TO: All Insurers Licensed to Write Accident & Sickness Insurance, All HMOs and Limited HMOs; Dental Plan Organizations; Dental/Optometric Service Plans; Optometric Services Plans; Health Services Plans; and MCHIPS; and All Interested Parties

RE: **Repeal of Chapters 120 and 140 of the Virginia Administrative Code and Adoption of Chapters 135 and 141 Effective January 1, 2023; INS-2022-00073**

The State Corporation Commission having considered the proposal to repeal and adopt rules referenced above, the comments filed, and the Bureau's response, concludes that Chapters 120 and 140 of the Virginia Administrative Code should be repealed effective **January 1,2023**, and that the proposed regulations should be adopted by the Commission, as modified, effective **January 1, 2023**. ***The new rules shall be applicable to any new form submitted to the Bureau for review on or after the effective date.***

This order repeals Chapter 120 (Rules Governing the Implementation of the Individual A&S Minimum Standards Act -Specified Disease Policies) and Chapter 140 (Rules Governing the Implementation of the Individual A&S Minimum Standards Act).

This order adopts new rules: Chapter 135 (Rules Governing Individual and Small Group Market Health Benefit Plans) and Chapter 141 (Rules Governing A&S Excepted Benefits Policies, Short-Term Limited Duration Insurance).

A copy of this order is attached as well as copies of new Chapters 135 and 141.

For questions about Chapter 135, please contact Sharon Holston at: **Sharon.Holston@scc.virginia.gov.**

For questions about Chapter 141, please contact Elsie Andy at: Elsie.Andy@scc.virginia.gov.

COMMONWEALTH OF VIRGINIA

STATE CORPORATION COMMISSION

AT RICHMOND, DECEMBER 8, 2022

COMMONWEALTH OF VIRGINIA, *ex rel.*

STATE CORPORATION COMMISSION
Ex Parte: In the matter of Repealing
and Adopting Rules Governing
Individual and Small Group Market
Health Benefit Plans and Excepted
Benefits Policies

CASE NO. INS-2022-00073

ORDER REPEALING AND ADOPTING REGULATIONS

On July 15, 2022, the State Corporation Commission ("Commission") entered an Order to Take Notice proposing to update its current rules regarding accident and sickness insurance following significant changes in this area. As part of this update, the Bureau of Insurance ("Bureau") submitted to the Commission a proposal to repeal two existing chapters and promulgate two new chapters of the Virginia Administrative Code.

Specifically, the order proposed to: (a) repeal Chapter 120 of Title 14 of the Virginia Administrative Code entitled "Rules Governing the Implementation of the Individual Accident and Sickness Insurance Minimum Standards Act with Respect to Specified Disease Policies," set out at 14 VAC 5-120-10 through 14 VAC 5-120-100; (b) repeal Chapter 140 of Title 14 of the Virginia Administrative Code entitled "Rules Governing the Implementation of the Individual Accident and Sickness Insurance Minimum Standards Act," set out at 14 VAC 5-140-10 through 14 VAC 5-140-100; (c) promulgate new Chapter 135 of Title 14 of the Virginia Administrative Code entitled "Rules Governing Individual and Small Group Market Health Benefit Plans," which sets forth new rules at 14 VAC 5-135-10 through 14 VAC 5-135-60; and (d) promulgate new Chapter 141 of Title 14 of the Virginia Administrative Code entitled "Rules Governing Accident and Sickness Excepted Benefits Policies; Short-Term Limited Duration Insurance," which sets forth new rules at 14 VAC 5-141-10 through 14 VAC 5-141-160.

The Bureau has recommended the repeal of Chapters 120 and 140 as well as the adoption of Chapters 135 and 141 as necessary revisions because of significant changes in the regulation of individual and small group health benefit plans, excepted benefits policies, and short-term limited duration insurance in the last decade. The Bureau has noted that separate and distinct requirements for most health benefit plans now exist, and a bright line divides these types of plans and "excepted benefits" policies as defined in § 38.2-3431 of the Code of Virginia ("Code") as well as the federal Public Health Service Act, 42 U.S.C. § 201 *et seq.* In light of these changes, the Bureau recommends repealing outdated rules and implementing new, separate chapters to clearly identify the requirements for each category of policies. Furthermore, proposed Chapters 135 and 141 implement the provisions of Chapters 34 (§ 38.2-3400 *et seq.*) and 35 (§ 38.2-3500 *et seq.*) of Title 38.2 of the Code.

The Order to Take Notice and proposed rules were posted on the Commission's website, sent to all carriers licensed in Virginia to write accident and sickness insurance and to all interested persons known to the Bureau to have an interest in life and health insurance on July 22, 2022, sent to the Virginia Attorney General's Division of Consumer Counsel ("Consumer Counsel"), and published in the *Virginia Register of Regulations* on August 15, 2022. Licensees, Consumer Counsel and other interested persons were afforded the opportunity to file written comments or request a hearing on or before September 30, 2022.

The Bureau received six sets of comments to the proposed rules, which were filed by the following: Health Benefits Institute; Delta Dental of Virginia; Virginia Association of Health Plans; UnitedHealthcare; American Council of Life Insurers; and William Schiffbauer on his own behalf. No request for a hearing was filed with the Clerk of the Commission ("Clerk").

