WEST VIRGINIA CODE CHAPTER 33 ARTICLE 15

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§33-15-1. Scope of article.

Nothing in this article shall apply to or affect:

(a) Any policy of liability or workers' compensation insurance nor shall any of the references to "other insurance" contained in this article be interpreted to mean, include, or apply to, any policy of liability or workers' compensation insurance.

(b) Any group accident and sickness policy issued in accordance with article sixteen of this chapter.

(c) Life insurance (including endowment or annuity contracts), or contracts supplemental thereto, which contain only such provisions relating to accident and sickness insurance as (1) provide additional benefits in case of death by accidental means, or as (2) operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity in the event that the insured shall become totally and permanently disabled as defined by the contract or supplemental contract.

(d) Reinsurance.

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§33-15-1a. Premium rate increase requests; loss ratio requirement.

To be eligible to make a premium rate increase request after July 1, 1995, any insurer offering or which has in force accident and sickness insurance policies which are subject to the provisions of this article shall have a minimum anticipated loss ratio of sixty-five percent as to such policy form. In calculating its minimum anticipated loss ratio, an insurer shall include in its actual incurred claims the amount of premium taxes for the same experience period which are attributable to the policy forms affected by this section and which were paid to the State of West Virginia pursuant to the provisions of article three of this chapter.

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§33-15-1b. Rates, individual major medical policies.

(a) No individual major medical coverage policy may be approved by the commissioner for use in this state unless:

(1) The premium rates for the policy, after adjustment for any difference in policy benefits, which include, but are not limited to, deductibles, copayments and levels of care management, do not exceed by more than thirty percent the premium rates charged by the same insurer on any and all other individual major medical policies for those individuals with similar characteristics and factors, which the insurer has had approved by the commissioner within a five-year period preceding the date of the new policy filing by the insurer;

(2) The insurer files with the commissioner the opinion of a qualified actuary or other person acceptable to the commissioner which states:

(A) That the policy premium rate is in compliance with subdivision (1) of this subsection; and

(B) That the anticipated loss ratio for the combined experience of the policy taken together with all other individual major medical coverage policies which the insurer has had approved by the commissioner within a five-year period preceding the date of the new policy filing is equal to or greater than the loss ratio requirements set forth in section one-a of this article.

(3) For a period of three years after the effective date of this section, an insurer may have one or more policy forms which exceed the one hundred thirty percent requirement of subdivision (2) of this subsection: Provided, That any rate schedule increase for such policy form shall not exceed thirty-three and one-third percent of the rate schedule increase for the lowest rate policy form. During the final twelve months of this three- year period, an insurer may request an extension of time for compliance from the commissioner based on extenuating circumstances.

(b) An initial individual major medical policy form may be disapproved by the commissioner if the commissioner determines that the rates proposed by the insurer for the policy form are set at a level substantially less than rates charged by other insurers for comparable insurance coverage.

(c) Nothing contained in this section may be construed to prevent the use of age, sex, area, industry, occupational, and avocational factors in setting premium rates or to prevent the use of different rates after approval by the commissioner for smokers and nonsmokers or for any other habit or habits of an insured person which have a statistically proven effect on the health of the person. Nothing contained in this section shall preclude the establishment of a substandard classification based upon the health condition of the insured: Provided, That the initial classification may not be changed adversely to the insured after the initial issuance of the policy.

(d) The commissioner has the right, upon application by an insurer, and for good cause

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shown, to grant relief from any requirement of this section.

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§33-15-2. Scope and format of policy.

No policy of accident and sickness insurance shall be delivered or issued for delivery to any person in this state unless:

(a) The entire money and other considerations therefor are expressed therein; and

(b) The time at which the insurance takes effect and terminates is expressed therein; and

(c) It purports to insure only one person, except that a policy may insure, originally or by subsequent amendment upon the application of an adult member of a family who shall be deemed the policyholder, any two or more eligible members of that family, including husband, wife, dependent children or any children under a specified age which shall not exceed nineteen years and any other person dependent upon the policyholder; and

(d) The policy is guaranteed to be renewable at the option of the insured except as provided in section two-d of this article; and

(e) The style, arrangement and over-all appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than ten-point with a lowercase unspaced alphabet length not less than one hundred and twenty-point (the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions), the policy shall clearly indicate on the first page the conditions of renewability; and

(f) The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in sections four and five of this article, are printed, at the insurer's option, either included with the benefit provisions to which they apply, or under an appropriate caption such as "Exceptions," or "Exceptions and Reductions": Provided, That if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies; and

(g) Each such form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first part thereof; and

(h) It contains no provision purporting to make any portion of the charter, rules, Constitution, or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the commissioner; and

(i) Effective July 1, 1997, the insurer offers and accepts for enrollment pursuant to section two-b of this article every eligible individual who applies for coverage within sixty-three days after termination of the individual's prior creditable coverage.

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§33-15-2a. Definitions.

For purposes of this section and sections two-b, two-c, two-d, two-e, two-f, two-g and four-e:

(a) "Accident and sickness insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy of certificate, hospital or medical service plan contract, or health maintenance organization contract offered by an insurer, but does not include short-term limited duration insurance.

(b) "Bona fide association" means an association which has been actively in existence for at least five years; has been formed and maintained in good faith for purposes other than obtaining insurance; does not condition membership in the association on any health status-related factor relating to an individual; makes accident and sickness insurance coverage offered through the association available to all members regardless of any health status-related factor relating to the members or individuals eligible for coverage through a member; does not make accident and sickness insurance coverage offered through the association available other than in connection with a member of the association; and meets any additional requirements as may be set forth in this chapter or by rule.

(c) "COBRA continuation provision" means any of the following:

(1) Section 4980B of the Internal Revenue Code of 1986, other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines;

(2) Part 6 of Subtitle B of Title I of the Employee Retirement Income Security Act of 1974, other than Section 609 of such act; or

(3) Title XXII of the Public Health Service Act.

(d) "Creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:

(1) A group health plan;

(2) Accident and sickness insurance coverage;

(3) Part A or Part B of Title XVIII of the Social Security Act;

(4) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;

(5) Chapter 55 of Title 10 of the United States Code;

(6) A medical care program of the Indian Health Service or of a tribal organization;

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(7) A state health benefits risk pool;

(8) A health plan offered under Chapter 89 of Title 5 of the United States Code;

(9) A public health plan (as defined in federal regulations); or

(10) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

The term "creditable coverage" does not include those benefits set forth in section two-g of this article.

(e) "Eligible individual" means an individual:

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

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

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

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

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

(f) "Group health plan" means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974) to the extent that the plan provides medical care to employees and their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement or otherwise.

(g) "Health status-related factor" means an individual's health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, and evidence of insurability (including conditions arising out of acts of domestic violence) or disability.

(h) "Higher-level coverage" means a policy form for which the actuarial value of the benefits under the coverage is at least fifteen percent greater than the actuarial value of lower-level

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coverage offered by the insurer in this state, and the actuarial value of the benefits under the coverage is at least one hundred percent but not greater than one hundred twenty percent of a weighted average.

(i) "Individual market" means the market for accident and sickness insurance coverage offered to individuals other than in connection with a group health plan.

(j) "Insurer" means an entity licensed by the commissioner to transact accident and sickness insurance in this state and subject to this chapter, but does not include a group health plan or short term limited duration insurance.

(k) "Lower-level coverage" means a policy form for which the actuarial value of the benefits under the coverage is at least eighty-five percent but not greater than one hundred percent of a weighted average.

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

(m) "Network plan" means accident and sickness insurance coverage of an insurer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a definite set of providers under contract with the insurer.

(n) "Preexisting condition exclusion" means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before such date.

(o) "Weighted average" means the average actuarial value of the benefits provided by all the accident and sickness insurance coverage issued (as elected by the insurer) either by that insurer or by all insurers in this state in the individual accident and sickness market during the previous year (not including coverage issued under this section), weighted by enrollment for the different coverage.

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§33-15-2b. Guaranteed issue; limitation of coverage; election; denial of coverage; network plans.

(a) Each insurer that offers accident and sickness insurance coverage in the individual market in this state may not, with respect to an eligible individual desiring to enroll in individual accident and sickness insurance coverage:

(1) Decline to offer coverage to, or deny enrollment of, an eligible individual; or

(2) Impose any preexisting condition exclusion with respect to such coverage.

(b) An insurer may elect to limit the coverage offered under subsection (a) of this section so long as:

(1) The insurer offers at least two different accident and sickness insurance policy forms, both of which are designed for, made generally available to, and actively marketed to, and enroll both eligible and other individuals; and

(2) As elected by the insurer:

(A) The insurer offers the policy forms for individual accident and sickness insurance coverage with the largest, and next to the largest, premium volume of all such policy forms offered by the insurer in this state in the period involved; or

(B) The insurer offers a lower-level coverage policy form and a higher-level coverage policy form each of which includes benefits substantially similar to other individual accident and sickness insurance coverage offered by the insurer in this state and each of which is covered under a risk adjustment, risk spreading, or financial subsidization method. The actuarial value of benefits under a lower-level coverage policy form and a higher-level coverage policy form shall be calculated based on a standardized population and a set of standardized utilization and cost factors.

(c) The elections made by the insurer under subsection (b) of this section shall apply uniformly to all eligible individuals in this state for that insurer, and shall be effective for policies offered during a period of at least two years. Policy forms which have different riders or different cost-sharing arrangements shall be considered to be different policy forms.

(d) An insurer may deny accident and sickness coverage in the individual market to an eligible individual if the insurer has demonstrated to the satisfaction of the commissioner that:

(1) It does not have the financial reserves necessary to underwrite additional coverage; and

(2) Coverage is denied uniformly to all individuals in the individual market in the state without regard to any health status-related factor of the individuals and without regard to

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whether the individuals are eligible individuals.

(e) An insurer denying insurance coverage pursuant to the provisions of subsection (d) of this section may not offer accident and sickness coverage in the individual market for a period of one hundred eighty days after the date coverage is denied or until the insurer has demonstrated to the satisfaction of the commissioner that it has sufficient financial reserves to underwrite additional coverage, whichever is later.

