b.D and 4.3 sparked comments by MSBCBS. The definition of "hospital" in **Section 3.4.b.D** in this agency-approved rule is based upon Section 5B(2)(d) of the Model

Regulation, except for the proviso which reiterates a prohibition contained in West Virginia Code § 33-16-7. That statute bars a group accident and sickness insurance policy providing hospital indemnity coverage from excluding coverage because of confinement in a state or federal government hospital. The Commissioner has relied upon the expertise of the NAIC in using this model provision in this agency-approved rule on group health insurance. He notes that MSBCBS has failed to cite with specificity the federal law that it believes might be violated by **Section 3.4.b.D** of this agency-approved rule, which the Commissioner declines to modify or delete.

Section 4.3 of this proposed new rule relates solely to group accident and sickness insurance policies providing hospital confinement indemnity coverage. It embodies the express requirements of West Virginia Code § 33-16-7, discussed in the preceding paragraph. Therefore, the Commissioner declines to modify or delete this section of the agency-approved rule pursuant to comments made by MSBCBS.

Section 4.1 of this agency-approved rule is the same as Section 3(a) of the existing Series 12 rule, which establishes minimum standards for individual accident and sickness insurance. The Model Regulation does not contain any provision similar to **Section 4.1** of this agency-approved group health insurance rule. The Commissioner agrees with MSBCBS that Section 4.1 of his proposed new Series 39 rule may deprive group health insurers and their potential customers of some flexibility regarding premium payment arrangements. Therefore, the Commissioner has deleted

Section 4.1 from this agency-approved Series 39 rule filed on August 16, 1993 with the West Virginia Legislative Rule-Making Review Committee (WVLRMRC) and the West Virginia Secretary of State.

Section 4.5 is virtually identical to Section 3(g) of the existing Series 12 rule, which took effect in West Virginia in the individual health insurance context more than eighteen years ago. Much of the language in this section of this new agency-approved rule regarding group health insurance is taken verbatim from Section 6H of the Model Regulation. The Commissioner concedes that **Section 4.5** of this agency-approved rule gives him broad discretionary powers to disapprove policy provisions which, in his opinion, are unjust, unfair or unfairly discriminatory. The Commissioner disagrees with the MSBCBS comment that the language of this section is "overbroad and . . . an improper delegation of legislative authority." Therefore, he declines to revise or delete **Section 4.5** from this agency-approved rule.

Section 5.1 of this rule cross-references the requirements of West Virginia Code § 33-6-9, which sets forth grounds that the Commissioner may use to disapprove or withdraw approval of insurance policy forms, applications and riders. MSBCBS contends that it is exempt from the provisions of West Virginia Code § 33-6-9, in accordance with West Virginia Code § 33-24-4. MSBCBS therefore maintains that **Section 5.1** of this agency-approved rule "is an unlawful attempt to extend this statute [Code § 33-6-9] to cover health service corporations such as MSBCBS." However, during its 1993 Regular Session, the West

Virginia Legislature passed Senate Bill 326 which changed the exemption claimed by MSBCBS. This legislation amended West Virginia Code § 33-16-3 to mandate that the Commissioner promulgate the instant agency-approved rule. Senate Bill 326 also amended West Virginia Code § 33-24-4 to specify that the provisions of West Virginia Code Chapter 33, Article 16 apply to health service corporations, including MSBCBS. (See lines 22-23 on page 3 of the attached copy of the Enrolled Committee Substitute for Senate Bill 326.) Therefore, reading West Virginia Code §§ 33-16-3 and 33-24-4 together with **Section 5.1** of the instant agency-approved rule, it is clear that MSBCBS and other insuring entities organized pursuant to West Virginia Code Chapter 33, Article 24 are now subject to the requirements of West Virginia Code § 33-6-9. For this reason, the Commissioner disagrees with the comments of MSBCBS regarding **Section 5.1** of this agency-approved rule and declines to revise or delete the same.

Section 5.1.b is a provision of the instant rule that appears in similar form as Section 4.2(f) of the existing Series 12 and Section 7A(6) of the Model Regulation on individual health insurance policies. **Section 5.1.b** of this agency-approved rule on group accident and sickness insurance relates to extension of pregnancy benefits. In the event that an insurer cancels or refuses to renew a group health insurance policy providing 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, the insurer must continue such pregnancy

benefits. The Commissioner does not intend to modify this consumer protection provision, which the insurance industry in West Virginia has managed to accommodate in the individual health insurance context since 1975, in his proposed Series 39 rule on group health insurance. Therefore, the Commissioner declines to revise or delete **Section 5.1.b** from this agency-approved rule.

Section 5.1.d contains provisions on continuation of health insurance coverage under specified conditions for a child of an insured after that child attains any limiting age set forth in the group health insurance policy. MSBCBS suggests that this section should reference Internal Revenue Code dependency requirements in subdivision two. The Commissioner disagrees that federal income tax law need be used to define dependency of an insured's adult child for health insurance purposes. The language of Section 5.1.d in this agency-approved rule is based upon similar wording in Section 4.2(h) of the existing Series 12 rule and Section 7A(8) of the Model Regulation. The Commissioner prefers to use these two rules as the basis for the dependency language in this agency-approved rule, rather than adopting Internal Revenue Code dependency requirements.

Section 5.1.i is the same as a provision that has been included in Section 4.2(n) of the existing Series 12 rule in West Virginia since 1975. It is also virtually identical to Section 7A(14) of the Model Regulation. The Commissioner declines to eliminate this pro-consumer provision, which relates to extension of benefits for a continuous loss following termination of a group health insurance policy subject to certain specified

limitations, from the instant agency-approved rule applicable to group accident and sickness insurance.

Sections 5.3 and 5.3.e of this proposed rule, relating to major medical expense coverage elicited comments from MSBCBS to the effect that these expenses should not be subject to eighty (80%) percent payment requirement placed on the insurer. This requirement is included in the existing Series 12 rule and the Model Regulation relating to individual health insurance, and the Commissioner finds no compelling reason to adopt a different requirement in this agency-approved rule on group health insurance.

Section 5.3.c employs "reasonably related" language regarding insurance coverage for expenses for each medically necessary surgical procedure after the first that is performed during the course of a single operation. MSBCBS maintains that such language is unclear and vague. The Commissioner paraphrased the wording of **Section 5.3.c** of this agency-approved rule from the PEIA's current explanation of surgical benefits for its members. The reasonableness standard employed in this section of this newly proposed rule is a commonly used objective legal test. The Commissioner does not believe that this "reasonably related" language is unclear or vague in the context in which it appears in **Section 5.3.c**. He therefore declines to modify this wording.

Sections 5.3.f. and 5.3.g are criticized in the MSBCBS comments because they make no reference to services that can be excluded from a group health insurance policy for out-of-hospital care and prosthetic appliances, respectively. The Commissioner

notes that these two sections, both of which are contained in the existing Series 12 rule, adequately describe what items and services must be included as minimum benefits provided under a group health insurance policy. He believes that these sections do not need to list specific items and services that an insurer can exclude from these two categories of major medical expense coverage. Therefore, the Commissioner declines to change these two sections of this agency-approved rule.

Section 6.2 of this proposed new rule is, according to comments filed by MSBCBS, "totally inappropriate for the group [health insurance] setting." The Commissioner disagrees with that characterization. However, he has modified the language in **Section 6.2** of the agency-approved rule to clarify that this section's required disclosures must be made by an insurer only to a group policyholder, and not to each individual certificateholder covered under the group health insurance policy. The Commissioner disagrees with the comment by MSBCBS that the insurer can apparently avoid having to make the disclosures required under this section, simply by reserving the right to amend the group policy at any time--without giving notice of any such amendments to the group policyholder. This section of this new agency-approved rule is a consumer protection provision which requires disclosure to and acceptance by the group policyholder of certain riders and endorsements added to an existing group health insurance policy. This section is nearly identical to Section 8A(2) of the Model Regulation. The Commissioner deems the disclosure requirements contained in this

section to be appropriate in the group health insurance context, and he therefore declines to revise or delete **Section 6.2** from this agency-approved rule.