The Bureau considered the comments filed and responded to them in its Response to Comments ("Response"), which the Bureau filed with the Clerk on November 10, 2022. In its

Response, the Bureau addressed the comments and either recommended that various sections of the proposed rules be amended or indicated why it did not believe suggested revisions were authorized or warranted.

NOW THE COMMISSION, having considered the proposal to repeal and adopt rules, the comments filed, and the Bureau's Response, concludes that Chapters 120 and 140 of the Virginia Administrative Code should be repealed effective January 1, 2023, and that the proposed regulations should be adopted by the Commission, as modified and attached hereto effective January 1, 2023. The new rules shall be applicable to any new form submitted to the Bureau for review on or after the effective date.

Accordingly, IT IS ORDERED THAT:

(1) Chapter 120 of Title 14 of the Virginia Administrative Code entitled "Rules Governing the Implementation of the Individual Accident and Sickness Insurance Minimum Standards Act with Respect to Specified Disease Policies," set out at 14 VAC 5-120-10 through 14 VAC 5-120-100, and Chapter 140 of Title 14 of the Virginia Administrative Code entitled "Rules Governing the Implementation of the Individual Accident and Sickness Insurance Minimum Standards Act," set out at 14 VAC 5-140-10 through 14 VAC 5-140-100 are hereby REPEALED effective January 1, 2023.

(2) Chapter 135 of Title 14 of the Virginia Administrative Code entitled "Rules Governing Individual and Small Group Market Health Benefit Plans," set out at 14 VAC 5-135-10 through 14 VAC 5-135-60, and Chapter 141 of Title 14 of the Virginia Administrative Code entitled "Rules Governing Accident and Sickness Excepted Benefits Policies; Short-Term Limited Duration Insurance," set out at 14 VAC 5-141-10 through 14 VAC 5-141-160, as modified and attached hereto, are hereby ADOPTED effective

January 1, 2023. The new rules shall be applicable to any new form submitted to the Bureau for review on or after the effective date.

(3) The Bureau shall provide notice of the repeal and adoption of rules to all carriers licensed in Virginia to write accident and sickness insurance and to all persons known to the Bureau to have an interest in life and health insurance.

(4) This Order and the attached regulations shall be made available on the Commission's website: scc.virginia.gov/pages/Case-Information.

(5) The Commission's Office of General Counsel shall provide a copy of this Order and the regulations to the Virginia Registrar of Regulations for publication in the *Virginia Register of Regulations*.

(6) The Bureau shall file with the Clerk an affidavit of compliance with the notice requirements of Ordering Paragraph (3) above.

(7) This case is dismissed.

A COPY hereof shall be sent by the Clerk of the Commission to: C. Meade Browder, Jr., Senior Assistant Attorney General, mbrowder@oag.state.va.us, Office of the Attorney General, Division of Consumer Counsel, 202 N. 9th Street, 8th Floor, Richmond, Virginia 23219-3424; and a copy hereof shall be delivered to the Commission's Office of General Counsel and the Bureau of Insurance in care of Deputy Commissioner Julie Blauvelt.

Project 4101

State Corporation Commission, Bureau of Insurance

~~Chapter 120~~

~~Rules Governing the Implementation of the Individual Accident and Sickness Insurance Minimum Standards Act with Respect to Specified Disease Policies~~ (REPEALED)

Chapter 135

Rules Governing Individual and Small Group Market Health Benefit Plans

14VAC5-135-10. Applicability and scope.

A. This chapter (14VAC5-135) implements the provisions of Chapters 34 (§ 38.2-3400 et seq.) and 35 (§ 38.2-3500 et seq.) of Title 38.2 of the Code of Virginia and sets forth the standards for compliance with the federal Affordable Care Act.

B. This chapter shall apply to all individual and small group market health benefit plans delivered or issued for delivery in this Commonwealth.

C. Health benefit plans filed in this Commonwealth and approved for sale in a health benefit exchange pursuant to § 38.2-326 of the Code of Virginia shall comply with the provisions of this chapter.

D. This chapter shall not apply to a grandfathered health plan, as defined in § 38.2-3438 of the Code of Virginia, for as long as the plan maintains its status in accordance with federal regulations.

E. This chapter shall not apply to excepted benefits policies, as defined in § 38.2-3431 of the Code of Virginia.

F. This chapter shall not apply to a short-term limited-duration medical plan, as defined in § 38.2-3407.21 of the Code of Virginia.

14VAC5-135-20. Definitions.

The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Affordable Care Act" or "ACA" means the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) and any federal regulations issued pursuant thereto.

"Covered benefits" or "benefits" means those health care services to which an enrollee is entitled under the terms of a health benefit plan.

"Dependent" means the spouse, child, or other class of persons of an enrollee or eligible individual, subject to the applicable terms of the policy, contract, or plan.

"Eligible individual" means an employee of a small employer as shall be determined (i) in accordance with the terms of the group health benefit plan; (ii) as provided by the health carrier under rules of the health carrier that are uniformly applicable to employers in the small group market; and (iii) in accordance with all applicable laws of the Commonwealth.

"Enrollee" means a policyholder, subscriber, participant, member, insured, or other individual covered by a health benefit plan.