(f) Insurers offering accident and sickness insurance coverage in the individual market through a network plan may:

(1) Limit the individuals who may be enrolled to those who live, reside or work within the service area for the network plan; and

(2) Deny coverage to those individuals within the service area if the insurer has demonstrated to the satisfaction of the commissioner that:

(A) It will not have the capacity to deliver services adequately to additional individual enrollees because of its obligations to existing group contract holders and enrollees and individual enrollees; and

(B) It is applying this subsection uniformly to individuals without regard to any health status-related factor of the individuals and without regard to whether the individuals are eligible individuals.

(g) An insurer denying accident and sickness insurance coverage through a network plan pursuant to the provisions of subsection (f) of this section may not offer coverage in the individual market within its service area for a period of one hundred eighty days after coverage is denied.

(h) The provisions of this section shall not be construed to require that an insurer offering accident and sickness coverage only in connection with group health plans or through one or more bona fide associations, or both, offer such accident and sickness insurance coverage in the individual market.

(i) An insurer offering accident and sickness insurance coverage in connection with group health plans shall not be deemed to be an insurer offering individual accident and sickness insurance coverage in the individual market solely because such insurer offers a conversion policy.

(j) The requirements of section one-b of this article do not apply to policies issued pursuant to this section. However, premium rate charges for individual accident and sickness policies issued pursuant to this section shall be filed with and approved by the commissioner pursuant to the provisions of article sixteen-b of this chapter.

(k) This section applies to individual accident and sickness insurance coverage offered, sold,

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issued, renewed or in effect after June 30, 1997.

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§33-15-2c. Feasibility study for alternatives to guaranteed issue.

The Legislature finds that alternatives to the provisions of this article relating to guaranteed issue of individual accident and sickness insurance policies do exist but the feasibility of these alternatives are not presently known. Therefore, the commissioner is to perform or have performed a study as to the feasibility of these alternatives and their impact upon the individual market. The results of this study shall be provided to the Legislature during its regular session in the year one thousand nine hundred ninety-eight.

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§33-15-2d. Exceptions to guaranteed renewability.

(a) An insurer may nonrenew or discontinue accident and sickness insurance coverage of an individual in the individual market based only on one or more of the following:

(1) The individual has failed to pay premiums or contributions in accordance with the terms of the policy or the insurer has not received timely premium payments;

(2) The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of coverage;

(3) The insurer is ceasing to offer coverage in accordance with the provisions of section two-e of this article;

(4) In the case of an insurer that offers coverage through a network plan, the individual no longer resides, lives or works in the service area but only if coverage is terminated uniformly without regard to any health status-related factor of covered individuals; or

(5) In the case of coverage made available in the individual market only through one or more bona fide associations, the individual's membership in the association ceases but only if coverage is terminated uniformly without regard to any health-status related factor of covered individuals.

(b) This section applies to individual accident and sickness insurance coverage offered, sold, issued, renewed or in effect after June 30, 1997.

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§33-15-2e. Discontinuation of particular type of coverage; uniform termination of all coverage; uniform modification of coverage.

(a) An insurer may discontinue offering a particular type of accident and sickness insurance coverage in the individual market only if:

(1) The insurer provides written notice to each individual provided this type of coverage at least ninety days prior to the date of the discontinuation of coverage;

(2) The insurer offers to each individual in the individual market provided this type of coverage the option to purchase any other type of individual accident and sickness insurance policy currently offered by that insurer; and

(3) The insurer acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for coverage.

(b) An insurer may discontinue offering all individual accident and sickness insurance coverage in the individual market offered in this state only if:

(1) The insurer provides written notice to the Insurance Commissioner and to each insured of the discontinuation at least one hundred eighty days prior to the expiration of coverage; and

(2) All accident and sickness insurance policies issued or delivered for issuance in this state in the individual market are discontinued and coverage under the policies in the individual market is not renewed.

(c) In the case of discontinuation under subsection (b) of this section, the insurer may not provide for the issuance of any accident and sickness insurance coverage in the individual market and state during the five-year period beginning on the date of the discontinuation of the last accident and sickness insurance coverage not so renewed.

(d) At the time of renewal, an insurer may modify coverage under an accident and sickness policy only if the modification is consistent with the provisions of this article and article twenty-eight of this chapter and is effective on a uniform basis among all individuals with that policy form. For individuals who are eligible for Medicare at the time of renewal, the insurer may modify coverage to reduce benefits by an amount no more than that paid by Medicare.

(e) This section applies to individual accident and sickness insurance coverage offered, sold, issued, renewed or in effect after June 30, 1997.

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§33-15-2f. Certification of creditable coverage.

An insurer offering accident and sickness insurance coverage pursuant to the provisions of this article shall provide certification of creditable coverage in the same manner as provided in section three-m, article sixteen of this chapter.

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§33-15-2g. Applicability.

(a) The requirements of sections two-b, two-d, two-e and two-f of this article and the provisions of this article which generally require policies of accident and sickness insurance to cover specific conditions or treatments, but which are not expressly made applicable to the following types of policies, do not apply to:

(1) Coverage only for accident, or disability income insurance or any combination thereof;

(2) Coverage issued as a supplement to liability insurance;

(3) Liability insurance, including general liability insurance and automobile liability insurance;

(4) Workers' Compensation or similar insurance;

(5) Automobile medical payment insurance;

(6) Credit-only insurance;

(7) Coverage for on-site medical clinics; and

(8) Other similar insurance coverage, which may be specified by rule, under which benefits for medical care are secondary or incidental to other insurance benefits.

(b) The requirements of sections two-b, two-d, two-e and two-f of this article and the provisions of this article which generally require policies of accident and sickness insurance to cover specific conditions or treatments, but which are not expressly made applicable to the following types of policies, do not apply to the following if provided under a separate policy, certificate, or contract of insurance:

(1) Limited scope dental or vision benefits;

(2) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;

(3) Coverage for only a specified disease or illness;

(4) Hospital indemnity or other fixed indemnity insurance;

(5) Medicare supplement insurance (as defined under section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under group accident and sickness insurance; and

(6) Any other benefits as may be specified by rule.

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§33-15-3. Age limit.

If any such policy contains a provision establishing as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date, the coverage provided by the policy will continue in force until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective, or would have ceased prior to the acceptance of such premium or premiums, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy.

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§33-15-4. Required policy provisions.

Except as provided in section six of this article, each such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in this section in the words in which the same appear in this section: Provided, That the insurer may, at its option, substitute for one or more of such provisions corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the caption appearing in this section or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

(a) A provision as follows:

"Entire Contract; Changes: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions."

(b) A provision as follows:

"Time Limit on Certain Defenses: (1) After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two-year period."

The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two-year period, nor to limit the application of subdivisions (a), (b), (c), (d) and (e) of section five of this article in the event of misstatement with respect to age or occupation or other insurance. A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (i) until at least age fifty, or (ii) in the case of a policy issued after age forty-four, for at least five years from its date of issue, may contain in lieu of the foregoing the following provision (from which the clause in parentheses may be omitted at the insurer's option) under the caption "Incontestable":

"After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.

(2) No claim for loss incurred or disability (as defined in the policy) commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy."

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(c) A provision as follows:

"Grace Period: A grace period of _____ (insert a number not less than '7' for weekly premium policies, '10' for monthly premium policies and '31' for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force."

(d) A provision as follows:

"Reinstatement: If any renewal premium be not paid within the time granted the insured for payment, as subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy: Provided, That if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer, or lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement."

(e) A provision as follows:

"Notice of Claim: Written notice of claim must be given to the insurer within twenty days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at _____ (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer."

In a policy providing a loss-of-time benefit which may be payable for at least two years, an insurer may at its option insert the following between the first and second sentences of the above provision:

"Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, he shall, at least once in every six months after having given notice of claim give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of six months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability, in whole or in part, by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six months preceding

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the date on which such notice is actually given."

(f) A provision as follows:

"Claim Forms: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made."

(g) A provision as follows:

"Proof of Loss: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required."

(h) A provision as follows:

"Time of Payment of Claims: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid _____ (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof."

(i) A provision as follows: "Payment of Claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured."

The following provisions, or either of them, may be included with the foregoing provisions at the option of the insurer:

"If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer

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may pay such indemnity, up to an amount not exceeding $_____ (insert an amount which shall not exceed $1,000), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment."

"Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person."

(j) A provision as follows:

"Physical Examinations and Autopsy: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law."

(k) A provision as follows:

"Legal Actions: No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished."

(l) A provision as follows:

"Change of Beneficiary: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy."

The first clause of this provision, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.

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§33-15-4a. Required coverage for scalp cooling system for cancer chemotherapy treatment.

(a) This section shall be known and cited as "Jessica Huffman's Law".

(b) For the purpose of this section, "scalp cooling system" means any device used to cool the human scalp to prevent or reduce hair loss during cancer chemotherapy treatment, provided that such device is designed and intended for repeated use and is primarily and customarily used to serve a medical purpose.

(c) Any insurer who delivers or issues a policy, plan, or contact that is issued or renewed on or after January 1, 2027, under the provisions of this article and provides coverage for cancer chemotherapy treatment shall provide coverage for scalp cooling systems used in connection with cancer chemotherapy treatment as defined by the Centers for Medicare and Medicaid Services. Coverage provided under this section may be subject to annual deductibles and coinsurance, including copayments, as may be deemed appropriate by the commissioner and as are consistent with those established for other benefits within a given policy.

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§33-15-4b. Policies to cover nursing services; definition.

(a) Any insurer who, on or after January 1, 1984, delivers or issues a policy of accident and sickness insurance in this state under the provisions of this article shall make available as benefits to all subscribers and members coverage for primary health care nursing services as hereinafter set forth if such services are currently being reimbursed when rendered by any other duly licensed health care practitioner. No insurer may be required to pay for duplicative health care services actually provided by both a registered professional nurse or licensed midwife and other health providers.

(b) For purposes of this section, section three-e, article sixteen and section seven-a, article twenty-four of this chapter, "primary health care nursing services" includes nursing care rendered by a nonsalaried duly licensed registered professional nurse engaged in private nursing practice or partnership with other health care providers within the lawful scope of practice as defined in section one, article seven, chapter thirty of this code, and care rendered by a licensed nurse-midwife or midwife as the occupation is defined in section one, article fifteen, chapter thirty of this code, and which care is within the scope of duties for such licensed nurse-midwife or midwife as permitted by the provisions of section seven, article fifteen of said chapter thirty.