Section 6.3 of this rule requires that any separate additional premium paid for benefits in connection with riders or endorsements shall be set forth in the "policy," which MSBCBS contends should be changed to "group contract" instead. However, the Commissioner maintains that this suggested language change is not necessary. "Policy" is defined in Section 2.7 of this agency-approved rule to include any contract of an "insurer" (which is defined in Section 2.4 to include a health service corporation such as MSBCBS) subject to this rule.

Section 6.9 requires a ten-day "free look" or trial examination provision in any group health insurance policy, which permits the group policyholder (but not an individual certificateholder covered under the group policy) to return the policy for any reason and have its premium refunded by the insurer. This section parallels a provision in the NAIC model regulation on group long-term care insurance upon which the Commissioner's existing long-term care insurance legislative rule (114CSR32) is based. An insurer can wait until after this ten-day "free look" period has ended before incurring any expense for printing and issuing identification cards, benefit brochures and the like. Therefore, the Commissioner declines to revise or delete **Section 6.9** of this agency-approved rule.



Mountain State
Blue Cross Blue Shield

700 Market Square
P.O. Box 1948
Parkersburg, West Virginia 26102

Local 304 / 424-7700
Toll Free 800 / 544-5514

Writer's Direct Dial Number

August 13, 1993

Linda Gay, Esquire
Associate Counsel
Offices of the Insurance Commissioner
2019 Washington Street, East
Charleston, West Virginia 25305-0540

RE: GROUP ACCIDENT AND SICKNESS INSURANCE MINIMUM POLICY COVERAGE STANDARDS

Dear Ms. Gay:

Please accept the following comments of Mountain State Blue Cross & Blue Shield, Inc., concerning the above entitled regulation:

- Section 1.2.g. As a matter of policy, governments should not impose requirements on private entities which it will not enforce against itself, particularly when the government is in direct competition with those private entities.
- Section 3.2. and Section 3.2.a. The definition is unclear inasmuch as it uses the defined term in the definition itself.
- Section 3.4.b.D. It is unclear whether this section complies with the federal law allowing private insurers to exempt coverage for veterans for service related accidents, injuries or illnesses.
- Section 4.1. This provision would apparently disallow contingent premium agreements wherein a group pays a percentage (usually 80% - 95%) of the full premium throughout the year and then pays the excess, if any, of claims expense over premium, usually if it exceeds 105%. These arrangements are requested by knowledgeable groups who do not need the protection afforded by this provision.
- Section 4.3. See comment to Section 3.4.b.D.
- Section 4.5. This section is overbroad and is an improper delegation of

legislative authority.

- Section 5.1. MSBCBS is exempt from the requirements of W.Va. Code Section 33-6-9 in accordance with W.Va. Section 33-24-4. Accordingly, this is an unlawful attempt to extend this statute to cover health services corporations.
- Section 5.1.b. The insurer should be able to cancel for non-payment of premium without having to continue to pay benefits beyond the period for which premiums have been paid. Furthermore, MSBCBS insures against the cost of health care not against the disease, injury, illness or condition itself. In addition, if the subscriber has moved out of area, payment of benefits may result in transacting the business of insurance in a state for which the insurer has no license.
- Section 5.1.d. Subdivision two should reference Internal Revenue Code dependency requirements.
- Section 5.1.i. See comments to Section 5.1.b.
- Section 5.3. The 80% requirement does not recognize the payment differentials normally associated with preferred provider organization (PPO) contracts. In addition, it reduces the group's options to obtain lower premiums in return for higher co-payments. This provision would price some groups out of the market. It would eliminate all of our managed care and PPO products, particularly those in the Northern Panhandle. Furthermore, MSBCBS limits out of pocket expenses (stop-loss) to limit group members' exposure.
- Section 5.3.c. The "reasonably related" language is unclear and vague.
- Section 5.3.g. See our comments to Section 5.3.
- Section 5.3.f. There is no reference to what services can be excluded.
- Section 5.3.e. See our comments to Section 5.3.f.
- Section 6.2. This provision is totally inappropriate for the group setting. The group selects the benefits for the members of the group. If each member of a group is allowed to pick and choose benefits, there would be chaos in the administration of groups. In addition, allowing subscribers to individually accept or deny benefits allows adverse selection. Insurers need to add or delete benefits to the entire risk pool as a whole in order to adequately distribute the risk. Apparently, however, if the insurer reserves the right to amend the

policy at any time, this procedure need not be followed.

Section 6.3. This requirement should relate to the "group contract", not policy.

Section 6.9. This requirement does not recognize the expenses associated with enrolling groups (identification cards, benefit booklets, etc.), the sophistication of the group administrators (they know what they are purchasing), not the inability of some groups to retain its previous carrier. The provision should be deleted. Consider the expenses an insurer would incur if it enrolled onto its computer system, issued identification cards and benefit booklets to a group of 1,000 members. As a practical matter, MSBCBS allows groups to cancel upon thirty days notice. Furthermore, the provision will not protect groups inasmuch as it takes between sixty to ninety days to find replacement coverage.

I hope these comments will be helpful. Should you need to contact us concerning these comments, please do not hesitate to do so. We would like to discuss the regulations at your convenience.

Sincerely,



Richard W. Adkins
Associate Corporate Counsel

RWA/kj

MODEL REGULATION TO IMPLEMENT THE INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE MINIMUM STANDARDS ACT

Table of Contents

Section 1.	Purpose
Section 2.	Authority
Section 3.	Applicability and Scope
Section 4.	Effective Date
Section 5.	Policy Definitions
Section 6.	Prohibited Policy Provisions
Section 7.	Accident and Sickness Minimum Standards for Benefits
Section 8.	Required Disclosure Provisions
Section 9.	Requirements for Replacement
Section 10.	Separability

Section 1. Purpose

The purpose of this regulation is to implement [cite section of law which sets forth the NAIC Individual Accident and Sickness Insurance Minimum Standards Act] so as to provide reasonable standardization and simplification of terms and coverages of individual accident and sickness insurance policies and individual subscriber contracts of hospital, medical and dental service corporations in order to facilitate public understanding and comparison and to eliminate provisions contained in individual accident and sickness insurance policies and individual subscriber contracts of hospital, medical and dental service corporations which may be misleading or confusing in connection either with the purchase of such coverages or with the settlement of claims, and to provide for full disclosure in the sale of such coverages.

Section 2. Authority

This regulation is issued pursuant to the authority vested in the commissioner under [cite appropriate section of law enacting NAIC Individual Accident and Sickness Insurance Minimum Standards Act and any other appropriate section of law regarding authority of commissioner to issue or promulgate rules and regulations].

Section 3. Applicability and Scope

This regulation shall apply to all individual accident and sickness insurance policies and subscriber contracts of hospital, medical and dental service corporations delivered or issued for delivery in this state on and after the effective date hereof, except it shall not apply to:

- A. Individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when such group or individual policy or contract includes provisions which are inconsistent with the requirements of this regulation;
- B. Policies being issued to employees or members as additions to franchise plans in existence on the effective date of this regulation;
- C. Medicare supplement policies subject to [cite rule implementing the Medicare Supplement Insurance Minimum Standards Regulation];
- D. Long-term care insurance policies subject to [cite rule implementing the Long-Term Care Insurance Act].

The requirements contained in this regulation shall be in addition to any other applicable regulations previously adopted.

Section 4. Effective Date

This regulation shall be effective on [insert a date not less than 120 days after the date of adoption or promulgation of the regulation] and shall be applicable to all individual accident and sickness insurance policies and nonprofit hospital, medical and dental service contracts delivered or issued for delivery in this state on and after such date which are not specifically exempt from this regulation.

Section 5. Policy Definitions

Except as provided hereafter, no individual accident or sickness insurance policy or hospital, medical or dental service corporation subscriber contract delivered or issued for delivery to any person in this state and to which this regulation applies shall contain definitions respecting the matters set forth below unless such definitions comply with the requirements of this section.

- A. "One 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 occurs 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 180 days.
- B. "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.
- (1) The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital:
- (a) Be an institution operated pursuant to law; and
 - (b) 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
 - (c) Provide twenty-four-hour nursing service by or under the supervision of registered graduate professional nurses (R.N.s).
- (2) The definition of the term "hospital" may state that such term shall not be inclusive of:
- (a) Convalescent homes, convalescent, rest, or nursing facilities; or
 - (b) Facilities primarily affording custodial, educational or rehabilitary care; or
 - (c) Facilities for the aged, drug addicts or alcoholics; or
 - (d) 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 such services.