"Exchange" means either (i) the federal health benefit exchange established pursuant to § 1321 of the Affordable Care Act or (ii) the Virginia Health Benefit Exchange established pursuant to Chapter 65 (§ 38.2-6500 et seq.) of Title 38.2 of the Code of Virginia, through which qualified health plans and qualified dental plans are made available to qualified individuals.

"Group health plan" means an employee welfare benefit plan as defined in § 3(1) of the Employee Retirement Income Security Act of 1974 (ERISA) (29 USC § 1002(1)) to the extent that the plan provides medical care within the meaning of § 733(a) of ERISA (29 USC § 1191b(a)) to

employees, including both current and former employees, or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

"Health benefit plan" means a policy, contract, certificate, or agreement offered by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, except as otherwise specifically exempted. "Health benefit plan" does not include the "excepted benefits" as defined in § 38.2-3431 of the Code of Virginia.

"Health carrier" means an entity subject to the insurance laws and regulations of the Commonwealth and subject to the jurisdiction of the State Corporation Commission that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a health carrier licensed to sell accident and sickness insurance, a health maintenance organization, a health services plan, or any other entity providing a plan of health insurance, health benefits, or health care services.

"Health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health carrier.

"Health status-related factor" means any of the following factors: health status; medical condition, including physical and mental illnesses; claims experience; receipt of health care services; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence or extra-hazardous activities; disability; or any other health status-related factor as determined by federal regulation.

"Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

"Medical necessity" or "medically necessary" means appropriate and necessary health care services that are rendered for a condition that, according to generally accepted principles of good medical practice, requires the diagnosis or direct care and treatment of an illness, injury, or pregnancy-related condition, and are not provided only as a convenience.

"Premium" means all moneys paid by an employer, eligible individual, or enrollee as a condition of coverage from a health carrier, including fees and other contributions associated with the health benefit plan.

"Small group market" means the health insurance market under which eligible individuals obtain health benefit plans directly or through any arrangement on behalf of themselves and their dependents through a group health plan maintained by a small employer.

14VAC5-135-30. General policy requirements.

A. Each health benefit plan shall contain a guaranteed renewability provision in accordance with § 38.2-3430.7 or 38.2-3432.1 of the Code of Virginia. The provision shall appear on the first page of the policy.

B. Each health benefit plan shall contain a termination, cancellation, or discontinuation of coverage policy provision in accordance with § 38.2-3430.7 or 38.2-3432.1 of the Code of Virginia.

C. Each health benefit plan shall contain a provision for grace periods:

1. An individual health benefit plan shall contain a grace period of not less than 31 days after the initial premium is paid. Further, in accordance with 45 CFR 156.270(d), an individual health benefit plan offered on the exchange shall also contain language that an enrollee receiving advance payments of the premium tax credit is instead subject to a grace period of three consecutive months, during which time the health carrier shall pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and

third months of the grace period. If the enrollee exhausts the three-month grace period, the health carrier shall terminate the policy effective the last day of the first month of the three-month grace period.

2. A group health benefit plan shall contain a grace period of not less than 31 days after the initial premium is paid.

D. A health benefit plan shall contain essential health benefits in accordance with § 38.2-3451 of the Code of Virginia. Benefits required by any applicable state or federal law shall also be covered.

E. The standard by which payment of benefits is made shall be clearly described in the policy. "Allowed amount" and other similar words shall be clearly defined.

14VAC5-135-40. Student health insurance coverage.

A. For purposes of this section, "student health insurance coverage" means a type of individual health insurance coverage offered in the individual market that (i) is provided pursuant to a written agreement between an institution of higher education, as defined by the Higher Education Act of 1965 (P.L. 89-329), and a health carrier and provided to students enrolled in that institution of higher education and their covered dependents; (ii) does not make health insurance coverage available other than in connection with enrollment as a student or as a covered dependent of a student of the institution of higher education; and (iii) does not condition eligibility for health insurance coverage on any health status-related factor related to a student or a covered dependent of the student.

B. Student health insurance coverage is subject to the requirements of the ACA, including essential health benefits, mental health parity, and the requirements of this chapter, except as noted in this section.

C. Student health insurance coverage is exempt from the guaranteed availability requirements of § 38.2-3430.3 of the Code of Virginia and the guaranteed renewability requirements of § 38.2-3430.7 of the Code of Virginia.

D. Student health insurance coverage is not subject to the single risk pool requirement outlined in § 1312(c) of the ACA.

E. Student health insurance coverage premium rates may be based on a school-specific community rating.

14VAC5-135-50. Prohibitions, limitations, and disclosures.

A. A health carrier shall not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, gender expression, sexual orientation, or status as a transgender individual. Nothing in this section shall be construed to prevent a health carrier from appropriately utilizing reasonable medical management techniques including medical necessity.

[~~B. A policy shall not limit or exclude medically necessary services that arise out of complications from contractually excluded services.~~]

[~~C.~~ B.] If a health carrier offers an optional benefit to a health benefit plan, the health carrier may file a separate schedule that includes the additional benefit and identify the health benefit plan to which the schedule applies. A different plan identification is necessary to distinguish the health benefit plan with the additional benefit.

[~~D.~~ C.] A health carrier may offer a health benefit plan that does not include pediatric oral health benefits if:

1. The health carrier is reasonably assured that pediatric oral health benefits are available to the purchaser of the health benefit plan in accordance with § 38.2-3451 B of the Code of Virginia, and

2. The plan contains the following statement on the first page of the policy and bold:

"This policy does not provide the ACA-required pediatric oral health benefits."