(c) Nothing in this section may be construed to permit any registered professional nurse licensee or midwife licensee to perform professional services beyond such individual's areas of professional competence as established by education, training and experience.

WV Legislature

§33-15-4c. Third party reimbursement for mammography, pap smear or human papilloma virus testing.

(a) Notwithstanding any provision of any policy, provision, contract, plan or agreement to which this article applies, whenever reimbursement or indemnity for laboratory or X-ray services are covered, reimbursement or indemnification shall not be denied for any of the following when performed for cancer screening or diagnostic purposes, at the direction of a person licensed to practice medicine and surgery by the board of Medicine:

(1) Mammograms when medically appropriate and consistent with the current guidelines from the United States Preventive Services Task Force.

(2) A pap smear, either conventional or liquid-based cytology, whichever is medically appropriate and consistent with the current guidelines from either the United States Preventive Services Task Force or The American College of Obstetricians and Gynecologists for women age eighteen or over; or

(3) A test for the human papilloma virus (HPV), for women age eighteen or over when medically appropriate and consistent with the current guidelines from either the United States Preventive Services Task Force or The American College of Obstetricians and Gynecologists for women age eighteen and over.

(b) A policy, provision, contract, plan or agreement may apply to mammograms, pap smears or human papilloma virus (HPV) test the same deductibles, coinsurance and other limitations as apply to other covered services.

WV Legislature

§33-15-4d. Third party reimbursement for rehabilitation services.

(a) Notwithstanding any provision of any policy, provision, contract, plan or agreement to which this article applies, any entity regulated by this article shall, on or after July 1, 1991, provide as benefits to all subscribers and members coverage for rehabilitation services as hereinafter set forth, unless rejected by the insured.

(b) For purposes of this article and section, "rehabilitation services" includes those services which are designed to remediate patient's condition or restore patients to their optimal physical, medical, psychological, social, emotional, vocational and economic status. Rehabilitative services include by illustration and not limitation diagnostic testing, assessment, monitoring or treatment of the following conditions individually or in a combination:

(1) Stroke;

(2) Spinal cord injury;

(3) Congenital deformity;

(4) Amputation;

(5) Major multiple trauma;

(6) Fracture of femur;

(7) Brain injury;

(8) Polyarthritis, including rheumatoid arthritis;

(9) Neurological disorders, including, but not limited to, multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy and Parkinson's disease;

(10) Cardiac disorders, including, but not limited to, acute myocardial infarction, angina pectoris, coronary arterial insufficiency, angioplasty, heart transplantation, chronic arrhythmias, congestive heart failure, valvular heart disease;

(11) Burns.

(c) Rehabilitation services includes care rendered by any of the following:

(1) A hospital duly licensed by the State of West Virginia that meets the requirements for rehabilitation hospitals as described in Section 2803.2 of the Medicare Provider Reimbursement Manual, Part 1, as published by the U.S. Health Care Financing Administration;

(2) A distinct part rehabilitation unit in a hospital duly licensed by the State of West Virginia.

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The distinct part unit must meet the requirements of Section 2803.61 of the Medicare Provider Reimbursement Manual, Part 1, as published by the U.S. Health Care Financing Administration;

(3) A hospital duly licensed by the State of West Virginia which meets the requirements for cardiac rehabilitation as described in Section 35-25, Transmittal 41, dated August, 1989, as promulgated by the U.S. Health Care Financing Administration.

(d) Rehabilitation services do not include services for mental health, chemical dependency, vocational rehabilitation, long-term maintenance or custodial services.

(e) A policy, provision, contract, plan or agreement may apply to rehabilitation services the same deductibles, coinsurance and other limitations as apply to other covered services.

WV Legislature

§33-15-4e. Benefits for mothers and newborns.

(a) Nothing in this section shall be construed to require a mother to give birth in a hospital or to stay in a hospital for a fixed period of time following the birth of her child. However, an insurer offering accident and sickness insurance coverage under this article may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or her newborn child to less than forty-eight hours following a normal vaginal delivery, or to less than ninety-six hours following a cesarean section, or require a provider to obtain authorization for such length hospital stays. The mother and her newborn child may be discharged prior to the expiration of the minimum length of stay required under this section only in those cases in which the decision to discharge is made by an attending provider in consultation with the mother.

(b) Coverage for maternity and pediatric care shall be provided in accordance with guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or other established professional medical associations.

(c) Benefits provided under this section may be subject to deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital stays in connection with childbirth for a mother or newborn child if the coinsurance or other cost-sharing for any portion of the hospital stay required under subsection (a) of this section is no greater than the coinsurance or cost-sharing for any preceding portion of the stay.

(d) Nothing in this section may be construed to prevent an insurer from negotiating the level and type of reimbursement with a provider for the care provided a mother or newborn child in connection with childbirth.

(e) This section shall not apply with respect to any accident and sickness insurance coverage which does not provide benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn child.

(f) This section shall apply to accident and sickness insurance coverage offered, sold, issued, renewed, or in effect in the individual market on or after January 1, 1998.

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§33-15-4f. Third party reimbursement for colorectal cancer examination and laboratory testing.

(a) Notwithstanding any provision of any policy, provision, contract, plan or agreement applicable to this article, reimbursement or indemnification for colorectal cancer examinations and laboratory testing may not be denied for any nonsymptomatic person fifty years of age or older, or a symptomatic person under fifty years of age, when reimbursement or indemnity for laboratory or X-ray services are covered under the policy and are performed for colorectal cancer screening or diagnostic purposes at the direction of a person licensed to practice medicine and surgery by the board of Medicine. The tests are as follows: An annual fecal occult blood test, a flexible sigmoidoscopy repeated every five years, a colonoscopy repeated every ten years and a double contrast barium enema repeated every five years.

(b) A symptomatic person is defined as: (i) An individual who experiences a change in bowel habits, rectal bleeding or stomach cramps that are persistent; or (ii) an individual who poses a higher than average risk for colorectal cancer because he or she has had colorectal cancer or polyps, inflammatory bowel disease, or an immediate family history of such conditions.

(c) The same deductibles, coinsurance, network restrictions and other limitations for covered services found in the policy, provision, contract, plan or agreement of the covered person may apply to colorectal cancer examinations and laboratory testing.

WV Legislature

§33-15-4g. Required coverage for reconstruction surgery following mastectomies.

(a) Any policy of insurance described in this article which provides medical and surgical benefits with respect to a mastectomy shall provide, in a case of a policyholder who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for:

(1) All stages of reconstruction of the breast on which the mastectomy has been performed;

(2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(3) Prostheses and physical complications of mastectomy, including lymphedemas in a manner determined in consultation with the attending physician and the patient. Coverage shall be provided for a minimum stay in the hospital of not less than forty-eight hours for a patient following a radical or modified mastectomy and not less than twenty-four hours of inpatient care following a total mastectomy or partial mastectomy with lymph node dissection for the treatment of breast cancer. Nothing in this section shall be construed as requiring inpatient coverage where inpatient coverage is not medically necessary or where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the health benefit plan policy or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter.

(b) A health benefit plan policy, and a health insurer providing health insurance coverage in connection with a health benefit plan policy, shall provide notice to each participant and beneficiary under such plan regarding the coverage required by this section. Such notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the issuer of the health benefit plan policy.

(c) A health benefit plan policy and a health insurer offering health insurance coverage in connection with a health benefit plan policy, may not:

(1) Deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section; and

(2) Penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide incentives (monetary or otherwise) to an attending provider, to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section.

(d) Nothing in this section shall be construed to prevent a health benefit plan policy or a health insurer offering health insurance coverage from negotiating the level and type of

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reimbursement with a provider for care provided in accordance with this section.

(e) The provisions of this section shall be included under any policy, contract or plan delivered after July 1, 2002.

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§33-15-4h. Coverage for patient cost of clinical trials.

The provisions relating to clinical trials established in article twenty-five-f of this chapter shall apply to the individual market regulated by this article.

WV Legislature

§33-15-4i. Third-party reimbursement for kidney disease screening.

(a) Notwithstanding any provision of any policy, provision, contract, plan or agreement applicable to this article, reimbursement or indemnification for annual kidney disease screening and laboratory testing as recommended by the National Kidney Foundation may not be denied for any person when reimbursement or indemnity for laboratory or X-ray services are covered under the policy and are performed for kidney disease screening or diagnostic purposes at the direction of a person licensed to practice medicine and surgery by the board of Medicine. The tests are as follows: Any combination of blood pressure testing, urine albumin or urine protein testing and serum creatinine testing.

(b) The same deductibles, coinsurance, network restrictions and other limitations for covered services found in the policy, provision, contract, plan or agreement of the covered person may apply to kidney disease screening and laboratory testing.

WV Legislature

§33-15-4j. Required coverage for dental anesthesia services.

(a) Notwithstanding any provision of any policy, provision, contract, plan or agreement to which this article applies, any entity regulated by this article shall, on or after July 1, 2009, provide as benefits to all subscribers and members coverage for dental anesthesia services as hereinafter set forth.

(b) For purposes of this article and section, "dental anesthesia services" means general anesthesia for dental procedures and associated outpatient hospital or ambulatory facility charges provided by appropriately licensed health care individuals in conjunction with dental care provided to an enrollee or insured if the enrollee or insured is:

(A) Seven years of age or younger or is developmentally disabled and is an individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual or other medically compromising condition of the enrollee or insured and for whom a superior result can be expected from dental care provided under general anesthesia; or

(B) A child who is twelve years of age or younger with documented phobias, or with documented mental illness, and with dental needs of such magnitude that treatment should not be delayed or deferred and for whom lack of treatment can be expected to result in infection, loss of teeth or other increased oral or dental morbidity and for whom a successful result cannot be expected from dental care provided under local anesthesia because of such condition and for whom a superior result can be expected from dental care provided under general anesthesia.

(c) Prior authorization. -- An entity subject to this section may require prior authorization for general anesthesia and associated outpatient hospital or ambulatory facility charges for dental care in the same manner that prior authorization is required for these benefits in connection with other covered medical care.