Drafting Note: The laws of the several states relating to the type of hospital facilities recognized in health insurance policies are not uniform. References to individual state law may be required in structuring this definition of this regulation.

- C. "Convalescent Nursing Home," "Extended Care Facility," or "Skilled Nursing Facility" shall be defined in relation to its status, facilities, and available services.
- (1) A definition of such home or facility shall not be more restrictive than one requiring that it:
 - (a) Be operated pursuant to law;
 - (b) Be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested;
 - (c) Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;
 - (d) Provide continuous twenty-four-hour-a-day nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and
 - (e) Maintains a daily medical record of each patient.
 - (2) The definition of such home or facility may provide that such term shall not be inclusive of:
 - (a) Any home, facility or part thereof used primarily for rest;
 - (b) A home or facility for the aged or for the care of drug addicts or alcoholics; or
 - (c) A home or facility primarily used for the care and treatment of mental diseases, or disorders, or custodial or educational care.

Drafting Note: The laws of the several states relating to nursing and extended care facilities recognized in health insurance policies are not uniform. Reference to the individual state law may be required in structuring this definition of this regulation.

- D. "Accident," "Accidental Injury," "Accidental Means" shall be defined to employ "result" language and shall 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.

The definition shall 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 are the direct cause, independent of disease or bodily infirmity or any other cause and occur while the insurance is in force.

Such definition may provide that injuries shall not include injuries for which benefits are provided under workmen's compensation, employer's liability or similar law, motor vehicle no-fault plan, unless prohibited by law, or injuries occurring while the insured person is engaged in any activity pertaining to any trade, business, employment, or occupation for wage or profit.

- E. "Sickness" shall not be defined to be more restrictive than the following: Sickness means sickness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force. A definition of sickness may provide for a probationary period which will not exceed thirty (30) days from the effective date of the coverage of the insured person. The definition may be further modified to exclude sickness or disease for which benefits are provided under any workman's compensation, occupational disease, employer's liability or similar law.

Minimum Benefits Standards Regulation

- F. "Preexisting condition" shall not be defined to be more restrictive than the following: Preexisting condition means the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within a five (5) year period preceding the effective date of the coverage of the insured person or a condition for which medical advice or treatment was recommended by a physician or received from a physician within a five (5) year period preceding the effective date of the coverage of the insured person.

Drafting Note: This definition does not prohibit an insurer, using an application form designed to elicit the complete health history of a prospective insured and on the basis of the answers on that application, from underwriting in accordance with that insurer's established standards. It is assumed that an insurer that elicits a complete health history of a prospective insured will act on the information and if the review of the health history results in a decision to exclude a condition, the policy will be endorsed or amended by including the specific exclusion. This same requirement of notice to the prospective insured of the specific exclusion will also apply to insurers which elect to use simplified application forms containing questions relating to the prospective insured's health.

This definition does, however, prohibit an insurer that elects to use a simplified application, with or without a question as to the applicant's health at the time of application, from reducing or denying a claim on the basis of the existence of a preexisting condition that is defined more restrictively than above.

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

Note: The laws of the several states relating to the type of practitioners services recognized in health insurance policies are not uniform. References to the individual state law may be required in structuring this definition of this regulation.

- H. "Nurses" 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" or "registered nurse" are used without specific instruction, then the use of such terms requires the insurer to recognize the services of any individual who qualifies under such terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state.

I. "Total Disability"

- (1) A general definition of total disability cannot be more restrictive than one requiring that the individual who is totally disabled not be engaged in any employment or occupation for which he is or becomes qualified by reason of education, training or experience; and not in fact engaged in any employment or occupation for wage or profit.
- (2) 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:
 - (a) Perform "any occupation whatsoever," "any occupational duty," or "any and every duty of his occupation," or
 - (b) Engage in any training or rehabilitation program.
- (3) An insurer may specify the requirement of the complete inability of the person to perform all of the substantial and material duties of his regular occupation or words of similar import. An insurer may require care by a physician (other than the insured or a member of the insured's immediate family).

MAR 27 1991

WEST VIRGINIA
INSURANCE COMMISSION

- J. "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 elimination period may be required.
- K. "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 must 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 insurer may use "proportionate disability" or other term of similar import which in the opinion of the commissioner adequately and fairly describes the benefit.
- L. "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 Laws 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.
- M. "Mental or Nervous Disorder" shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychosis, or mental or emotional disease or disorder of any kind.

Section 6. Prohibited Policy Provisions

- A. Except as provided in Section 5E, no policy shall contain provisions establishing a probationary or waiting period during which no coverage is provided under the policy, subject to the further exception that a policy may specify a probationary or waiting period not to exceed six (6) months for specified diseases or conditions and losses resulting therefrom for hernia, disorder of reproduction organs, varicose veins, adenoids, appendix and tonsils. However, the permissible six (6) months exception shall not be applicable where such specified diseases or conditions are treated on an emergency basis. Accident policies shall not contain probationary or waiting periods.
- B. No policy or rider for additional coverage may be issued as a dividend unless an equivalent cash payment is offered to the policyholder as an alternative to such dividend policy or rider. No such dividend policy or rider shall be issued for an initial term of less than six (6) months.

The initial renewal subsequent to the issuance of any policy or rider as a dividend shall clearly disclose that the policyholder is renewing the coverage that was provided as a dividend for the previous term and that such renewal is optional with the policyholder.
- C. No policy shall exclude coverage for a loss due to a preexisting condition for a period greater than twelve (12) months following policy issue where the application for such insurance does not seek disclosure of prior illness, disease or physical conditions or prior medical care and treatment and such preexisting condition is not specifically excluded by the terms of the policy.

Minimum Benefits Standards Regulation

Drafting Note: Where the jurisdiction has enacted the 1973 NAIC Individual Accident and Sickness Insurance Minimum Standard Act this provision is unnecessary.

- D. A disability income policy may contain a "return of premium" or "cash value benefit" so long as: (1) such return of premium or cash value benefit is not reduced by an amount greater than the aggregate of any claims paid under the policy; and (2) the insurer demonstrates that the reserve basis for such policies is adequate. No other policy shall provide a return of premium or cash value benefit, except return of unearned premium upon termination or suspension of coverage, retroactive waiver of premium paid during disability, payment of dividends on participating policies, or experience rating refunds.

Drafting Note: This provision is optional and the desirability of its use should be reviewed by the individual states.

- E. Policies providing hospital confinement indemnity coverage shall not contain provisions excluding coverage because of confinement in a hospital operated by the federal government.

- F. No policy shall limit or exclude coverage by type of illness, accident, treatment or medical condition, except as follows:

- (1) Preexisting conditions or diseases, except for congenital anomalies of a covered dependent child;
- (2) Mental or emotional disorders, alcoholism and drug addiction;
- (3) Pregnancy, except for complications of pregnancy, other than for policies defined in Section 7F of this regulation;
- (4) Illness, treatment or medical condition arising out of:
 - (i) War or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; service in the armed forces or units auxiliary thereto,
 - (ii) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury;
 - (iii) Aviation,
 - (iv) With respect to short-term nonrenewable policies, interscholastic sports;
- (5) Cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect;
- (6) Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet;
- (7) Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column;

Editor's Note: When adopting this model, states should examine any existing "freedom of choice" statutes which require reimbursement of treatment provided by chiropractors, and make adjustments if needed.

- (8) Treatment provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), any state or federal workmen's com-

pensation, employers liability or occupational disease law, or any motor vehicle no-fault law; services rendered by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family; and services for which no charge is normally made in the absence of insurance.

- (9) Dental care or treatment;
- (10) Eye glasses, hearing aids and examination for the prescription or fitting thereof;
- (11) Rest cures, custodial care, transportation and routine physical examinations;
- (12) Territorial limitations.

Drafting Note: Some of the exclusions set forth in this provision may be unnecessary or in conflict with existing state legislation and, thus, should be deleted.