[~~E.~~ D.] If an individual policy contains a military service exclusion or a provision that suspends coverage during military service, the policy shall provide for a refund of unearned premium upon receipt of written notice of the military service.

[~~F.~~ E.] A policy application shall not contain questions about any health-status related factors other than age and tobacco use.

[~~G.~~ F.] A policy shall only be rated on age, tobacco use, geographic location, plan category, and whether the policy covers dependents in accordance with § 38.2-3447 of the Code of Virginia.

[~~H.~~ G.] No policy shall contain a provision that allows for increase in premium or change in deductible except during renewal.

[~~I.~~ H.] A health benefit plan shall not impose any preexisting condition exclusion.

[~~J.~~ I.] Policy exclusions may be no more restrictive than allowed by the state-selected essential health benefits benchmark plan.

14VAC5-135-60. Severability.

If any provision of this chapter or its application to any person or circumstance is for any reason held to be invalid, the remainder of the chapter and the application of the provisions to other persons or circumstances shall not be affected.

~~Chapter 140~~

~~Rules Governing the Implementation of the Individual Accident and Sickness Insurance Minimum Standards Act~~ (REPEALED)

Chapter 141

Rules Governing Accident and Sickness Excepted Benefits Policies; Short-Term Limited Duration Insurance

14VAC5-141-10. Applicability and scope.

A. This chapter implements the provisions of Chapters 34 (§ 38.2-3400 et seq.) and 35 (§ 38.2-3500 et seq.) of Title 38.2 of the Code of Virginia as it applies to excepted benefits as defined in § 38.2-3431 of the Code of Virginia, 45 CFR § 146.145, and 45 CFR 148.220, as well as short-term limited-duration insurance.

B. This chapter applies to all individual and group market insurance policies delivered or issued for delivery in Virginia that qualify as accident and sickness excepted benefits.

C. This chapter applies to all short-term limited-duration insurance delivered or issued for delivery in Virginia, including a certificate delivered in Virginia that is issued under a short-term limited-duration plan in any other jurisdiction.

D. This chapter outlines the types of accident and sickness excepted benefits policies and the allowable combinations of such policies that may be approved for use in Virginia. No other combinations or types of such policies may be filed without prior approval by the commission.

E. This chapter does not apply to Medicare Supplement policies, which are governed under Rules Governing Minimum Standards for Medicare Supplement Policies (14VAC5-170) and long-term care insurance, which is governed under Rules Governing Long-Term Care Insurance (14VAC5-200).

14VAC5-141-20. Definitions.

The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Accident" means an unintentional or unexpected event or circumstance that results in injury.

"Accident only coverage" means a policy that provides benefits for accidental injury.

"Accidental injury" means bodily injury sustained by the insured that is the direct result of an accident independent of disease, infirmity, or any other cause. "Accidental injury" shall not include words that establish an accidental means test or use words such as "external," "violent," "visible wounds," or similar words of description or characterization.

"Commission" means the State Corporation Commission.

"Disability income insurance" means a policy that provides for weekly or monthly periodic payments for a specified period during the continuance of the insured's partial or total disability resulting from either sickness or injury or a combination of the two.

"Elimination period" means a period of time [after coverage begins and is] between the date of loss and when benefits commence. An elimination period may only be included in a disability income policy or a short-term convalescent care policy, unless otherwise specified in this chapter.

"Excepted benefits" has the same meaning as in § 38.2-3431 of the Code of Virginia. For purposes of this regulation:

1. The following benefits are excepted in all circumstances:

a. Coverage only for accident (including accidental death and dismemberment); or

b. Disability income insurance.

2. The following benefits are excepted if the benefits are provided under a separate individual or group policy, certificate, or contract of insurance, or are not an integral part of the group health plan:

a. Limited scope dental, limited scope vision, or limited scope hearing benefits; or

b. Other similar, limited benefits as may be filed and approved by the commission.

3. The following benefits are excepted if offered as independent, noncoordinated benefits:

a. Specified disease or critical illness; or

b. Hospital indemnity or other fixed indemnity insurance.

4. Similar supplemental coverage qualifies as excepted benefits if the coverage supplements and fills gaps in a group health plan and is provided in a separate policy.

"Hospital" means a facility licensed as a hospital under state law. The term "hospital" may be [further] defined with no [~~further~~ more] restrictions than the applicable [state] licensure requirements.

"Major medical coverage" or "minimum essential coverage" as defined in 45 CFR 156.600 means any of the following:

1. Employer-sponsored coverage (including Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage and retiree coverage);

2. Coverage purchased in the individual market, including a qualified health plan offered through the Health Insurance Marketplace (also known as the Health Benefit Exchange);

3. Coverage under a grandfathered health plan;

4. Medicare Part A coverage and Medicare Advantage plans;

5. Most Medicaid coverage, except for limited coverage plans;

6. Children's Health Insurance Program (CHIP) coverage;

7. Most student health plans;

8. Certain types of veterans' health coverage administered by the Department of Veterans Affairs;

9. TRICARE;

10. Coverage provided to Peace Corps volunteers;

11. Coverage under the Nonappropriated Fund Health Benefit Program;

12. Refugee Medical Assistance supported by the Administration for Children and Families; or

13. State high-risk pools for plan or policy years that started on or before December 31, 2014.

"Partial disability" or "residual disability," if such term is used in the policy or certificate, means the insured's inability to perform one or more but not all of the major or essential duties of employment or occupation or may be related to a percentage of time worked, a specified number of hours, or amount of compensation. Where a policy provides total and partial or residual disability benefits, no more than one elimination period may be required for any one period of disability.