(d) An entity subject to this section may restrict coverage for general anesthesia and associated outpatient hospital or ambulatory facility charges unless the dental care is provided by:

(1) A fully accredited specialist in pediatric dentistry; (2) A fully accredited specialist in oral and maxillofacial surgery; and

(3) A dentist to whom hospital privileges have been granted.

(e) Dental care coverage not required. -- The provisions of this section may not be construed to require coverage for the dental care for which the general anesthesia is provided.

(f) Temporal mandibular joint disorders. -- The provisions of this section do not apply to dental care rendered for temporal mandibular joint disorders.

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(g) A policy, provision, contract, plan or agreement may apply to dental anesthesia services the same deductibles, coinsurance and other limitations as apply to other covered services.

WV Legislature

§33-15-4k. Maternity coverage.

Notwithstanding any provision of any policy, provision, contract, plan or agreement applicable to this article, any health insurance policy subject to this article, issued or renewed on or after January 1, 2014, which provides health insurance coverage for maternity services, shall provide coverage for maternity services for all persons participating in or receiving coverage under the policy. To the extent that the provisions of this section require benefits that exceed the essential health benefits specified under section 1302(b) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended, the specific benefits that exceed the specified essential health benefits are not required of a health benefit plan when the plan is offered by a health care insurer in this state. Coverage required under this section may not be subject to exclusions or limitations which are not applied to other maternity coverage under the policy.

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§33-15-4l. Deductibles, copayments and coinsurance for anti-cancer medications.

(a) Any accident and sickness insurance policy issued by an insurer pursuant to this article that covers anti-cancer medications that are injected or intravenously administered by a health care provider and patient administered anti-cancer medications, including, but not limited to, those medications orally administered or self-injected, may not require a less favorable basis for a copayment, deductible or coinsurance amount for patient administered anti-cancer medications than it requires for injected or intravenously administered anti-cancer medications, regardless of the formulation or benefit category determination by the policy or plan.

(b) An accident or sickness insurance policy may not comply with subsection (a) of this section by:

(1) Increasing the copayment, deductible or coinsurance amount required for injected or intravenously administered anti-cancer medications that are covered under the policy or plan; or

(2) Reclassifying benefits with respect to anti-cancer medications.

(c) As used in this section, "anti-cancer medication" means a FDA approved medication prescribed by a treating physician who determines that the medication is medically necessary to kill or slow the growth of cancerous cells in a manner consistent with nationally accepted standards of practice.

(d) This section is effective for policy and plan years beginning on or after January 1, 2016. This section applies to all group accident and sickness insurance policies and plans subject to this article that are delivered, executed, issued, amended, adjusted or renewed in this state, on and after the effective date of this section.

(e) Notwithstanding any other provision in this section to the contrary, in the event that an insurer can demonstrate actuarially to the Insurance Commissioner that its total costs for compliance with this section will exceed or have exceeded two percent of the total costs for all accident and sickness insurance coverage issued by the insurer subject to this article in any experience period, then the insurer may apply whatever cost containment measures may be necessary to maintain costs below two percent of the total costs for the coverage: Provided, That the cost containment measures implemented are applicable only for the plan year or experience period following approval of the request to implement cost containment measures.

(f) For any enrollee that is enrolled in a catastrophic plan as defined in Section 1302(e) of the Affordable Care Act or in a plan that, but for this requirement, would be a High Deductible Health Plan as defined in section 223(c)(2)(A) of the Internal Revenue Code of 1986, and that, in connection with every enrollment, opens and maintains for each enrollee a Health Savings Account as that term is defined in section 223(d) of the Internal Revenue

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Code of 1986, the cost-sharing limit outlined in subsection (a) of this section shall be applicable only after the minimum annual deductible specified in section 223(c)(2)(A) of the Internal Revenue Code of 1986 is reached. In all other cases, this limit shall be applicable at any point in the benefit design, including before and after any applicable deductible is reached.

WV Legislature

§33-15-4m. Eye drop prescription refills.

An insurance policy issued by an insurer pursuant to this article for prescription topical eye medication may not deny coverage for the refilling of a prescription for topical eye medication when:

(1) The medication is to treat a chronic condition of the eye;

(2) The refill is requested by the insured prior to the last day of the prescribed dosage period and after at least 70% of the predicted days of use; and

(3) A person licensed under chapter thirty and authorized to prescribe topical eye medication indicates on the original prescription that refills are permitted and that the early refills requested by the insured do not exceed the total number of refills prescribed.

WV Legislature

§33-15-4n. Deductibles, copayments and coinsurance for abuse-deterrent opioid analgesic drugs.

(a) As used in this section:

(1) "Abuse-deterrent opioid analgesic drug product" means a brand name or generic opioid analgesic drug product approved by the United States Food and Drug Administration with abuse-deterrent labeling that indicates its abuse-deterrent properties are expected to deter or reduce its abuse;

(2) "Cost-sharing" means any coverage limit, copayment, coinsurance, deductible or other out-of-pocket expense requirements;

(3) "Opioid analgesic drug product" means a drug product that contains an opioid agonist and is indicated by the United States Food and Drug Administration for the treatment of pain, regardless of whether the drug product:

(A) Is in immediate release or extended release form; or

(B) Contains other drug substances.

(b) Notwithstanding any provision of any accident and sickness insurance policy issued by an insurer, on or after January 1, 2017:

(1) Coverage shall be provided for at least one abuse-deterrent opioid analgesic drug product for each active opioid analgesic ingredient;

(2) Cost-sharing for brand name abuse-deterrent opioid analgesic drug products shall not exceed the lowest tier for brand name prescription drugs on the entity's formulary for prescription drug coverage;

(3) Cost-sharing for generic abuse-deterrent opioid analgesic drug products covered pursuant to this section shall not exceed the lowest cost-sharing level applied to generic prescription drugs covered under the applicable health plan or policy; and

(4) An entity subject to this section may not require an insured or enrollee to first use an opioid analgesic drug product without abuse-deterrent labeling before providing coverage for an abuse-deterrent opioid analgesic drug product covered on the entity's formulary for prescription drug coverage.

(c) Notwithstanding subdivision (3), subsection (b) of this section, an entity subject to this section may undertake utilization review, including preauthorization, for an abuse-deterrent opioid analgesic drug product covered by the entity, if the same utilization review requirements are applied to nonabuse-deterrent opioid analgesic drug products and with the same type of drug release, immediate or extended.

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(d) For purposes of subsection (b) of this section, the lowest tier and the lowest cost-sharing level shall not mean the cost-sharing tier applicable to preventive care services which are required to be provided at no cost-sharing under the Patient Protection and Affordable Care Act.

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§33-15-4o. Step therapy.

(a) As used in this article:

(1) “Health benefit plan” means a policy, contract, certificate or agreement entered into, offered or issued by a health plan issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

(2) “Health plan issuer” or “issuer” means an entity required to be licensed under this chapter that contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan, including accident and sickness insurers, nonprofit hospital service corporations, medical service corporations and dental service organizations, prepaid limited health service organizations, health maintenance organizations, preferred provider organizations, provider sponsored network, and any pharmacy benefit manager that administers a fully-funded or self-funded plan.

(3) “Step therapy protocol” means a protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition, and medically appropriate for a particular patient, are covered by a health plan issuer or health benefit plan.

(4) “Step therapy override determination” means a determination as to whether a step therapy protocol should apply in a particular situation, or whether the step therapy protocol should be overridden in favor of immediate coverage of the health care provider’s selected prescription drug. This determination is based on a review of the patient’s or prescriber’s request for an override, along with supporting rationale and documentation.

(5) “Utilization review organization” means an entity that conducts utilization review, other than a health plan issuer performing utilization review for its own health benefit plan.

(b) A health benefit plan that includes prescription drug benefits, and which utilizes step therapy protocols, and which is issued for delivery, delivered, renewed, or otherwise contracted in this state on or after January 1, 2018, shall comply with the provisions of this article.

(c) Step therapy protocol exceptions include:

(1) When coverage of a prescription drug for the treatment of any medical condition is restricted for use by health plan issuer or utilization review organization through the use of a step therapy protocol, the patient and prescribing practitioner shall have access to a clear and convenient process to request a step therapy exception determination. The process shall be made easily accessible on the health plan issuer’s or utilization review organization’s website. The health plan issuer or utilization review organization must provide a prescription drug for treatment of the medical condition at least until the step therapy exception

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determination is made.

(2) A step therapy override determination request shall be expeditiously granted if:

(A) The required prescription drug is contraindicated or will likely cause an adverse reaction by or physical or mental harm to the patient.

(B) The required prescription drug is expected to be ineffective based on the known relevant physical or mental characteristics of the patient and the known characteristics of the prescription drug regimen.

(C) The patient has tried the required prescription drug while under their current or a previous health insurance or health benefit plan, or another prescription drug in the same pharmacologic class or with the same mechanism of action and such prescription drug was discontinued due to a lack of efficacy or effectiveness, diminished effect, or an adverse event.

(D) The required prescription drug is not in the best interest of the patient, based upon medical appropriateness.

(E) The patient is stable on a prescription drug selected by their health care provider for the medical condition under consideration.

(3) Upon the granting of a step therapy override determination, the health plan issuer or utilization review organization shall authorize coverage for the prescription drug prescribed by the patient’s treating healthcare provider, provided such prescription drug is a covered prescription drug under such policy or contract.

(4) This section shall not be construed to prevent:

(A) A health plan issuer or utilization review organization from requiring a patient to try an AB-Rated generic equivalent prior to providing coverage for the equivalent branded prescription drug.

(B) A health care provider from prescribing a prescription drug that is determined to be medically appropriate.

WV Legislature

§33-15-4p. Lyme disease to be covered by all health insurance policies.

Any insurer who, on or after January 1, 2019, delivers or issues a policy of accident and sickness insurance in this state under the provisions of this article shall make available as benefits to all subscribers and members coverage on an expense-incurred basis and individual and group service or indemnity type contracts issued by a nonprofit corporation shall provide coverage for long-term antibiotic therapy for a patient with Lyme disease when determined to be medically necessary and ordered by a licensed physician after making a thorough evaluation of the patient's symptoms, diagnostic test results, or response to treatment.

WV Legislature

§33-15-4q. Coverage for amino acid-based formulas.