- G. This regulation shall not impair or limit the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases, physical condition or extra hazardous activity. Where waivers are required as a condition of issuance, renewal or reinstatement, signed acceptance by the insured is required unless on initial issuance the full text of the waiver is contained either on the first page or specification page.
- H. Policy provisions precluded in this section shall not be construed as a limitation on the authority of the commissioner to disapprove other policy provisions in accordance with [cite Section 3B of the Individual Accident and Sickness Insurance Minimum Standards Act] which in the opinion of the commissioner are unjust, unfair, or unfairly discriminatory to the policyholders, beneficiary or any person insured under the policy.

Section 7. Accident and Sickness Minimum Standards for Benefits

The following minimum standards for benefits are prescribed for the categories of coverage noted in the following subsections. No individual policy of accident and sickness insurance or nonprofit hospital, medical or dental service corporation contract shall be delivered or issued for delivery in this state which does not meet the required minimum standards for the specified categories unless the commissioner finds that such policies or contracts are approvable as limited benefit health insurance and the outline of coverage complies with the appropriate outline in Section 8L of this regulation.

Nothing in this section shall preclude the issuance of any policy or contract combining two or more categories set forth in [cite Section 4A and B of the Model Act].

A. General Rules

- (1) A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" policy shall not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than nonpayment of premium. The policy shall provide that in the event of the insured's death, the spouse of the insured, if covered under the policy, shall become the insured.
- (2) The terms "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" shall not be used without further explanatory language in accordance with the disclosure requirements of Section 8A(1). The terms "noncancellable" or "noncancellable and guaranteed renewable" may be used only in a policy which the insured

Minimum Benefits Standards Regulation

has the right to continue in force by the timely payment of premiums set forth in the policy until the age of sixty-five (65) or to eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force: Provided however, any accident and health or accident-only policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age sixty (60) if, at age sixty (60), the insured has the right to continue the policy in force at least to age sixty-five (65) while actively or regularly employed. Except as provided above, the term "guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums until the age of sixty-five (65) or to eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes: Provided however, any accident and health or accident-only policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age sixty (60) if, at age sixty (60), the insured has the right to continue the policy in force at least to age sixty-five (65) while actively and regularly employed.

- (3) In a family policy covering both husband and wife the age of the younger spouse must be used as the basis for meeting the age and durational requirements of the definitions of "noncancellable" or "guaranteed renewable." However, this requirement shall not prevent termination of coverage of the older spouse upon attainment of the stated age limit (e.g., age 65) so long as the policy may be continued in force as to the younger spouse to the age or for the durational period as specified in said definition.
- (4) When accidental death and dismemberment coverage is part of the insurance coverage offered under the contract, the insured shall have the option to include all insureds under such coverage and not just the principal insured.
- (5) If a policy contains a status-type military service exclusion or a provision which suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to such person on a pro rata basis.
- (6) In the event the insurer cancels or refuses to renew, policies providing pregnancy benefits 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.
- (7) Policies providing convalescent or extended care benefits following hospitalization shall not condition such benefits upon admission to the convalescent or extended care facility within a period of less than fourteen (14) days after discharge from the hospital.
- (8) Family coverage shall continue for any dependent child who is incapable of self-sustaining employment due to mental retardation or physical handicap on the date that such child's coverage would otherwise terminate under the policy due to the attainment of a specified age limit for children and is chiefly dependent on the insured for support and maintenance. The policy may require that within thirty-one (31) days of such date the company receive due proof of such incapacity in order for the insured to elect to continue the policy in force with respect to such child, or that a separate converted policy be issued at the option of the insured or policyholder.

- (9) Any policy providing coverage for the recipient in a transplant operation shall also provide 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.
- (10) A policy may contain a provision relating to recurrent disabilities; provided however, that no such provision shall specify that a recurrent disability be separated by a period greater than six (6) months.
- (11) 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, shall not require the loss to commence less than thirty (30) days after the date of accident, nor shall any policy which the 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.
- (12) Specific dismemberment benefits shall not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits.
- (13) Any accident-only policy providing benefits which vary according to the type of accidental cause shall prominently set forth in the outline of coverage the circumstances under which benefits are payable which are lesser than the maximum amount payable under the policy.
- (14) Termination of the policy shall be without prejudice of 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 total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.

B. Basic Hospital Expense Coverage

"Basic Hospital Expense Coverage" is a policy of accident and sickness insurance which provides coverage for a period of not less than thirty-one (31) days during any continuous hospital confinement for each person insured under the policy, for expense incurred for necessary treatment and services rendered as a result of accident or sickness for at least the following:

- (1) Daily hospital room and board in an amount not less than the lesser of (a) [80%] of the charges for semiprivate room accommodations or (b) [\$30] per day;

Drafting Note: The material in brackets is variable so that a commissioner may determine the level of daily room and board benefits which he considers appropriate as a minimum for a basic hospital contract in his state. It should be an underlying principle for the establishment of any such benefits that the amounts are to be minimums, not maximums. In order to accommodate those states which have a substantial differential in hospital room and board costs between urban and rural areas within a state, the following language may be used in addition to the language in B(1) above: "except that \$[insert amount] may be reduced to \$[insert amount] outside the area." Other dollar amounts and percentage applicable to the various minimum benefits which follow are also bracketed to permit a commissioner to set the level of minimum benefits for his particular state.

- (2) Miscellaneous hospital services for expenses incurred for the charges made by the hospital for services and supplies which are customarily rendered by the hospital and provided for use only during any one period of confinement in an amount not less than either [80%] of the charges incurred up to at least [\$1,000] or [ten times] the daily hospital room and board benefits; and

RECEIVED

SEP 21 1989

W.VA. INS. DEPT.

Minimum Benefits Standards Regulation

- (3) Hospital outpatient services consisting of (a) hospital services on the day surgery is performed, (b) hospital services rendered within seventy-two (72) hours after accidental injury, in an amount not less than [\$50], and (c) X-ray and laboratory tests to the extent that benefits for such services would have been provided to an extent of less than [\$100] if rendered to an in-patient of the hospital.
- (4) Benefits provided under (1) and (2) of (B) above, may be provided subject to a combined deductible amount not in excess of [\$100].

C. Basic Medical-Surgical Expense Coverage

"Basic Medical-Surgical Expense Coverage" is a policy of accident and sickness insurance which provides coverage for each person insured under the policy for the expenses incurred for the necessary services rendered by a physician for treatment of an injury or sickness for at least the following:

- (1) Surgical services:
 - (a) In amounts not less than those provided on a fee schedule based on the relative values contained in the State of New York Certified Surgical Fee Schedule, or the 1964 California Relative Value Schedule or other acceptable relative value scale of surgical procedures, up to a maximum of at least [\$500] for any one procedure; or
 - (b) Not less than [80%] of the reasonable charges.
- (2) Anesthesia services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical service rendered by a physician other than the physician (or his assistant) performing the surgical services:
 - (a) In an amount not less than [80%] of the reasonable charges; or
 - (b) [15%] of the surgical service benefit.
- (3) In-hospital medical services, consisting of physician 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 [80%] of the reasonable charges; or [\$5] per day for not less than twenty-one (21) days during one period of confinement.

D. Hospital Confinement Indemnity Coverage

"Hospital Confinement Indemnity coverage" is a policy of accident and sickness insurance which provides daily benefits for hospital confinement on an indemnity basis in an amount not less than [\$20] per day and not less than thirty-one (31) days during any one period of confinement for each person insured under the policy.