"Policy" means an insurance policy, contract, certificate, evidence of coverage, or other agreement of insurance, including any attached rider, endorsement, or application.

"Preexisting condition" means a disease or physical condition [~~that, during a one-year period immediately preceding the effective date of coverage~~ for which medical advice] or treatment was received [during a period not to exceed one-year immediately preceding the effective date of

coverage] . "Preexisting condition" shall not include congenital anomalies of a covered dependent child.

A preexisting condition exclusion shall not exceed one year for individual policies, unless otherwise specified in this chapter.

A preexisting condition exclusion for group policies shall not apply to loss incurred or disability commencing after the earlier of (i) the end of a continuous period of 12 months commencing on or after the effective date of the person's coverage during which the person receives no medical advice or treatment in connection with the disease or physical condition, or (ii) the end of the two-year period commencing on the effective date of the person's coverage, unless otherwise specified in this chapter.

"Renewable" means the right of a policyholder to continue the policy in force by the timely payment of premiums, during which period the insurer shall not unilaterally make any change in any provision of the policy while the policy is in force; however, the insurer may adjust premium rates upon renewal in accordance with rate filing requirements.

"Short-term limited-duration insurance" means health insurance coverage in which the period of coverage or policy duration is three months or less and complies with the requirements of § 38.2-3407.21 of the Code of Virginia. "Short-term limited-duration insurance" is not individual health insurance coverage and is not excepted benefits as those terms are defined in § 38.2-3431 of the Code of Virginia.

"Sickness" means an illness, disease, condition, or disorder.

"Total disability" means the insured's inability to perform the substantial and material duties of the insured's regular occupation or the insured's inability to engage in an employment or occupation for which the insured is or becomes qualified by reason of education, training, or experience. Total disability shall not be based solely upon an insured's inability to (i) perform any

occupation, any occupational duty, any and every duty of the insured's occupation, or words of similar meaning; or (ii) engage in any training or rehabilitation program.

"Waiting period" means the period of time commencing from the effective date of coverage during which no benefits are provided under the policy [but does not include an eligibility waiting period imposed by a group or employer before coverage begins] .

14VAC5-141-30. General policy provisions.

A. Each excepted benefits policy shall contain a notice displayed prominently in advertising, application and plan materials and on the face of the policy in at least 14-point type the following language:

"THIS IS AN EXCEPTED BENEFITS POLICY. IT PROVIDES COVERAGE ONLY FOR THE LIMITED BENEFITS OR SERVICES SPECIFIED IN THE POLICY."

B. A policy that [~~is intended to cover~~ covers] specific types of benefits or services may not then exclude the same or similar types of conditions, illnesses, or events, except for any preexisting condition limitations. Benefits shall be reasonable in relation to the premium charged [~~and specific~~ . Specific] prohibitions [~~shall~~ may] be limited as determined by the commission.

C. Each individual policy issued under this chapter may be renewable at the option of the insured, unless otherwise specified in this chapter. The renewability provisions shall appear on the first page of the policy and be appropriately captioned.

D. If covered, pregnancy, childbirth, or miscarriage shall be treated like any other sickness.

[Complications that arise from pregnancy shall be covered.]

E. In the event an insurer cancels an individual policy in accordance with § 38.2-3504 of the Code of Virginia, any coverage for pregnancy shall provide for an extension of benefits for the

duration of the pregnancy if the pregnancy commenced while the policy was in force and for which benefits would be payable had the policy remained in force.

F. A policy that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or similar words shall include an explanation of these terms.

G. An individual policy that provides for dependent coverage shall provide that in the event of the insured's death, a covered spouse of the insured shall become the insured.

H. A policy may [~~only~~] exclude 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.

I. If [~~a~~ an individual] policy contains a military service exclusion or a provision that suspends coverage during military service, the policy shall provide for a refund or credit of unearned premium upon receipt of written notice of the military service.

J. For any individual policy, if additional premium is charged for benefits provided in connection with a rider or endorsement, a separate premium amount shall be stated in the policy.

K. If a policy contains any preexisting condition limitations, these shall appear in a separate paragraph in the policy and labeled as "Preexisting Conditions Limitation."

L. If age is used to reduce the maximum aggregate benefits available in the policy, this shall be prominently stated in the policy.

M. If a policy contains a conversion provision, it shall appear in a separate paragraph and shall state eligibility requirements, limitations on the conversion, and the benefits provided.

14VAC5-141-40. Prohibitions, limitations and disclosures.

A. No excepted benefits policy or short-term limited-duration insurance policy may be advertised, offered for sale, or sold as minimum essential coverage.

B. A policy shall not have a waiting period that exceeds 30 days, unless otherwise specified in this chapter.

C. If a policy contains a preexisting condition exclusion, it shall conform to the requirements included in the definition of "preexisting condition" in this chapter, unless otherwise specified in this chapter.