(a) A policy, plan, or contract that is issued or renewed on or after January 1, 2019, and that is subject to this article shall provide coverage, through the age of 20, for amino acid-based formula for the treatment of severe protein-allergic conditions or impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract. This includes the following conditions, if diagnosed as related to the disorder by a physician licensed to practice in this state pursuant to either §30-3-1 et seq. or §30-14-1 et seq. of this code:

(1) Immunoglobulin E and Nonimmunoglobulin E-medicated allergies to multiple food proteins;

(2) Severe food protein-induced enterocolitis syndrome;

(3) Eosinophilic disorders as evidenced by the results of a biopsy; and

(4) Impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract (short bowel).

(b) The coverage required by §33-15-4p(a) of this code shall include medical foods for home use for which a physician has issued a prescription and has declared them to be medically necessary, regardless of methodology of delivery.

(c) For purposes of this section, “medically necessary foods” or “medical foods” shall mean prescription amino acid-based elemental formulas obtained through a pharmacy: Provided, That these foods are specifically designated and manufactured for the treatment of severe allergic conditions or short bowel.

(d) The provisions of this section shall not apply to persons with an intolerance for lactose or soy.

WV Legislature

§33-15-4r. Substance use disorder.

(a) As used in this section, the following words have the following meanings:

(1) "Concurrent review" means inpatient care is reviewed as it is provided. Medically qualified reviewers monitor appropriateness of the care, the setting, and patient progress, and, as appropriate, the discharge plans.

(2) "Covered person" means an individual, other than a Medicaid recipient, for whom coverage has been provided pursuant to the provisions of this article.

(3) "Insurance Commissioner" means the person appointed pursuant to the provisions of §33-2-1 et seq. of this code.

(4) "Insurer" means the same as that term is defined in §33-15-2 of this code.

(5) "Physician" or "psychiatrist" means a person licensed pursuant to the provisions of either §30-3-1 et seq. or §30-14-1 et seq. of this code.

(6) "Psychologist" means a person licensed pursuant to the provisions of §30-21-1 et seq. of this code.

(7) "Substance use disorder" means the same as that term is defined by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, and shall include substance use withdrawal.

(b) An accident and sickness policy that provides hospital or medical expense benefits and is delivered, issued, executed, or renewed in this state, or approved for issuance or renewal by the Insurance Commissioner, on or after January 1, 2019, shall provide benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities at the same level as other medical services offered by the accident and sickness policy.

(c) The services for the treatment of substance use disorder shall be:

(1) Prescribed by a physician or psychiatrist licensed pursuant to the provisions of §30-3-1 et seq. or §30-14-1 et seq. of this code or recommended by a psychologist licensed pursuant to the provisions of §30-21-1 et seq. of this code; and

(2) Provided by licensed health care professionals or licensed or certified substance use disorder providers in licensed or otherwise state-approved facilities, as required by this code.

(d) The inpatient and outpatient treatment of substance use disorders shall be provided when determined medically necessary by the covered person's physician, psychologist, or psychiatrist. The facility shall notify the insurer of both the admission and the initial

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treatment plan within 48 hours of the admission or initiation of treatment. If there is no in-network facility immediately available for a covered person, an accident and sickness policy shall provide necessary exceptions to its network to ensure admission in a treatment facility within 72 hours. If a covered person is being treated at an out-of-network facility and an in-network facility becomes available during the course of the treatment plan, an insurer may transfer the covered person to the in-network facility.

(e) Providers of treatment for substance use disorders to persons covered under a covered contract shall not require prepayment of medical expenses during this 180 days in excess of applicable copayment, deductible, or coinsurance as provided in the contract.

(f) The benefits for outpatient visits may be subject to concurrent or retrospective review of medical necessity or any other utilization management review.

(g)(1) If an insurer determines that continued inpatient care in a facility is no longer medically necessary, the insurer shall, within 72 hours, provide written notice to the covered person and the covered person's physician of its decision and the right to file for an expedited review of an adverse decision.

(2) The insurer shall review and make a determination with respect to the internal appeal within 72 hours and communicate that determination to the covered person and the covered person's physician.

(3) If the determination is to uphold the denial, the covered person and the covered person's physician have the right to file an expedited external appeal with an independent review organization. An independent utilization review organization shall make a determination within 72 hours.

(4) If the insurer's determination is upheld and it is determined continued inpatient care is not medically necessary, the insurer remains responsible to provide benefits for the inpatient care through the day following the date the determination is made and the covered person is only responsible for any applicable copayment, deductible, and coinsurance for the stay through that date as applicable under the contract.

(5) The covered person shall not be discharged or released from the inpatient facility until all internal appeals and independent utilization review organization appeals are exhausted. For any costs incurred after the day following the date of determination until the day of discharge, the covered person is only responsible for any applicable cost-sharing, and any additional charges shall be paid by the facility or provider.

(h) The Insurance Commissioner shall propose rules in accordance with the provisions of §29A-3-1 et seq. of this code to develop a procedure for an expedited review of an adverse decision as set forth in this section. The Legislature finds that for the purposes of §20A-3-15 of this code, an emergency exists requiring the promulgation of an emergency rule to respond to the growing need in our state for substance abuse treatment.

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(i)(1) The benefits for the first five days of intensive outpatient or partial hospitalization services shall be provided without any retrospective review of medical necessity, and medical necessity shall be determined by the covered person's physician.

(2) The benefits beginning day six and every six days thereafter of intensive outpatient or partial hospitalization services is subject to a concurrent review of the medical necessity of the services.

(j) Medical necessity review shall use an evidence-based and peer-reviewed clinical review tool. This tool shall be developed by the Insurance Commissioner. Rules shall ensure that the tool is based on appropriate evidence-based criteria that has been peer reviewed. The Insurance Commissioner shall propose rules for legislative approval in accordance with the provisions of §29A-3-1 et seq. of this code to develop the tool.

(k) The benefits for outpatient prescription drugs to treat substance use disorder shall be provided when determined medically necessary by the covered person's physician or psychiatrist without the imposition of any prior authorization or other prospective utilization management requirements.

(l) The days per plan year of benefits shall be computed based on inpatient days. One or more unused inpatient days may be exchanged for two outpatient visits. All extended outpatient services such as partial hospitalization and intensive outpatient, shall be considered inpatient days for the purpose of the visit-to-day exchange provided in this subsection.

(m) Except as provided in this section, the benefits and cost-sharing shall be provided to the same extent as for any other medical condition covered under the contract.

(n) The benefits required by this section are to be provided to all covered persons with a diagnosis of substance use disorder. The presence of additional related or unrelated diagnoses shall not be a basis to reduce or deny the benefits required by this section.

(o) The provisions of this section apply to all insurance contracts in which the insurer has reserved the right to change the premium.

WV Legislature

§33-15-4s. Prior authorization.

(a) As used in this section, the following words and phrases have the meanings given to them in this section unless the context clearly indicates otherwise:

"Episode of care" means a specific medical problem, condition, or specific illness being managed including tests, procedures, and rehabilitation initially requested by the health care practitioner, to be performed at the site of service, excluding out-of-network care: *Provided*, That any additional testing or procedures related or unrelated to the specific medical problem, condition, or specific illness being managed may require a separate prior authorization.

"National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard" means the NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United States Department of Health and Human Services. Subsequently released versions may be used provided that the new version is backward compatible with the current version approved by the United States Department of Health and Human Services;

"Prior authorization" means obtaining advance approval from a health insurer about the coverage of a service or medication.

(b) The health insurer shall require prior authorization forms, including any related communication, to be submitted via an electronic portal and shall accept one prior authorization for an episode of care. The portal shall be placed in an easily identifiable and accessible place on the health insurer's webpage and the portal web address shall be included on the insured's insurance card. The portal shall:

(1) Include instructions for the submission of clinical documentation;

(2) Provide an electronic notification to the health care provider confirming receipt of the prior authorization request for forms submitted electronically;

(3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment, durable medical equipment, and anything else for which the health insurer requires a prior authorization. The standard for including any matter on this list shall be science-based using a nationally recognized standard. This list shall be updated at least quarterly to ensure that the list remains current;

(4) Inform the patient if the health insurer requires a plan member to use step therapy protocols as set forth in this chapter. This shall be conspicuous on the prior authorization form. If the patient has completed step therapy as required by the health insurer and the step therapy has been unsuccessful, this shall be clearly indicated on the form, including information regarding medication or therapies which were attempted and were unsuccessful; and

(5) Be prepared by July 1, 2024.

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(c) Provide electronic communication via the portal regarding the current status of the prior authorization request to the health care provider.

(d) After the health care practitioner submits the request for prior authorization electronically, and all of the information as required is provided, the health insurer shall respond to the prior authorization request within five business days from the day on the electronic receipt of the prior authorization request, except that the health insurer shall respond to the prior authorization request within two business days if the request is for medical care or other service for a condition where application of the time frame for making routine or non-life-threatening care determinations is either of the following:

(1) Could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state; or

(2) In the opinion of a health care practitioner with knowledge of the patient's medical condition would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.

(e) If the information submitted is considered incomplete, the health insurer shall identify all deficiencies, and within two business days from the day on the electronic receipt of the prior authorization request return the prior authorization to the health care practitioner. The health care practitioner shall provide the additional information requested within three business days from the time the return request is received by the health care practitioner. The health insurer shall render a decision within two business days after receipt of the additional information submitted by the health care provider. If the health care provider fails to submit additional information, the prior authorization is considered denied and a new request shall be submitted.

(f) If the health insurer wishes to audit the prior authorization or if the information regarding step therapy is incomplete, the prior authorization may be transferred to the peer review process within two business days from the day on the electronic receipt of the prior authorization request.

(g) A prior authorization approved by a health insurer is carried over to all other managed care organizations, health insurers, and the Public Employees Insurance Agency for three months if the services are provided within the state.

(h) The health insurer shall use national best practice guidelines to evaluate a prior authorization.

(i) If a prior authorization is rejected by the health insurer and the health care practitioner who submitted the prior authorization requests an appeal by peer review of the decision to reject, the peer review shall be with a health care practitioner, similar in specialty, education, and background. The health insurer's medical director has the ultimate decision regarding the appeal determination and the health care practitioner has the option to

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consult with the medical director after the peer-to- peer consultation. Time frames regarding this peer-to-peer appeal process shall take no longer than five business days from the date of the request of the peer-to-peer consultation. Time frames regarding the appeal of a decision on a prior authorization shall take no longer than 10 business days from the date of the appeal submission.