E. Major Medical Expense Coverage

"Major medical expense coverage" is an accident and sickness insurance policy which provide hospital, medical and surgical expense coverage, to an aggregate maximum of not less than [\$10,000]; copayment by the covered person not to exceed twenty-five percent (25%) of covered charges; 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 such deductible may be increased by the amount of the benefits provided by such underlying insurance, for each covered person for at least:

- (1) Daily hospital room and board expenses, prior to application of the copayment percentage, for not less than [\$50] daily (or in lieu thereof the average daily cost of the semiprivate room rate in the area where the insured resides) for a period of not less than thirty-one (31) days during continuous hospital confinement;
- (2) Miscellaneous hospital services, prior to application of the copayment percentage, for an aggregate maximum of not less than [\$4,500] or [15] times the daily room and board rate if specified in dollar amounts;
- (3) Surgical services, prior to application of the copayment percentage to a maximum of not less than [\$600] for the most severe operation with the amounts provided for other operations reasonably related to such maximum amount;
- (4) Anesthesia services prior to application of the copayment percentage, for a maximum of not less than [15] percent of the covered surgical fees or, alternatively, if the surgical schedule is based on relative values, not less than the amount provided therein for anesthesia services at the same unit value as used for the surgical schedule;
- (5) In-hospital medical services, prior to application of the co-payment percentage, as defined in Section 7C(3);
- (6) Out-of-hospital care prior to application of the copayment percentage, 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 ordered by a physician; and
- (7) Not fewer than three of the following additional benefits, prior to application of the copayment percentage, for an aggregate maximum of such covered charges of not less than [\$1,000]:
 - (a) In-hospital private duty graduate registered nurse services;
 - (b) Convalescent nursing home care;
 - (c) Diagnosis and treatment by a radiologist or physiotherapist;
 - (d) Rental of special medical equipment, as defined by the insurer in the policy;
 - (e) Artificial limbs or eyes, casts, splints, trusses or braces;
 - (f) Treatment for functional nervous disorders, and mental and emotional disorders;
or
 - (g) Out-of-hospital prescription drugs and medications.

RECEIVED

SEP 21 1989

W.VA. INS. DEPT.

F. Disability Income Protection Coverage

"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 thereof which:

- (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 sixty-two.
- (2) Contains an elimination period no greater than:
 - (a) Ninety (90) days in the case of a coverage providing a benefit of one (1) year or less;
 - (b) One hundred and 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.
- (3) Has a maximum period of time for which it is payable during disability of at least six (6) months except in the case of a policy covering disability arising out of pregnancy, childbirth or miscarriage in which case the period for such disability may be one (1) month. No reduction in benefits shall be put into effect because of an increase in Social Security or similar benefits during a benefit period. Section 7F does not apply to those policies providing business buy-out coverage.

G. 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 such a policy shall be at least [\$1,000] and a single dismemberment amount shall be at least [\$500].

H. Specified Disease and Specified Accident Coverage

- (1) "Specified disease coverage" pays benefits for the diagnosis and treatment of a specifically named disease or diseases. Any such policy must 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 condition(s) or disease(s)—must meet the standards of Subparagraph (c), (d), or (e); insurance covering specified disease(s) other than cancer must meet the standards of Subparagraph (b) or (e).

(a) General Rules

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 rules shall apply to specified disease coverages in addition to all other rules imposed by this regulation; in cases of conflict between the following and other rules, the following ones shall govern:

- (i) 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.
- (ii) 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.
- (iii) Notwithstanding any other provision of this regulation, 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).
- (iv) Policies containing specified disease coverage shall be at least Guaranteed Renewable.
- (v) No policy issued pursuant to this section shall contain a waiting or probationary period greater than thirty (30) days.
- (vi) 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 (Medicaid, MediCal or any similar name). Such statement may be combined with any other statement for which the insurer may require the applicant's signature.
- (vii) Payments may be conditioned upon a covered person's receiving medically necessary care, given in a medically appropriate location, under a medically accepted course of diagnosis or treatment.
- (viii) Except for the uniform provision regarding other insurance with this insurer, benefits for specified disease coverage shall be paid regardless of other coverage available through individual health insurance.

Drafting Note: Specified disease coverage is recognized as supplemental coverage. Any specified disease coverage, therefore, must be payable in addition to and regardless of other individual coverage. The same general rule should apply so that group insurance cannot reduce its benefits because of the existence of an individual specified disease policy. Section 3F of the Group Coordination of Benefits Model Regulation states that the definition of a "plan" (for the purpose of COB) "shall not include individual or family insurance contracts..." It is recommended that states use this language to prevent benefit reductions that could otherwise occur because of the existence of an individual specified disease policy purchased by the insured.

- (ix) After the effective date of the coverage (or applicable waiting period, if any) benefits shall begin with the first day of care or confinement if such care or confinement is for a covered disease even though the diagnosis is made at some later date. The retroactive application of such coverage may not be less than ninety (90) days prior to such diagnosis.
- (b) The following minimum benefits standards apply to noncancer coverages:
- (i) Coverage for each person insured under the policy for a specifically named disease (or diseases) with a deductible amount not in excess of [\$250] and an overall aggregate benefit limit of no less than [\$5,000] and a benefit period of not less than [two (2) years] for at least the following incurred expenses.

Minimum Benefits Standards Regulation

- (A) Hospital room and board and any other hospital furnished medical services or supplies;
 - (B) Treatment by a legally qualified physician or surgeon;
 - (C) Private duty services of a registered nurse (R.N.);
 - (D) X-ray, radium and other therapy procedures used in diagnosis and treatment;
 - (E) Professional ambulance for local service to or from a local hospital;
 - (F) Blood transfusions, including expense incurred for blood donors;
 - (G) Drugs and medicines prescribed by a physician;
 - (H) The rental of an iron lung or similar mechanical apparatus;
 - (I) Brace, crutches and wheel chairs as are deemed 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; and
 - (K) May include coverage of any other expenses necessarily incurred in the treatment of the disease.
- (ii) 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 [\$25,000] payable at the rate of not less than [\$50] a day while confined in a hospital and a benefit period of not less than 500 days.
- (c) 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 [\$250], and an overall aggregate benefit limit of not less than [\$10,000] and a benefit period of not less than three (3) years for at least the following:
- (i) Treatment by, or under the direction of, a legally qualified physician or surgeon;
 - (ii) X-ray, radium chemotherapy and other therapy procedures used in diagnosis and treatment;
 - (iii) Hospital room and board and any other hospital furnished medical services or supplies;
 - (iv) Blood transfusions, and the administration thereof, including expense incurred for blood donors;

- (v) Drugs and medicines prescribed by a physician;
- (vi) Professional ambulance for local service to or from a local hospital;
- (vii) Private duty services of a registered nurse (R.N.) provided in a hospital;
- (viii) May include coverage of any other expenses necessarily incurred in the treatment of the disease; provided however, that Items (i), (ii), (iv), (v) and (vii) 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;
- (ix) Braces, crutches and wheelchairs as are deemed necessary by the attending physician for the treatment of the disease;
- (x) Emergency transportation if in the opinion of the attending physician in its necessary to transport the insured to another locality for treatment of the disease; and
- (xi) 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 treatment must be prescribed in writing by the covered person's attending physician, who must approve the program prior to its start. The physician must certify that hospital confinement would be otherwise required. A "home health care agency" is (1) an agency approved under Title XVIII of the Social Security Act (Medicare), or (2) is licensed to provide home health care under applicable state law, or (3) meets all of the following requirements:
 - (A) It is primarily engaged in providing home health care services;
 - (B) Its policies are established by a group of professional personnel (including at least one physician and one registered nurse (R.N.));
 - (C) Supervision of home health care services is provided by a physician or a registered nurse (R.N.);
 - (D) It maintains clinical records on all patients; and
 - (E) It has a full time administrator

Drafting Note: State licensing laws vary concerning the scope of "home health care" or "home health agency services" and should be consulted. In addition, a few states have mandated benefits for home health care including the definition of required services.

Home health includes, but is not limited to:

- (A) Part-time or intermittent skilled nursing services provided by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.);
- (B) Part-time or intermittent home health aide services which provide supportive services in the home under the supervision of a registered nurse or a physical, speech or hearing occupational therapists;
- (C) Physical, occupational or speech and hearing therapy; and

Minimum Benefits Standards Regulation

(D) Medical supplies, drugs and medicines prescribed by a physician and related pharmaceutical services, and laboratory services to the extent such charges or costs would have been covered under the policy if the insured person had remained in the hospital.

(xii) Physical, speech, hearing and occupational therapy;

(xiii) Special equipment including hospital bed, toilette, pulleys, wheelchairs, aspirator, chux, oxygen, surgical dressings, rubber shields, colostomy and ileostomy appliances;

(xiv) Prosthetic devices including wigs and artificial breasts;

(xv) Nursing home care for noncustodial services.

(d) The following minimum benefits standards apply to cancer coverages written on a per diem indemnity basis. Such coverages must offer covered persons:

(i) A fixed-sum payment of at least [\$100] for each day of hospital confinement for at least [365] days.

