Wellness Benefits in Excepted Benefits Policies Guidance from the Virginia Bureau of Insurance (the Bureau)

This guidance supersedes previous guidance issued by the Bureau related to Excepted Benefits policies written in Virginia.

The Bureau has developed the following guidance to assist in the filing and review of excepted benefits coverage and accompanying rates. This guidance is effective **July 1, 2025,** as coverage is marketed, sold, issued, or renewed in Virginia on or after that date. As of that date, carriers must cease issuing any policy forms previously approved that are not compliant with this guidance. A policy or certificate is exempt from this guidance to the extent it is issued prior to the effective date of this guidance and the policy or certificate prohibits unilateral benefit revisions by the carrier.

All policy forms and rates currently under review or submitted for review will not be approved unless they comply with this guidance.

Through careful analysis performed in conjunction with the Bureau's development of regulations at 14 VAC 5-141, *Rules Governing Accident and Sickness Excepted Benefits Policies; Short-Term Limited Duration Insurance,* which became effective January 1, 2023, the Bureau will no longer allow certain wellness benefits in or attached to certain excepted benefits policies. The Bureau acknowledges that this position is not based on any new law or rule change. However, it is based on current federal and state requirements.

Previous to this guidance and the development of 14 VAC 5-141, the Bureau allowed a wide variety of additional benefits, including wellness benefits, to be included in or attached to certain accident and sickness policies, including excepted benefits policies. These additional benefits were often unrelated to the primary policy type. However, as the Bureau developed 14 VAC 5-141 and reviewed the requirements for excepted benefits policies more closely, it became clear that the inclusion of benefits that do not meet the definition of or standards for the various types of excepted benefits policies takes the policy outside of the rubric of an excepted benefits policy, and therefore may not be approved as such.

Carriers that continue to market, sell, issue, or renew forms that are not in compliance with this guidance on or after **July 1, 2025**, may be subject to knowing and willful violations of § 38.2-316 A and C 1 as well as § 38.2-3519 B of the Code of Virginia. Carriers are encouraged to review policy forms and rates for new business and renewing policies and certificates well in advance of this deadline to determine what action must be taken.

It is expected that rates associated with these policy forms may need to be revised to ensure premiums remain reasonable in relation to the benefits provided per 14 VAC 5-130-65, 14 VAC 5-130-75 and 14 VAC 5-130-90.

What is a Wellness Benefit?

I. One or more of the following provided on an outpatient basis under the supervision of a physician, but not medically necessary:

- a wellness or preventive test;
- a routine physical exam; or
- a medically accepted screening test used to evaluate risk or promote prevention of an illness or injury.

II. A medical health assessment survey requesting basic vital statistic and/or lab results (i.e., weight, height, blood pressure, lipid panel results, some metabolic panel results, etc.).

What is not a Wellness Benefit?

A medically necessary test or service performed after a triggering event that is necessary to determine information about the sickness or bodily injury that is covered by the policy.

Applicable Code and Regulations:

Code of Federal Regulations 45 CFR 148.220, 45 CFR 146.145
Code of Virginia §§ 38.2-3431, 38.2-3519, 38.2-109
Virginia Administrative Code 14 VAC 5-141
Excepted benefits policies must meet specific requirements in order for these policies to be "excepted" from state and federal laws that apply to health benefit plans. Benefits that take the policy outside of the rubric of these specific requirements disqualify a policy from being "excepted" and will be disapproved when filed as such.

General Rules
Acceptable combinations of accident and sickness excepted benefits are specified in 14 VAC 5-141 and mentioned in this guidance. As stated in 14 VAC 5-141-10 D, these are the only acceptable combinations. No other combinations of excepted benefits may be filed under a single policy unless approved in advance by the Bureau. Wellness benefits that are compliant with the rules below may be embedded in the body of a policy or included via a rider.

Specific Rules for Types of Excepted Benefits:

I. Accident

Wellness benefits cannot be included in Accident Only policies, based on federal and state definitions of "Accident Only" policies. The word "only" implies that this coverage is limited to coverage for accidents, including accidental death and dismemberment.

Accident Only coverage may be combined with other benefits as allowed under 14 VAC 5-141-50. However, the added benefits must conform to Accident Only coverage requirements, specified in 14 VAC 5-141-50.

II. Specified Disease

Any wellness benefit included in a Specified Disease policy must be related to the disease for which coverage is being provided. For instance, in a cancer-only policy, a wellness benefit that has nothing to do with cancer is not allowed.

III. Hospital or other Fixed Indemnity

In the individual market, wellness benefits may be included in a hospital or other fixed indemnity policy if the terms of 45 CFR 148.220 (b)(4) and 14 VAC 5-141-120 are satisfied. The definition of fixed indemnity in the individual market allows for payment of benefits to be structured on a fixed dollar amount "per period" of hospitalization or illness (which can be per day or other period of time) and/or "per service" (i.e., $100 per day or $50 per visit). These benefits must be paid as a fixed dollar amount regardless of the amount of expenses incurred. The benefit must not be a percentage of expenses incurred.

In the group market, the fixed dollar amount provided to the enrollee must be structured on a "per day (or per other period) of hospitalization or illness" basis; "per service" benefits in the group market are not permitted under 45 CFR 146.145 (b)(4) and 14 VAC 5-141-120 C. Services that are performed related to a day or other period of hospitalization or illness are diagnostic - not screening or preventive tests. As a result, wellness benefits are not allowable in group hospital or other fixed indemnity policies. A Tri-agency FAQ issued January 24, 2013 made clear that a group policy that pays on a per-service basis as opposed to on a per-period basis is a form of health coverage instead of an income replacement policy, and does not meet the conditions for an excepted benefits policy.

IV. Disability Income

Wellness benefits are not allowed in a disability income policy. This is because the policy trigger (disability) must first occur before any benefit may be paid. Disability income insurance may be combined with other benefits as allowed under 14 VAC 5-141-60. However, the added benefits must conform to disability income insurance requirements, specified in 14 VAC 5-141-60.

V. Limited Scope

Routine dental, hearing or vision exams that are specifically covered in limited scope dental, hearing or vision policies are allowable. Otherwise, limited scope excepted benefits policies may not include wellness benefits that do not adhere to the General Rules above.

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