(j) (1) Any prescription written for an inpatient at the time of discharge requiring a prior authorization may not be subject to prior authorization requirements and shall be immediately approved for not less than three days: *Provided*, That the cost of the medication does not exceed $5,000 per day and the physician shall note on the prescription or notify the pharmacy that the prescription is being provided at discharge. After the three-day time frame, a prior authorization shall be obtained.

(2) If the approval of a prior authorization requires a medication substitution, the substituted medication shall be as required under §30-5-1 *et seq*. of this code.

(k) If a health care practitioner has performed an average of 30 procedures per year and in a six-month time period during that year has received a 90 percent final prior approval rating, the health insurer may not require the health care practitioner to submit a prior authorization for at least the next six months, or longer if the insurer allows: *Provided*, That at the end of the six-month time frame, or longer if the insurer allows, the exemption shall be reviewed prior to renewal. If approved, the renewal shall be granted for a time period equal to the previously granted time period, or longer if the insurer allows. This exemption is subject to internal auditing, at any time, by the health insurer and may be rescinded if the health insurer determines the health care practitioner is not performing services or procedures in conformity with the health insurer's benefit plan, it identifies substantial variances in historical utilization, or identifies other anomalies based upon the results of the health insurer's internal audit. The insurer shall provide a health care practitioner with a letter detailing the rationale for revocation of his or her exemption. Nothing in this subsection may be interpreted to prohibit an insurer from requiring a prior authorization for an experimental treatment, non-covered benefit, pharmaceutical medication, or any out-of-network service or procedure.

(l) This section is effective for policy, contract, plans, or agreements beginning on or after January 1, 2024. This section applies to all policies, contracts, plans, or agreements, subject to this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on or after the effective date of this section.

(m) The Insurance Commissioner shall request data on a quarterly basis, or more often as needed, to oversee compliance with this article. The data shall include, but not be limited to, prior authorizations requested by health care providers, the total number of prior authorizations denied broken down by health care provider, the total number of prior authorizations appealed by health care providers, the total number of prior authorizations approved after appeal by health care providers, the name of each gold card status physician, and the name of each physician whose gold card status was revoked and the reason for

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revocation.

(n) The Insurance Commissioner may assess a civil penalty for a violation of this section pursuant to §33-3-11 of this code.

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§33-15-4t. Fairness in Cost-Sharing Calculation.

(a) As used in this section:

"Cost sharing" means any copayment, coinsurance, or deductible required by or on behalf of an insured in order to receive a specific health care item or service covered by a health plan.

"Drug" means the same as the term is defined in §30-5-4 of this code.

"Person" means a natural person, corporation, mutual company, unincorporated association, partnership, joint venture, limited liability company, trust, estate, foundation, nonprofit corporation, unincorporated organization, or government or governmental subdivision or agency.

"Pharmacy benefits manager" means the same as that term is defined in §33-51-3 of this code.

(b) When calculating an insured's contribution to any applicable cost sharing requirement, including, but not limited to, the annual limitation on cost sharing subject to 42 U.S.C. § 18022(c) and 42 U.S.C. § 300gg-6(b):

(1) An insurer shall include any cost sharing amounts paid by the insured or on behalf of the insured by another person; and

(2) A pharmacy benefits manger shall include any cost sharing amounts paid by the insured or on behalf of the insured by another person.

(c) The commissioner is authorized to propose rules for legislative approval in accordance with §29A-3-1 *et seq*. of this code to implement the provisions of this section.

(d) This section is effective for policy, contract, plans, or agreements beginning on or after January 1, 2020. This section applies to all policies, contracts, plans, or agreements, subject to this article that are delivered, executed, issued, amended, adjusted, or renewed in this state on or after the effective date of this section.

(e) If under federal law application of subsection (b) of this section would result in Health Savings Account ineligibility under Section 223 of the Internal Revenue Code, this requirement shall apply only for Health Savings Account-qualified High Deductible Health Plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under Section 223 of the Internal Revenue Code: *Provided*, That with respect to items or services that are preventive care pursuant to Section 223(c)(2)(C) of the Internal Revenue Code, the requirements of subsection (b) of this section shall apply regardless of whether the minimum deductible under Section 223 of the Internal Revenue Code has been satisfied.

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§33-15-4u. Mental health parity.

(a) As used in this section, the following words and phrases have the meaning given them in this section unless the context clearly indicates otherwise:

To the extent that coverage is provided "behavioral health, mental health, and substance use disorder" means a condition or disorder, regardless of etiology, that may be the result of a combination of genetic and environmental factors and that falls under any of the diagnostic categories listed in the mental disorders section of the most recent version of:

(A) The International Statistical Classification of Diseases and Related Health Problems;

(B) The Diagnostic and Statistical Manual of Mental Disorders; or

(C) The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood; and

Includes autism spectrum disorder: *Provided,* That any service, even if it is related to the behavioral health, mental health, or substance use disorder diagnosis if medical in nature, shall be reviewed as a medical claim and undergo all utilization review as applicable.

(b) The carrier is required to provide coverage for the prevention of, screening for, and treatment of behavioral health, mental health, and substance use disorders that is no less extensive than the coverage provided for any physical illness and that complies with the requirements of this section. This screening shall include, but is not limited to, unhealthy alcohol use for adults, substance use for adults and adolescents, and depression screening for adolescents and adults.

(c) The carrier shall:

(1) Include coverage and reimbursement for behavioral health screenings using a validated screening tool for behavioral health, which coverage and reimbursement is no less extensive than the coverage and reimbursement for the annual physical examination;

(2) Comply with the nonquantitative treatment limitation requirements specified in 45 CFR §146.136(c)(4), or any successor regulation, regarding any limitations that are not expressed numerically but otherwise limit the scope or duration of benefits for treatment, which in addition to the limitations and examples listed in 45 CFR §146.136(c)(4)(ii) and (c)(4)(iii), or any successor regulation and 78 FR 68246, include the methods by which the carrier establishes and maintains its provider network and responds to deficiencies in the ability of its networks to provide timely access to care;

(3) Comply with the financial requirements and quantitative treatment limitations specified in 45 CFR §146.136(c)(2) and (c)(3), or any successor regulation;

(4) Not apply any nonquantitative treatment limitations to benefits for behavioral health,

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mental health, and substance use disorders that are not applied to medical and surgical benefits within the same classification of benefits;

(5) Establish procedures to authorize treatment with a nonparticipating provider if a covered service is not available within established time and distance standards and within a reasonable period after service is requested, and with the same coinsurance, deductible, or copayment requirements as would apply if the service were provided at a participating provider, and at no greater cost to the covered person than if the services were obtained at, or from a participating provider; and

(6) If a covered person obtains a covered service from a nonparticipating provider because the covered service is not available within the established time and distance standards, reimburse treatment or services for behavioral health, mental health, or substance use disorders required to be covered pursuant to this subsection that are provided by a nonparticipating provider using the same methodology that the carrier uses to reimburse covered medical services provided by nonparticipating providers and, upon request, provide evidence of the methodology to the person or provider.

(d) If the carrier offers a plan that does not cover services provided by an out-of-network provider, it may provide the benefits required in subsection (c) of this section if the services are rendered by a provider who is designated by and affiliated with the carrier only if the same requirements apply for services for a physical illness.

(e) In the event of a concurrent review for a claim for coverage of services for the prevention of, screening for, and treatment of behavioral health, mental health, and substance use disorders, the service continues to be a covered service until the carrier notifies the covered person of the determination of the claim.

(f) Unless denied for nonpayment of premium, a denial of reimbursement for services for the prevention of, screening for, or treatment of behavioral health, mental health, and substance use disorders by the carrier must include the following language:

(1) A statement explaining that covered persons are protected under this section, which provides that limitations placed on the access to mental health and substance use disorder benefits may be no greater than any limitations placed on access to medical and surgical benefits;

(2) A statement providing information about the Consumer Services Division of the West Virginia Office of the Insurance Commissioner if the covered person believes his or her rights under this section have been violated; and

(3) A statement specifying that covered persons are entitled, upon request to the carrier, to a copy of the medical necessity criteria for any behavioral health, mental health, and substance use disorder benefit.

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(g) On or after June 1, 2021, and annually thereafter, the Insurance Commissioner shall submit a written report to the Joint Committee on Government and Finance that contains the following information on plans which fall under this section regarding plans offered pursuant to this section:

(1) Data that demonstrates parity compliance for adverse determination regarding claims for behavioral health, mental health, or substance use disorder services and includes the total number of adverse determinations for such claims;

(2) A description of the process used to develop and select:

(A) The medical necessity criteria used in determining benefits for behavioral health, mental health, and substance use disorders; and

(B) The medical necessity criteria used in determining medical and surgical benefits;

(3) Identification of all nonquantitative treatment limitations that are applied to benefits for behavioral health, mental health, and substance use disorders and to medical and surgical benefits within each classification of benefits; and

(4) The results of analyses demonstrating that, for medical necessity criteria described in subdivision (2) of this subsection and for each nonquantitative treatment limitation identified in subdivision (3) of this subsection, as written and in operation, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each nonquantitative treatment limitation to benefits for behavioral health, mental health, and substance use disorders within each classification of benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each nonquantitative treatment limitation to medical and surgical benefits within the corresponding classification of benefits.

(5) The Insurance Commissioner’s report of the analyses regarding nonquantitative treatment limitations shall include at a minimum:

(A) Identifying factors used to determine whether a nonquantitative treatment limitation will apply to a benefit, including factors that were considered but rejected;

(B) Identify and define the specific evidentiary standards used to define the factors and any other evidence relied on in designing each nonquantitative treatment limitation;

(C) Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each nonquantitative treatment limitation, as written, and the written processes and strategies used to apply each nonquantitative treatment limitation for benefits for behavioral health, mental health, and substance use disorders are comparable to, and are applied no more stringently than, the processes and strategies used to design and apply each nonquantitative treatment limitation,

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as written, and the written processes and strategies used to apply each nonquantitative treatment limitation for medical and surgical benefits;

(D) Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for benefits for behavioral health, mental health, and substance use disorders are comparable to, and are applied no more stringently than, the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for medical and surgical benefits; and

(E) Disclose the specific findings and conclusions reached by the Insurance Commissioner that the results of the analyses indicate that each health benefit plan offered under the provisions of this section complies with subsection (c) of this section.