(ii) A fixed-sum payment equal to one half the hospital inpatient benefit for each day of hospital or nonhospital outpatient surgery, chemo- and radiation therapy, for at least 365 days of treatment.

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:

(iii) A fixed-sum payment equal to one-fourth the hospital in-patient benefit for each day of skilled nursing home confinement for at least 100 days.

(iv) A fixed-sum payment equal to one-fourth the hospital inpatient benefit for each day of home health care for at least 100 days.

(v) Benefit payments shall begin with the first day of care or confinement after the effective date of coverage if such 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 such covered disease.

(vi) Notwithstanding any other provision of this regulation, any restriction or limitation applied to the benefits in (d) (iii) and (d) (iv), whether by definition or otherwise, shall be no more restrictive than those under Medicare.

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

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

Drafting Note: Policies that offer extremely high dollar benefits may induce fraud and concealment on the part of applicants for coverage. Commissioners should be sensitive to this possibility in approving policies.

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

Drafting Note: The purpose of requiring equal coverage for all subtypes of a specified disease is to ensure that specified disease policies actually provide what people reasonable expect them to. In approving skin cancer or other exceptions, commissioners should consider whether a specified disease policy might mislead if it treats a subtype of a disease differently from the rest of the specified disease.

- (2) "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 [\$1,000] for accidental death, [\$1,000] for double dismemberment [\$500] for single dismemberment.

I. Limited Benefit Insurance Coverage

"Limited Benefit Health Insurance Coverage" is any policy or contract, other than a policy or contract covering only a specified disease or diseases, which provides benefits that are less than the minimum standards for benefits required under Section 7B, C, D, E, G, and H. A policy covering a single specified disease or combination of diseases shall meet the requirements of Section 7H and shall not be offered for sale as a "Limited Coverage." Such policies or contracts may be delivered or issued for delivery in this state only if the outline of coverage required by Section 8H of this regulation is completed and delivered as required by Section 8B of this regulation. This subsection does not apply to policies designed to provide coverage for long-term care or Medicare supplements, as defined in [cite provisions of Long-Term Care Act and Medicare Supplement Insurance Minimum Standards Act].

Section 8. Required Disclosure Provisions

A. General Rules

- (1) Each individual policy of accident and sickness insurance or hospital, medical or dental service corporation subscriber contract shall include a renewal, continuation or nonrenewal provision. The language or specification of such provision must be consistent with the type of contract to be issued. Such provision shall be appropriately captioned, shall appear on the first page of the policy, 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.
- (2) Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder 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 shall require signed acceptance by the policyholder. After date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage is required by law.

RECEIVED

SEP 21 1989

171-17

Minimum Benefits Standards Regulation

- (3) Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.
- (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 such terms and an explanation of such terms in its accompanying outline of coverage.
- (5) If a policy contains any limitations with respect to preexisting conditions, such limitations must appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."
- (6) All accident-only policies shall contain a prominent statement 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."
- (7) All policies, except single-premium nonrenewable policies and as otherwise provided in this paragraph, shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the 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 policyholder is not satisfied for any reason.

Drafting Note: This section should be included only if state has proper legislation.

- (8) If age is to be used as a determining factor for reducing the maximum aggregate benefits made available in the policy as originally issued, such fact must be prominently set forth in the outline of coverage.
- (9) 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 insurer for that purpose.
- (10) Outlines of coverage delivered in connection with policies defined in this regulation as hospital confinement indemnity (Section 7D), Specified Disease (Section 7H), or Limited Benefit Health Insurance Coverages (Section 7I) to persons eligible for Medicare by reason of age shall contain, in addition to the requirements of subsections 8F and 8J, the following language which shall be printed on or attached to the first page of the outline of coverage:

This policy IS NOT A MEDICARE SUPPLEMENT policy. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the company.
- (11) Insurers, except direct response insurers, shall give any person applying for specified disease insurance a Buyer's Guide approved by the commissioner at the time of application and shall obtain all recipients' written acknowledgement of the guide's delivery. Direct response insurers shall provide the Buyer's Guide upon request but not later than the time the policy is delivered.

- (12) All specified disease policies shall contain a prominent statement on the first page of the policy or attached thereto in either contrasting color or in boldface type at least equal to the size type used for policy captions, a prominent statement as follows:
CAUTION: This is a limited policy. Read it carefully with the outline of coverage and the Buyer's Guide.

Drafting Note: The second sentence of this caption should only be required in those states where the commissioner exercises his discretionary authority and requires such guide.

B. Outline of Coverage Requirements for Individual Coverages

No individual accident and sickness insurance policy or nonprofit hospital, medical or dental service corporation subscriber contract subject to this regulation shall be delivered or issued for delivery in this state unless an appropriate outline of coverage, as prescribed in Section 8C through K is completed as to such policy or contract and the outline is either:

- (1) Delivered with the policy; or
(2) Delivered to the applicant at the time application is made and acknowledgement of receipt or certification of delivery of such outline of coverage is provided to the insurer.

If an outline of coverage was delivered at the time of application and the policy or contract is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or contract must accompany the policy or contract when it is delivered and contain the following statement in no less than twelve (12) point type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application, and the coverage originally applied for has not been issued."

The appropriate outline of coverage for policies or contracts providing hospital coverage which only meets the standards of Section 7B shall be that statement contained in Section 8C. The appropriate outline of coverage for policies providing coverage which meets the standards of both Sections 7B and C shall be the statement contained in Section 8E. The appropriate outline of coverage for policies providing coverage which meets the standards of both Sections 7B and E or Section 7C and E or Section 7B, C, and E shall be the statement contained in Section 8G.

Appropriate changes in terminology may be made in the outline of coverage in the case of contracts of hospital, medical or dental service corporations. In any other case where the prescribed outline of coverage is inappropriate for the coverage provided by the policy or contract, an alternate outline of coverage shall be submitted to the commissioner for prior approval.

C. Basic Hospital Expense Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7B of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

RECEIVED

SEP 21 1989

W VA. INS. DEPT. 171-19

[COMPANY NAME]

BASIC HOSPITAL EXPENSE COVERAGE

OUTLINE OF COVERAGE

- (1) Read Your Policy Carefully — This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**
- (2) Basic Hospital Coverage — Policies of this category are designed to provide, to persons insured, coverage for hospital expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services and hospital outpatient services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for physicians or surgeons fees or unlimited hospital expenses.
- (3) [A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:
 - (a) Daily hospital room and board;
 - (b) Miscellaneous hospital services;
 - (c) Hospital out-patient services; and
 - (d) Other benefits, if any.]

Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.

- (4) [A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in (3) above.]
- (5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

D. Basic Medical-Surgical Expense Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7C of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

BASIC MEDICAL-SURGICAL EXPENSE COVERAGE

OUTLINE OF COVERAGE

- (1) Read Your Policy Carefully — This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control your policy. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

- (2) Basic Medical-Surgical Expense Coverage—Policies of this category are designed to provide, to persons insured, coverage for medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for 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 hospital expenses fees or unlimited medical-surgical expenses.
- (3) [A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:
 - (a) surgical services;
 - (b) anesthesia services;
 - (c) in-hospital medical services; and
 - (d) other benefits, if any]

RECEIVED

SEP 21 1989

W.VA. INS. DEPT.

Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.

- (4) [A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in (3) above.]
- (5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

E. Basic Hospital and Medical-Surgical Expense Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7B and C of this regulation. The items included in the outline of coverage must appear in the sequence prescribed.

[COMPANY NAME]

BASIC HOSPITAL AND MEDICAL-SURGICAL EXPENSE COVERAGE

OUTLINE OF COVERAGE

- (1) Read Your Policy Carefully—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore important that your READ YOUR POLICY CAREFULLY!
- (2) Basic Hospital and Medical-Surgical Expense Coverage—Policies of this category are designed to provide, to persons insured, coverage for hospital and medical-surgical expenses 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.
- (3) [A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:

Minimum Benefits Standards Regulation

- (a) Daily hospital room and board;
- (b) Miscellaneous hospital services;
- (c) Hospital out-patient services;
- (d) Surgical services;
- (e) Anesthesia services;
- (f) In-hospital medical services; and
- (g) Other benefits, if any.]

Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.