D. Any limit or reduction of coverage or benefits for specifically named or described preexisting conditions that goes beyond the limitations in subsection C of this section or extrahazardous activity that is a condition of issuance, renewal, or reinstatement requires a signed acceptance by the policyholder and shall be attached to the policy.

E. Except for riders or endorsements by which the insurer fulfills a request made in writing by the policyholder, an insurer shall not reduce or eliminate benefits or coverage except at reinstatement or renewal. After the date of policy issue and during the policy term, any rider or endorsement that increases benefits or coverage with an increase in premium shall be agreed to in writing by the policyholder, except if the increased benefits or coverage is required by law.

14VAC5-141-50. Accident.

A. Accident only coverage is a benefit provided for accidental bodily injury sustained by the insured person. Accident only coverage shall not contain a waiting period.

B. Accident only coverage may be filed in combination with the following:

1. Accidental death and dismemberment;

2. Disability income; or

3. Hospital indemnity or fixed indemnity.

C. A policy that covers an accidental injury may provide that injuries shall not include:

1. Injuries for which benefits are provided under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law; or

2. Injuries incurred while the insured person is engaged in any activity pertaining to any trade, business, employment, or occupation for wage or profit.

D. Accidental death and dismemberment benefits shall be payable if the loss occurs within 180 days from the date of the accident, the loss is a result of the accident, and the policy was in force at the time of the accident.

E. Specific dismemberment benefits shall not be payable in lieu of other benefits under the policy unless the specific dismemberment benefit equals or exceeds any other benefits contained in the policy.

F. An elimination period may be applied to an incidental benefit that is in addition to the accident benefit, such as a fixed or lump-sum payment for a coma resulting from an accident.

14VAC5-141-60. Disability income insurance.

A. Disability income insurance is a policy that provides for weekly or monthly periodic payments for a specified period during the continuance of partial or total disability resulting from either sickness or injury or a combination of the two.

B. Disability income insurance may be filed in combination with the following:

1. Accident only coverage;

2. Accidental death and dismemberment; or

3. Hospital indemnity or fixed indemnity.

C. A disability income policy may contain an elimination period no greater than:

1. 30 days in the case of coverage providing a benefit of one year or less, unless otherwise provided in subsection F of this section;

2. 90 days in the case of coverage providing a benefit of more than one year but not greater than two years; or

3. 180 days in all other cases during the continuance of disability resulting from sickness or injury.

D. A disability income policy shall allow at least 30 days after the date of an accident for a covered loss to start.

E. A disability policy shall cover complications arising out of pregnancy, childbirth, or miscarriage.

F. A disability income individual policy shall contain a minimum period of time for which benefits are paid that is not less than 180 days. A disability income group policy may contain a minimum period of time for which benefits are paid that is not less than 90 days. A policy that is 90 days but less than 180 days may have an elimination period of not more than seven days.

G. If a disability income policy contains a provision for recurrent disabilities, the period of time required between recurrent disabilities shall be no greater than six months.

H. If the insurer terminates a disability income policy, any claim for a covered loss that commenced while the policy was in force shall not be affected, subject to the terms and conditions of the policy.

I. If a disability income policy contains a return of premium or cash value benefit, it shall not be reduced by an amount greater than the aggregate of claims paid under the policy. The insurer shall also demonstrate that the reserve basis for the policy is adequate.

J. A rider or endorsement that provides a specific dollar payment to the employer or business that may suffer a financial loss in the event of the disability of a key person may be attached to a disability income policy.

K. If a disability income policy provides coverage for disability from childbirth, it shall provide for a payable benefit of at least 12 weeks immediately following childbirth in accordance with § 38.2-3407.11:4 of the Code of Virginia. No waiting or elimination period shall apply.

14VAC5-141-70. Limited scope benefits - dental, vision, and hearing.

A. Limited scope dental, limited scope vision, and limited scope hearing are plans that provide for benefits primarily for the treatment of the mouth, eyes, and ears, respectively.

B. Limited scope dental, limited scope vision, and limited scope hearing plans may be provided either as separate policies, certificates, or contracts of insurance, or not part of an integral group health plan. Benefits are not part of an integral group health plan if the participant has the right to opt-out of coverage, or if claims for the benefits are administered under a separate contract from the claims administration for any other benefits under the group health plan.

C. Except for [~~basic or~~ diagnostic and] preventive benefits, a limited scope dental plan may apply waiting periods that exceed 30 days but no longer than 12 months to specific services or benefits. [A waiting period not to exceed 24 months may be applied to orthodontic services.]

D. For any limited scope dental plan to be recognized as meeting essential health benefits in accordance with § 38.2-3451 of the Code of Virginia and be treated as a qualified health plan in accordance with 45 CFR 155.1065, pediatric dental essential health benefits shall be included in the plan.

E. In addition to the notice required in 14VAC5-141-30 A, any limited scope dental plan that is not an exchange certified stand-alone dental plan shall include the following language on the face of the policy:

"THIS IS A STAND-ALONE DENTAL POLICY THAT IS NOT EXCHANGE CERTIFIED AND MAY NOT PROVIDE MINIMUM ESSENTIAL PEDIATRIC DENTAL BENEFITS."

14VAC5-141-80. Limited scope benefits - accident and sickness insurance while traveling.

A. Limited scope accident and sickness insurance while traveling is a separate policy providing accident and sickness benefits only for the limited duration of an insured's trip.