(h) The Insurance Commissioner shall adopt legislative rules to comply with the provisions of this section. These rules shall specify the information and analyses that carriers shall provide to the Insurance Commissioner necessary for the Insurance Commissioner to complete the report described in subsection (g) of this section and shall delineate the format in which the carriers shall submit such information and analyses. These rules or amendments to rules shall be proposed pursuant to the provisions of §29A-3-1 *et seq.* of this code within the applicable time limit to be considered by the Legislature during its regular session in the year 2021. The rules shall require that each carrier first submit the report to the Insurance Commissioner no earlier than one year after the rules are promulgated, and any year thereafter during which the carrier makes significant changes to how it designs and applies medical management protocols.

(i) This section is effective for policies, contracts, plans, or agreements, beginning on or after January 1, 2021. This section applies to all policies, contracts, plans, or agreements, subject to this article that are delivered, executed, issued, amended, adjusted, or renewed in this state on or after the effective date of this section.

(j) The Insurance Commissioner shall enforce this section and may conduct a financial examination of the carrier to determine if it is in compliance with this section, including, but not limited to, a review of policies and procedures and a sample of mental health claims to determine these claims are treated in parity with medical and surgical benefits. The results of this examination shall be reported to the Legislature. If the Insurance Commissioner determines that the carrier is not in compliance with this section, the Insurance Commissioner may fine the carrier in conformity with the fines established in the legislative rule.

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§33-15-4v. Incorporation of the Health Benefit Plan Network Access and Adequacy Act.

The provisions of the Health Benefit Plan Network Access and Adequacy Act codified at §33-55-1 *et seq.* of this code are made applicable to the provisions of this article.

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§33-15-4w. Incorporation of the coverage for 12-month refill for contraceptive drugs.

The provision requiring coverage for 12-month refill for contraceptive drugs codified at §33-58-1 of this code is made applicable to the provisions of this article.

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§33-15-4x. Coverage of emergency medical services to triage and transport to alternative destination or treat in place.

(a) The following terms are defined:

(1) "911 call" means a communication indicating that an individual may need emergency medical services;

(2) "Alternative destination" means a lower-acuity facility that provides medical services, including without limitation:

(A) A federally-qualified health center;

(B) An urgent care center;

(C) A rural health clinic;

(D) A physician office or medical clinic as selected by the patient; and

(E) A behavioral or mental health care facility including, without limitation, a crisis stabilization unit.

"Alternative destination" does not include a:

(A) Critical access hospital;

(B) Dialysis center;

(C) Hospital;

(D) Private residence; or

(E) Skilled nursing facility;

(3) "Emergency medical services agency" means any agency licensed under §16-4C-6a of this code to provide emergency medical services: *Provided*, That rotary and fixed wing air ambulances are specifically excluded from the definition of an emergency medical services agency;

(4) "Medical command" means the issuing of orders by a physician from a medical facility to emergency medical services personnel for the purpose of providing appropriate patient care; and

(5) "Telehealth services" means the use of synchronous or asynchronous telecommunications technology or audio-only telephone calls by a health care practitioner to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and professional health-related

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education; public health services; and health administration. The term does not include e-mail messages or facsimile transmissions.

(b) An insurer which issues or renews a health insurance policy on or after January 1, 2025, shall provide coverage for:

(1) An emergency medical services agency to:

(A) Treat an enrollee in place if the ambulance service is coordinating the care of the enrollee through telehealth services with a physician for a medical-based complaint or with a behavioral health specialist for a behavioral-based complaint;

(B) Triage or triage and transport an enrollee to an alternative destination if the ambulance service is coordinating the care of the enrollee through telehealth services with a physician for a medical-based complaint or with a behavioral health specialist for a behavioral-based complaint; or

(C) An encounter between an ambulance service and enrollee that results in no transport of the enrollee if:

(i) The enrollee declines to be transported against medical advice; and

(ii) The emergency medical services agency is coordinating the care of the enrollee through telehealth services or medical command with a physician for a medical-based complaint or with a behavioral health specialist for a behavioral-based complaint.

(c) The coverage under this section:

(1) Only includes emergency medical services transportation to the treatment location;

(2) Is subject to the initiation of response, triage, and treatment as a result of a 911 call that is documented in the records of the emergency medical services agency;

(3) Is subject to deductibles or copayment requirements of the policy, contract, or plan;

(4) Does not diminish or limit benefits otherwise allowable under a health benefit plan, even if the billing claims for medical or behavioral health services overlap in time that is billed by the ambulance service also providing care; and

(5) Does not include rotary or fixed wing air ambulance services.

(d) The reimbursement rate for an emergency medical services agency that triages, treats, and transports a patient to an alternative destination, or triages, treats, and does not transport a patient, if the patient declines to be transported against medical advice, if the ambulance service is coordinating the care of the enrollee through medical command or telemedicine with a physician for a medical-based complaint, or with a behavioral health

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specialist for a behavioral-based complaint under this section, shall be reimbursed at the same rate as if the patient were transported to an emergency room of a facility provider.

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§33-15-5. Optional policy provisions.

Except as provided in section six of this article, no such policy delivered or issued for delivery to any person in this state shall contain provisions respecting the matters set forth below unless such provisions are in the words in which the same appear in this section: Provided, That the insurer may, at its option, use in lieu of any such provision a corresponding provision of different wording approved by the commissioner which is not less favorable in any respect to the insured or the beneficiary. Any such provision contained in the policy shall be preceded individually by the appropriate caption appearing in this section or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

(a) A provision as follows:

"Change of Occupation: If the insured be injured or contract sickness after having changed his occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes his occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation."

(b) A provision as follows:

"Misstatement of Age: If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age."

(c) A provision as follows:

"Other Insurance in This Insurer: If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured be in force concurrently herewith, making the aggregate indemnity for _____ (insert type of coverage or coverages) in excess of $_____ (insert maximum limit of indemnity or indemnities) the excess

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insurance shall be void and all premiums paid for such excess shall be returned to the insured or to his estate."

Or, in lieu thereof:

"Insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to the one such policy elected by the insured, his beneficiary or his estate, as the case may be, and the insurer will return all premiums paid for all other such policies."

Provided that no policy hereafter issued for delivery in this state which provides, with or without other benefits, for the payment of benefits or reimbursement for expenses with respect to hospitalization, nursing care, medical or surgical examination or treatment, or ambulance transportation shall contain any provision for a reduction of such benefits or reimbursement, or any provision for avoidance of the policy, on account of other insurance of such nature carried by the same insured with the same or another insurer.

(d) A provision as follows:

"Insurance with Other Insurers: If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro rata portion for the indemnities thus determined."

The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the commissioner, which definitions shall be limited in subject matter to coverage provided by organizations subject to regulations by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and to any other coverage the inclusion of which may be approved by the commissioner. In the absence of such definition such term shall not include group insurance, or benefits provided by union welfare plans or by employer or employee benefit organizations. For the purpose of applying the foregoing policy provisions with respect to any insured any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third party liability coverage shall be included as "other valid coverage."

(e) A provision as follows:

"Relation of Earnings to Insurance: If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether

payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or his average monthly earnings for the period of two years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two years as shall exceed the pro rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of $200 or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time."

The insurer may, at its option, include in this provision a definition of "valid loss of time coverage," approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the commissioner or any combination of such coverages. In the absence of such definition such term shall not include any coverage provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute), or benefits provided by union welfare plans or by employer or employee benefit organizations.

(f) A provision as follows:

"Unpaid Premium: Upon the payment of a claim under this policy, any premiums then due and unpaid or covered by any note or written order may be deducted therefrom."

(g) A provision as follows:

"Return of Premium on Cancellation: If the insured cancels this policy, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation."

(h) A provision as follows:

"Conformity with State Statutes: Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes."

(i) A provision as follows:

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"Illegal Occupation: The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation."

(j) A provision as follows:

"Intoxicants and Narcotics: The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician."

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§33-15-6. Inapplicable or inconsistent provisions.

If any provision of this article is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the commissioner, shall omit from such policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

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§33-15-7. Order of certain provisions.

The provisions which are the subject of sections four and five of this article or any corresponding provisions which are used in lieu thereof in accordance with such sections, shall be printed in consecutive order of the provisions in such sections or, at the option of the insurer, any such provisions may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued.

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§33-15-8. Third party ownership of policy covering insured.

The word "insured" as used in this article, shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured or from being entitled under such a policy to any indemnities, benefits and rights provided therein.

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§33-15-9. Requirements of other jurisdictions.

(a) Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this state, may contain any provision which is not less favorable to the insured or the beneficiary than the provisions of this article and which is prescribed or required by the law of the state under which the insurer is organized.

(b) Any policy of a domestic insurer may, when issued for delivery in any other state or country, contain any provision permitted or required by the laws of such other state or country.

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§33-15-10. Franchise insurance.

Accident and sickness insurance on a franchise plan is hereby declared to be that form of accident and sickness insurance issued to:

(a) Five or more employees of any corporation, copartnership or individual employer or any governmental corporation, agency or department thereof, or

(b) Five or more members of any trade or professional association or of a labor union or of any other association having had an active existence for at least two years where such association or union has a Constitution or bylaws and is formed in good faith for purposes other than that of obtaining insurance; where such persons, with or without their dependents, are issued the same form of an individual policy varying only as to amounts and kinds of coverage applied for by such persons, under an arrangement whereby the premiums on such policies may be paid to the insurer periodically by the employer, with or without payroll deductions, or by the association or union for its members, or by some designated person acting on behalf of such employer or association or union. The term "employees" as used in this section shall be deemed to include the officers, managers, employees and retired employees of the employer and the individual proprietor or partners if the employer is an individual proprietor or partnership.

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§33-15-11. Hospital indemnity policies not to exclude coverage for confinement in government hospital.

No policy providing hospital indemnity coverage may exclude coverage because of confinement in a hospital operated by the federal or state government.

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§33-15-12. Continuum of care services.