- (4) [A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in (3) above.]
- (5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

F. Hospital Confinement Indemnity Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7D of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

HOSPITAL CONFINEMENT INDEMNITY COVERAGE

OUTLINE OF COVERAGE

- (1) Read Your Policy Carefully — This outline of coverage provides a very brief description of the important feature of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!
- (2) Hospital Confinement Indemnity Coverage — Policies of this category are designed to provide, to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Such policies do not provide any benefits other than the fixed daily indemnity for hospital confinement and any additional benefit described below.
- (3) [A brief specific description of the benefits contained in this policy, in the following order:
 - (a) Daily benefit payable during hospital confinement and
 - (b) Duration of benefit described in (a).]

Note: The above description of benefits shall be stated clearly and concisely.

- (4) [A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefit, described in (3) above.]
- (5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]
- (6) [Any benefits provided in addition to the daily hospital benefit.]

G. Major Medical Expense Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7E of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

MAJOR MEDICAL EXPENSE COVERAGE

OUTLINE OF COVERAGE

- (1) **Read Your Policy Carefully** — This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**
- (2) **Major Medical Expense Coverage** — Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations which may be set forth in the policy. Basic hospital or basic medical insurance coverage is not provided.
- (3) [A brief specific description of the benefits, including dollar amounts, contained in this policy, in the following order:
 - (a) Daily hospital room and board;
 - (b) Miscellaneous hospital services,
 - (c) Surgical services;
 - (d) Anesthesia services;
 - (e) In-hospital medical services,
 - (f) Out-of-hospital care;
 - (g) Maximum dollar amount for covered charges; and
 - (h) Other benefits, if any]

RECEIVED
MAR 05 1990
W.VA. INS. DEPT.

Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.

Minimum Benefits Standards Regulation

- (4) [A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in (3) above.]
- (5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

H. Disability Income Protection Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7F of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

DISABILITY INCOME PROTECTION COVERAGE

OUTLINE OF COVERAGE

- (1) Read Your Policy Carefully — This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!
- (2) Disability Income protection Coverage — Policies of this category are designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.
- (3) [A brief specific description of the benefits contained in this policy:]

Note: The above description of benefits shall be stated clearly and concisely.

- (4) [A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in (3) above.]
- (5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

I. Accident-Only Coverage (Outline of Coverage)

An outline of coverage in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7G of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

ACCIDENT-ONLY COVERAGE

OUTLINE OF COVERAGE

- (1) Read Your Policy Carefully — This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you

and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

- (2) Accident-Only coverage—Policies of this category are designed to provide, to persons insured, coverage for certain losses resulting from a covered accident **ONLY**, subject to any limitations contained in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.
- (3) [A brief specific description of the benefits contained in this policy.]

Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with Section 7A(13) of this regulation.

- (4) [A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in (3) above.]
- (5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

J. Specified Disease or Specified Accident Coverage (Outline of Coverage)

An outline of coverage in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7H of this regulation. The coverage shall be identified by the appropriate bracketed title. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]
 [SPECIFIED DISEASE] [SPECIFIED ACCIDENT] COVERAGE
 OUTLINE OF COVERAGE

RECEIVED
 SEP 21 1989
 W VA. INS. DEPT.

- (1) This policy is designed only as a supplement to a comprehensive health insurance policy and should not be purchased unless you have this underlying coverage. It should not be purchased by persons covered under Medicaid. Read the Buyer's Guide's discussion of the possible limits on benefits in this type of policy.
- (2) **Read Your Policy Carefully** — This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**
- (3) [Specified Disease] [Specified Accident] Coverage — Policies of this category are designed to provide, to persons insured, restricted coverage paying benefits **ONLY** when certain losses occur as a result of [specified diseases] or [specified accidents]. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.
- (4) [A brief specific description of the benefits, including dollar amounts, contained in this policy.]

Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provisions applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with Section 7A(13) of this regulation.

K. Limited Benefit Health Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies which do not meet the minimum standards of Section 7B, C, D, E, F, G and H of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

LIMITED BENEFIT HEALTH COVERAGE

OUTLINE OF COVERAGE

- (1) Read Your Policy Carefully — The outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore important that you READ YOUR POLICY CAREFULLY!
- (2) Limited Benefit Health Coverage — Policies of this category are designed to provide, to persons insured, limited or supplemental coverage.
- (3) [A brief specific description of the benefits, including dollar amounts, contained in this policy.]

Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provisions applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with Section 7A(13) of this regulation.

- (4) [A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in (3) above.]
- (5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

Section 9. Requirements for Replacement

- A. Application forms shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other accident and sickness insurance presently in force. A supplementary application or other form to be signed by the applicant containing such questions may be used.
- B. Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent shall furnish the applicant, prior to issuance or delivery of the policy, the notice described in C below. One (1) copy of such notice shall be retained by the insurer. A direct response insurer shall deliver to the applicant upon issuance of the policy, the notice described in D below. In no event, however, will such a notice be required in the solicitation of the following types of policies; accident-only and single-premium nonrenewable policies.
- C. The notice required by B above for an insurer, other than a direct response insurer, shall provide, in substantially the following form:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND SICKNESS INSURANCE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by [insert company name] Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

- (1) Health conditions which you may presently have, (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits present under the new policy, whereas a similar claim might have been payable under your present policy.

Drafting Note: This subsection may be modified if preexisting conditions are covered under the new policy.

- (2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
- (3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concern your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

RECEIVED

MAR 05 1990

W.VA. INS. DEPT.

(Date)

(Applicant's Signature)

D. The notice required by B above for a direct response insurer shall be as follows:

**NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND SICKNESS INSURANCE**

According to [your application] [information you have furnished] you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with the policy delivered herewith issued by [insert company name] Insurance Company. Your new policy provides ten days within which you may decide without cost whether you desire to keep the policy. For your own information and protection you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

- (1) Health conditions which you may presently have, (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
- (2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

Minimum Benefits Standards Regulation

- (3) [To be included only if the application is attached to the policy]. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [insert company name and address] within ten days if any information is not correct and complete, or if any past medical history has been left out of the application.

[COMPANY NAME]

Section 10. Separability

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

Legislative History (all references are to the Proceedings of the NAIC).

1975 Proc. I 2, 6, 573, 575, 590-605 (adopted).

1977 Proc. I 26, 28, 54-77, 317, 325 (amended).

1979 Proc. II 31, 34, 327, 333, 339-344 (amended regarding Medicare supplement insurance).

1980 Proc. II 22, 26, 588, 591, 594, 622, 634-636 (amended).

1989 Proc. II 13, 23-24, 467-468, 518-519, 548-570 (amended to remove reference to Medicare supplement insurance).

E N R O L L E D

COMMITTEE SUBSTITUTE

FOR

Senate Bill No. 326

(SENATORS MINARD AND HELMICK, *original sponsors*)

[Passed April 5, 1993; in effect ninety days from passage.]

AN ACT to amend and reenact section three, article sixteen, chapter thirty-three of the code of West Virginia, one thousand nine hundred thirty-one, as amended; to amend and reenact section four, article twenty-four of said chapter; to amend and reenact section six, article twenty-five of said chapter; and to amend and reenact section twenty-four, article twenty-five-a of said chapter, all relating to the promulgation of rules for minimum policy provisions on group accident and sickness coverage; applying the same to hospital service corporations, medical service corporations, dental service corporations, health service corporations, health care corporations and health maintenance organizations.

Be it enacted by the Legislature of West Virginia:

That section three, article sixteen, chapter thirty-three of the code of West Virginia, one thousand nine hundred thirty-one, as amended, be amended and reenacted; that section four, article twenty-four of said chapter be amended and reenacted; that section six, article twenty-five

of said chapter be amended and reenacted; and that section twenty-four, article twenty-five-a of said chapter be amended and reenacted, all to read as follows:

ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.

§33-16-3. Required policy provisions.

1 Each such policy hereafter delivered or issued for
2 delivery in this state shall contain in substance the
3 following provisions:

4 (a) A provision that the policy, the application of the
5 policyholder, a copy of which shall be attached to such
6 policy, and the individual applications, if any, submit-
7 ted in connection with such policy by the employees or
8 members, shall constitute the entire contract between
9 the parties, and that all statements made by any
10 applicant or applicants shall be deemed representa-
11 tions and not warranties, and that no such statement
12 shall void the insurance or reduce benefits thereunder
13 unless contained in a written application.