B. A limited scope accident and sickness insurance while traveling policy:

1. Shall not contain preexisting condition exclusions;

2. Shall not contain a waiting period;

3. Shall not contain a deductible applied to benefits;

4. Shall not coordinate benefits with any other accident and sickness policy;

5. Shall not be renewable;

6. Shall not include benefits for trip interruption or trip cancellation; and

7. Shall provide accident and sickness benefits only for the limited duration of an insured's trip.

C. Travel insurance in which the primary purpose of the insurance is trip cancellation or interruption shall be reviewed as miscellaneous casualty insurance in accordance with § 38.2-111 of the Code of Virginia and is exempt from this chapter.

14VAC5-141-90. Limited scope benefits - short-term convalescent care.

A. A short-term convalescent care policy may include care provided in a nursing home, assisted living facility, hospice, adult day care center, or home. A short-term convalescent care policy is a policy with a maximum lifetime benefit period that does not exceed 364 days and that is provided under a separate policy, certificate, or contract of insurance.

B. There is no coordination of benefits with any other accident and sickness policy.

C. A short-term convalescent care policy shall contain the following provisions:

1. Eligibility for benefits shall be based on loss due to accident or sickness and loss of functional capacity or cognitive impairment.

2. Once the maximum benefit period under the policy has been exhausted, the policy may not be renewed.

3. If a policy contains a period in which benefits may be restored, the maximum period of time between benefit periods shall be no more than 180 days.

4. If a policy conditions benefits on an insured's inability to perform activities of daily living or on cognitive impairment, such requirements shall be defined.

5. Eligibility for benefits shall not be more restrictive than the presence of cognitive impairment or a deficiency of no more than two activities of daily living.

6. Reimbursement for any covered service that is legally performed by a person licensed to perform such services may not be denied.

D. If a policy provides short-term convalescent care or extended care benefits following hospitalization, qualification for benefits for the convalescent care or extended care facility shall not require admission less than 14 days after discharge from the hospital.

E. In addition to the provisions of 14VAC5-141-30 A, the following disclosure shall appear on the face of the policy:

"This is a policy that provides benefits for short-term convalescent care. THIS IS NOT A LONG-TERM CARE POLICY."

14VAC5-141-100. Limited scope benefits - group blanket policies.

A. A group blanket insurance policy is a policy of limited accident and sickness insurance that provides coverage for specified circumstances and a specific class of persons defined in the policy issued to a master policyholder. Such policy does not specifically name persons covered,

by certificate or otherwise, although a statement of the coverage provided may be given, or required by the policy to be given, to eligible persons.

B. An individual application is not required from a person covered under a blanket insurance policy.

C. No insurer issuing a blanket insurance policy shall be required to furnish a certificate to each person covered by the policy.

D. A blanket insurance policy to be issued or issued for delivery in Virginia shall comply with the requirements of § 38.2-3521.2 of the Code of Virginia.

14VAC5-141-110. Specified disease insurance.

A. Specified disease insurance is a policy that pays benefits for the diagnosis or treatment of a specifically named disease or a critical illness.

B. Specified disease insurance benefits shall be provided under a separate policy, certificate, or contract of insurance.

C. Any policy provision that provides for the coordination or reduction of benefits because benefits are payable under any other health insurance coverage is prohibited.

D. A specified disease policy shall not exclude coverage for any subtype of disease or illness covered under the policy. The dollar value of benefits may only be limited based on the severity of the disease or illness where the insurer shows actuarial justification for the lower amount.

E. As a condition for eligibility for benefits under the policy, a clinical diagnosis shall be accepted if a pathological diagnosis cannot be reasonably obtained.

F. If a policy provides convalescent care or extended care benefits following hospitalization, qualification for benefits for the convalescent care or extended care facility shall not require admission less than 14 days after discharge from the hospital.

G. Policy benefits shall begin with the first day of care or confinement if the care or confinement is for a covered disease or illness even though a diagnosis is made at a later date. The retroactive application of coverage may not be limited to less than 90 days prior to the diagnosis.

H. If a specified disease policy contains a return of premium or cash value benefit, it shall not be reduced by an amount greater than the aggregate of claims paid under the policy. The insurer shall also demonstrate that the reserve basis for the policy is adequate.

14VAC5-141-120. Hospital indemnity or other fixed indemnity insurance.

A. Hospital indemnity or other fixed indemnity insurance means a policy that provides supplementary benefits that are paid to the insured in a single lump sum or a fixed dollar amount per specified event, per day, or per other period of hospitalization or illness regardless of the amount of expenses incurred. The policy shall not be a substitute for major medical coverage.

B. Hospital indemnity or other fixed indemnity insurance that is offered in the individual market shall meet the following criteria:

1. Benefits shall be provided under a separate policy, certificate, or contract of insurance;

2. Benefits paid may be a single lump sum or a fixed dollar amount per service, per specified event, per day, or per other period of time. Benefits shall be determined based on the category of services and not the billed amount. Dollar amounts shall be expressed in the policy;

3. There is no coordination between the provision of benefits and an exclusion of benefits under any other health coverage;

4. A pregnancy that exists on the effective date of coverage may be considered a preexisting condition;

5. No waiting period shall be applied to loss due to accidental injury; and

6. In addition to the notice required in 14VAC5-141-30 A, the following notice shall be displayed prominently on the face of the policy: "THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE."