14 (b) A provision that the insurer will furnish to the
15 policyholder, for delivery to each employee or
16 member of the insured group, an individual certificate
17 setting forth in substance the essential features of the
18 insurance coverage of such employee or member and
19 to whom benefits thereunder are payable. If depend-
20 ents are included in the coverage, only one certificate
21 need be issued for each family unit.

22 (c) A provision that all new employees or members,
23 as the case may be, in the groups or classes eligible for
24 insurance, shall from time to time be added to such
25 groups or classes eligible to obtain such insurance in
26 accordance with the terms of the policy.

27 (d) No provision relative to notice or proof of loss or
28 the time for paying benefits or the time within which
29 suit may be brought upon the policy shall be less
30 favorable to the insured than would be permitted in
31 the case of an individual policy by the provisions set
32 forth in article fifteen of this chapter.

33 (e) A provision that all members in groups or classes

34 eligible for insurance provided through an employee's
 35 group plan shall be permitted to pay the premiums at
 36 the same group rate and receive the same coverages
 37 for a period not to exceed eighteen months when they
 38 are involuntarily laid off from work.

39 (f) Such further provisions establishing group acci-
 40 dent and sickness minimum policy coverage standards
 41 as the commissioner shall promulgate by rule pursu-
 42 ant to chapter twenty-nine-a of this code.

**ARTICLE 24. HOSPITAL SERVICE CORPORATIONS, MEDICAL SER-
 VICE CORPORATIONS, DENTAL SERVICE CORPOR-
 ATIONS AND HEALTH SERVICE CORPORATIONS.**

§33-24-4. Exemptions; applicability of insurance laws.

1 Every corporation defined in section two of this
 2 article is hereby declared to be a scientific, nonprofit
 3 institution and exempt from the payment of all
 4 property and other taxes. Every corporation, to the
 5 same extent the provisions are applicable to insurers
 6 transacting similar kinds of insurance and not incon-
 7 sistent with the provisions of this article, shall be
 8 governed by and be subject to the provisions as
 9 hereinbelow indicated, of the following articles of this
 10 chapter: Article two (insurance commissioner), except
 11 that, under section nine of said article, examinations
 12 shall be conducted at least once every four years;
 13 article four (general provisions), except that section
 14 sixteen of said article shall not be applicable thereto;
 15 article six, section thirty-four (fee for form and rate
 16 filing); article six-c (guaranteed loss ratio); article
 17 seven (assets and liabilities); article eleven (unfair
 18 trade practices); article twelve (agents, brokers and
 19 solicitors), except that the agent's license fee shall be
 20 five dollars; section fourteen, article fifteen (individual
 21 accident and sickness insurance); article fifteen-a
 22 (long-term care insurance); section three, article
 23 sixteen (required policy provisions); section three-a,
 24 article sixteen (mental illness); section three-c, article
 25 sixteen (group accident and sickness insurance);
 26 section three-d, article sixteen (medicare supplement
 27 insurance); section three-f, article sixteen (treatment

28 of temporomandibular joint disorder and cranioman-
29 dibular disorder); article sixteen-a (group health
30 insurance conversion); article sixteen-c (small employ-
31 er group policies); article sixteen-d (marketing and
32 rate practices for small employers); article twenty-six-
33 a (West Virginia life and health insurance guaranty
34 association act), after the first day of October, one
35 thousand nine hundred ninety-one; article twenty-
36 seven (insurance holding company systems); article
37 twenty-eight (individual accident and sickness insur-
38 ance minimum standards); article thirty-three (annual
39 audited financial report); article thirty-four (adminis-
40 trative supervision); article thirty-four-a (standards
41 and commissioner's authority for companies deemed
42 to be in hazardous financial condition); article thirty-
43 five (criminal sanctions for failure to report impair-
44 ment); and article thirty-seven (managing general
45 agents); and no other provision of this chapter may
46 apply to these corporations unless specifically made
47 applicable by the provisions of this article. If, however,
48 the corporation is converted into a corporation organ-
49 ized for a pecuniary profit or if it transacts business
50 without having obtained a license as required by
51 section five of this article, it shall thereupon forfeit its
52 right to these exemptions.

ARTICLE 25. HEALTH CARE CORPORATIONS.

**§33-25-6. Supervision and regulation by insurance commis-
sioner: exemption from insurance laws.**

1 Corporations organized under this article are subject
2 to supervision and regulation of the insurance com-
3 missioner. The corporations organized under this
4 article, to the same extent these provisions are appli-
5 cable to insurers transacting similar kinds of insurance
6 and not inconsistent with the provisions of this article,
7 shall be governed by and be subject to the provisions
8 as hereinbelow indicated, of the following articles of
9 this chapter: Article four (general provisions), except
10 that section sixteen of said article shall not be applica-
11 ble thereto; article six-c (guaranteed loss ratio); article
12 seven (assets and liabilities); article eight (invest-
13 ments); article ten (rehabilitation and liquidation):

14 section fourteen, article fifteen (individual accident
15 and sickness insurance); section three, article sixteen
16 (required policy provisions); article sixteen-a (group
17 health insurance conversion); article sixteen-c (small
18 employer group policies); article sixteen-d (marketing
19 and rate practices for small employers); article twenty-
20 six-a (West Virginia life and health insurance guaranty
21 association act); article twenty-seven (insurance hold-
22 ing company systems); article thirty-three (annual
23 audited financial report); article thirty-four-a (stan-
24 dards and commissioner's authority for companies
25 deemed to be in hazardous financial condition); article
26 thirty-five (criminal sanctions for failure to report
27 impairment); and article thirty-seven (managing
28 general agents); and no other provision of this chapter
29 may apply to these corporations unless specifically
30 made applicable by the provisions of this article.

ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.

§33-25A-24. Statutory construction and relationship to other laws.

1 (a) Except as otherwise provided in this article,
2 provisions of the insurance law and provisions of
3 hospital or medical service corporation laws shall not
4 be applicable to any health maintenance organization
5 granted a certificate of authority under this article.
6 This provision shall not apply to an insurer or hospital
7 or medical service corporation licensed and regulated
8 pursuant to the insurance laws or the hospital or
9 medical service corporation laws of this state except
10 with respect to its health maintenance corporation
11 activities authorized and regulated pursuant to this
12 article.

13 (b) Factually accurate advertising or solicitation
14 regarding the range of services provided, the premi-
15 ums and copayments charged, the sites of services and
16 hours of operation, and any other quantifiable, non-
17 professional aspects of its operation by a health
18 maintenance organization granted a certificate of
19 authority, or its representative shall not be construed
20 to violate any provision of law relating to solicitation

21 or advertising by health professions: *Provided*. That
22 nothing contained herein shall be construed as autho-
23 rizing any solicitation or advertising which identifies
24 or refers to any individual provider or makes any
25 qualitative judgment concerning any provider.

26 (c) Any health maintenance organization authorized
27 under this article shall not be deemed to be practicing
28 medicine and shall be exempt from the provision of
29 chapter thirty of this code, relating to the practice of
30 medicine.

31 (d) The provisions of section fifteen, article four
32 (general provisions); article six-c (guaranteed loss
33 ratio); article seven (assets and liabilities); article eight
34 (investments); section fourteen, article fifteen (individ-
35 ual accident and sickness insurance); article fifteen-b
36 (uniform health care administration act); section
37 three, article sixteen (required policy provisions);
38 section three-f, article sixteen (treatment of temporo-
39 mandibular disorder and craniomandibular disorder);
40 article sixteen-a (group health insurance conversion);
41 article sixteen-c (small employer group policies);
42 article sixteen-d (marketing and rate practices for
43 small employers); article twenty-seven (insurance
44 holding company systems); article thirty-four-a (stan-
45 dards and commissioner's authority for companies
46 deemed to be in hazardous financial condition); article
47 thirty-five (criminal sanctions for failure to report
48 impairment) and article thirty-seven (managing
49 general agents) shall be applicable to any health
50 maintenance organization granted a certificate of
51 authority under this article.

52 (e) Any long-term care insurance policy delivered or
53 issued for delivery in this state by a health mainte-
54 nance organization shall comply with the provisions of
55 article fifteen-a of this chapter.