C. Hospital indemnity or other fixed indemnity insurance offered in the group market shall meet the following criteria:

1. There is no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor;

2. The benefits are paid with respect to an event without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor; and

3. Benefits shall be paid in a single lump sum or a fixed dollar amount per day or other period of hospitalization or illness regardless of the amount of expenses incurred. [~~A group policy shall not pay benefits on a per service basis.~~] Benefits shall not be determined based on the billed amount. Dollar amounts shall be expressed in the policy.

14VAC5-141-130. Similar supplemental coverage.

A. Similar supplemental coverage that qualifies as excepted benefits is coverage that supplements and fills gaps in a group health plan. The supplemental coverage shall:

1. Cover benefits that are not covered by the primary coverage and are not essential health benefits as described in § 38.2-3451 of the Code of Virginia; or

2. Fill gaps in cost-sharing for primary coverage, including copayments, coinsurance, and deductibles.

B. Similar supplemental coverage shall be provided under a separate policy.

C. Similar supplemental coverage does not include coverage that becomes secondary or supplemental only under a coordination of benefits provision.

14VAC5-141-140. Short-term limited-duration insurance coverage.

A. Short-term limited-duration insurance is health insurance coverage in which the period of coverage or policy duration is three months or less. Based on the insured's eligibility, coverage may be renewed or extended so that coverage may not exceed six months in any 12-month period in accordance with § 38.2-3407.21 of the Code of Virginia. An application form shall include a question on whether the applicant had any short-term limited-duration coverage within 12 months of the application date.

B. A short-term limited-duration insurance policy issued by a health maintenance organization shall cover basic health care services as defined in § 38.2-4300 of the Code of Virginia. A short-term limited-duration insurance policy issued by any health carrier other than a health maintenance organization shall include at a minimum emergency services, hospital and physician care, outpatient medical services, surgical benefits, and radiology and laboratory benefits.

C. Short-term limited-duration insurance coverage may be nonrenewable or renewable, but not guaranteed renewable in accordance with § 38.2-3514.2 of the Code of Virginia.

1. A nonrenewable short-term limited-duration policy shall include all applicable state mandates that do not specifically exempt short-term nonrenewable policies.

2. A renewable short-term limited-duration policy shall include all applicable state mandates, including those mandates that exempt short-term nonrenewable policies.

D. A policy shall not subject a person to a preexisting condition exclusion of more than three months in any 12-month period. Any preexisting condition exclusion shall credit for any prior creditable coverage.

E. A short-term limited-duration policy shall not contain any waiting period or elimination period prior to receiving benefits.

F. Any advertising, sales call, solicitation, or other marketing practices shall include a disclosure that a short-term limited-duration policy is not minimum essential coverage or major medical coverage.

G. Each short-term limited-duration policy shall contain the following notice displayed prominently in the application, plan materials and on the face of the policy in at least 14-point type:

> "THIS COVERAGE IS NOT REQUIRED TO COMPLY WITH FEDERAL MARKET REQUIREMENTS FOR HEALTH INSURANCE, PRINCIPALLY THOSE CONTAINED IN THE AFFORDABLE CARE ACT. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage."

H. Short-term limited-duration insurance forms and rates shall be filed with and approved by the commission in accordance with §§ 38.2-316 and 38.2-316.1 of the Code of Virginia.

I. A short-term limited-duration insurance policy shall be subject to internal appeal process requirements and external review requirements of Chapter 35.1 (§ 38.2-3556 et seq.) of Title 38.2 of the Code of Virginia.

J. An insurer shall not issue a short-term limited-duration policy during any open enrollment period. [~~No application for short-term limited duration insurance may be accepted during any open enrollment period.~~]

14VAC5-141-150. Requirements for replacement of an individual policy.

A. The application form for an excepted benefits or short-term limited-duration policy shall include a question regarding whether the insurance to be issued is intended to replace any other insurance presently in force.

B. An insurer may not replace any policy that qualifies as minimum essential coverage with an excepted benefits or a short-term limited-duration policy unless specifically requested in writing by the insured.

C. If the sale will involve replacement, an insurer or its agent shall furnish to the applicant prior to issuance or delivery of the policy the notice required in subsection D of this section. A direct response insurer shall deliver the notice to the applicant upon issuance of the policy. A copy signed by the applicant shall be retained by the insurer.

D. Notice to applicants shall be provided in substantially the following form:

"NOTICE TO APPLICANT REGARDING REPLACEMENT OF AN INSURANCE POLICY

According to your application, you intend to lapse or otherwise terminate an existing policy and replace it with an excepted benefits or short-term limited-duration policy issued by (insert Company Name). In accordance with the terms of your policy, you may have at least 10 days to decide without cost whether you desire to keep the policy. For your own protection you should consider certain factors that may affect the insurance provisions available to you under the new policy.

1. 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, where a similar claim may have been payable under your present policy.

2. You may wish to consult with your present insurer or its agent regarding the proposed replacement of your present policy. It is your right and in your best interest to make sure you understand all the factors involved in replacing your present coverage.

3. If you still wish to terminate your present policy and replace it with new coverage, carefully check all the information in the application before you sign it.

The above "Notice to Applicant" was delivered to the applicant on (date).

(Applicant's signature _____)"

14VAC5-141-160. Severability.

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