Any insurer which, on or after July 1, 1986, delivers or issues for delivery in this state any policy of accident and sickness insurance under the provisions of this article, shall make available for purchase, at a reasonable rate, supplemental insurance coverage for continuum of care services pursuant to article five-d, chapter sixteen of this code: Provided, That any insurance carrier required to provide supplemental insurance coverage for continuum of care services hereunder shall not be required to expend funds for underwriting such supplemental coverage until the continuum of care board, in cooperation with the West Virginia state Insurance Commissioner, shall have completed a written master plan related to insurance coverage as set forth in section five, article five-d, chapter sixteen of the Code of West Virginia, 1931, as amended, including, but not limited to, the specific standards and coverages to be provided in such supplemental coverage: Provided, however, That a public hearing shall be held pursuant to the provisions of chapter twenty-nine-a of this code applicable to such proceedings prior to the considerations of the aforesaid plan by said board. The rates for continuum of care coverage shall accurately reflect the cost of such coverage and shall not be subsidized by the rate structure for any other coverage.

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§33-15-13. Policies not to terminate coverage because of diagnosis or treatment of acquired immune deficiency syndrome.

No insurer may cancel or nonrenew the accident and sickness insurance policy of any insured because of diagnosis or treatment of acquired immune deficiency syndrome.

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§33-15-14. Policies discriminating among health care providers.

Notwithstanding any other provisions of law, when any health insurance policy, health care services plan or other contract provides for the payment of medical expenses, benefits or procedures, such policy, plan or contract shall be construed to include payment to all health care providers including medical physicians, osteopathic physicians, podiatric physicians, chiropractic physicians, midwives, physician assistants and nurse practitioners who provide medical services, benefits or procedures which are within the scope of each respective provider's license. Any limitation or condition placed upon services, diagnoses or treatment by, or payment to, any particular type of licensed provider shall apply equally to all types of licensed providers without unfair discrimination as to the usual and customary treatment procedures of any of the aforesaid providers.

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§33-15-15.

Repealed.

Acts, 1997 Reg. Sess., Ch. 109.

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§33-15-16. Policies not to exclude insured's children from coverage; required services; coordination with other insurance.

(a) An insurer issuing accident and sickness policies in this state shall provide coverage for the child or children of the insured without regard to the amount of child support ordered to be paid or actually paid by the insured, if any, and without regard to the fact that the insured may not have legal custody of the child or children or that the child or children may not be residing in the home of the insured.

(b) An insurer issuing accident and sickness policies in this state shall provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply to natural, dependent children of participants and beneficiaries, irrespective of whether the adoption has become final.

(c) An insurer shall not deny enrollment of a child under the health plan of the child's parent on the grounds that:

(1) The child was born out of wedlock;

(2) The child is not claimed as a dependent on the parent's federal tax return; or

(3) The child does not reside with the parent or in the insurer's service area.

(d) Where a child has health coverage through an insurer of a noncustodial parent the insurer shall:

(1) Provide such information to the custodial parent as may be necessary for the child to obtain benefits through that coverage;

(2) Permit the custodial parent, or the provider, with the custodial parent's approval, to submit claims for covered services without the approval of the noncustodial parent; and

(3) Make payments on claims submitted in accordance with subdivision (2) of this subsection directly to the custodial parent, the provider or the state Medicaid agency: Provided, That upon payment to the custodial parent, the provider or the state Medicaid agency, the insurer's obligation to the noncustodial parent under the policy with respect to the covered child's claims shall be fully satisfied.

(e) Where a parent is required by a court or administrative order to provide health coverage for a child, and the parent is eligible for family health coverage, the insurer shall:

(1) Permit the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions;

(2) If the parent is enrolled but fails to make application to obtain coverage for the child, enroll the child under family coverage upon application of the child's other parent, the state

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agency administering the Medicaid program or the state agency administering 42 U.S.C. §651 through §669, the child support enforcement program; and

(3) Not disenroll or eliminate coverage of the child unless the insurer is provided satisfactory written evidence that:

(A) The court or administrative order is no longer in effect; or

(B) The child is or will be enrolled in comparable health coverage through another insurer which will take effect not later than the effective date of disenrollment.

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§33-15-17. Child immunization services coverage.

All policies issued pursuant to this article shall cover the cost of child immunization services as described in section five, article three, chapter sixteen of this code, including the cost of the vaccine, if incurred by the health care provider, and all costs of vaccine administration. These services shall be exempt from any deductible, per-visit charge and/or copayment provisions which may be in force in these policies or contracts. This section does not require that other health care services provided at the time of immunization be exempt from any deductible and/or copayment provisions.

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§33-15-18. Equal treatment of state agency.

An insurer may not impose requirements on a state agency, which has been assigned the rights of an individual eligible for medical assistance under Medicaid and covered for health benefits from the insurer, that are different from requirements applicable to an agent or assignee of any other individual so covered.

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§33-15-19. Coordination of benefits with Medicaid.

Any health insurer, health maintenance organization as defined in article twenty-five-a of this chapter, prepaid limited health service organization as defined in article twenty-five-d of this chapter or hospital and medical service corporations as defined in article twenty-four of this chapter is prohibited from considering the availability or eligibility for medical assistance in this or any other state under 42 U.S.C. §1396a, Section 1902 of the Social Security Act, referred to in this article as Medicaid, when considering eligibility for coverage or making payments under its plan for eligible enrollees, subscribers, policyholders or certificateholders.

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§33-15-20. Individual medical savings accounts; definitions; ownership; trustees; regulations.

(a) Any individual resident of this state may establish an individual medical savings account to serve as self-insurance for the payment of medical expenses: Provided, That an individual establishing an individual medical savings account may designate a percentage of the account assets that may be withdrawn by the individual if not needed for the payment of medical expenses: Provided, however, That any amount remaining in an individual medical savings account on the earlier of the date of retirement, at the age of fifty-nine and one-half years or more, of the individual who established the account, or the date of death of that individual, may be withdrawn by the individual or by his or her personal representative for a purpose other than the payment of medical expenses: Provided further, That no withdrawal pursuant to this subsection shall be subject to the additional twenty percent tax as provided in subsection (d) of this section. As used in this section, "individual medical savings account" means a trust that meets the definition of "medical savings account" set forth in paragraph (1), subsection (d), section 220 of the Internal Revenue Code of 1986, as amended, when that definition is applied without regard to sub-subparagraph (ii), subparagraph (A) of that paragraph. "Medical expenses" means expenses that fall within the definition of "qualified medical expenses" set forth in paragraph (2), subsection (d), section 220 of the Internal Revenue Code of 1986, as amended, when that definition is applied without regard to subparagraph (C) of that paragraph.

(b) Any insurer issuing accident and sickness policies in this state in accordance with the provisions of this article may offer a benefit plan including deductibles or copayments combined with individual self-insurance through the establishment of individual medical savings accounts. A benefit plan established pursuant to this subsection shall provide that medical expenses included within deductible or copayment provisions of the accident and sickness policy for the individual or for his or her covered dependents and therefore not payable under that policy be paid by the trustee, either directly or as reimbursement to an individual who has previously paid medical expenses, from the individual medical savings account. A benefit plan may limit payment of medical expenses until the group plan annual deductible is met from the individual medical savings account to expenses which are covered services under the policy.

(c) Within one hundred eighty days of the passage of this legislation, the Tax Commissioner may promulgate emergency rules as to the keeping of records, the content and form of returns and statements, and the filing of copies of income tax returns and determination by trustees of individual medical savings accounts and by individuals establishing individual medical savings accounts: Provided, That for purposes of sections fifteen, fifteen-a and fifteen-b, article three, chapter twenty-nine-a of this code, a sufficient emergency to justify the promulgation of those rules shall be deemed to exist. The power granted by this subsection shall be in addition to the rule-making powers granted to the Tax Commissioner elsewhere in this code.

(d) If any amount distributed out of an individual medical savings account is used for any

purpose other than to defray medical expenses, except as specifically provided in subsection (a) of this section or except for a distribution of account assets pursuant to order of a federal bankruptcy court, the West Virginia personal income tax of the individual establishing the account, for the taxable year in which the distribution is made shall be increased by an amount equal to twenty percent of the distribution.

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§33-15-21. Coverage of emergency services.

From July 1, 1998:

(a) Every insurer shall provide coverage for emergency medical services, including prehospital services, to the extent necessary to screen and to stabilize an emergency medical condition. The insurer shall not require prior authorization of the screening services if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. Prior authorization of coverage shall not be required for stabilization if an emergency medical condition exists. Payment of claims for emergency services shall be based on the retrospective review of the presenting history and symptoms of the covered person.

(b) The coverage for prehospital screening and stabilization of an emergency medical condition shall include ambulance services provided under the provisions of §16-4C-1 *et seq*. of this code, excluding air ambulance services as defined in §16-4C-3(a) of this code. The insurer shall pay claims for prehospital screening and stabilization of emergency condition by ambulance service if the insured is transported to an emergency room of a facility provider or if the patient declines to be transported against medical advice. The coverage under this section is subject to deductibles or copayment requirements of the policy, contract, or plan.

(c) An insurer that has given prior authorization for emergency services shall cover the services and shall not retract the authorization after the services have been provided unless the authorization was based on a material misrepresentation about the covered person's health condition made by the referring provider, the provider of the emergency services, or the covered person.

(d) Coverage of emergency services shall be subject to coinsurance, copayments, and deductibles applicable under the health benefit plan.

(e) The emergency department and the insurer shall make a good faith effort to communicate with each other in a timely fashion to expedite post evaluation or post stabilization services in order to avoid material deterioration of the covered person's condition.

(f) As used in this section:

(1) "Emergency medical services" means those services required to screen for or treat an emergency medical condition until the condition is stabilized, including prehospital care;

(2) "Prudent layperson" means a person who is without medical training and who draws on his or her practical experience when making a decision regarding whether an emergency medical condition exists for which emergency treatment should be sought;

(3) "Emergency medical condition for the prudent layperson" means one that manifests itself

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by acute symptoms of sufficient severity, including severe pain, such that the person could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the individual's health, or, with respect to a pregnant woman, the health of the unborn child; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part;

(4) "Stabilize" means with respect to an emergency medical condition, to provide medical treatment of the condition necessary to assure, with reasonable medical probability, that no medical deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility: *Provided*, That this provision may not be construed to prohibit, limit, or otherwise delay the transportation required for a higher level of care than that possible at the treating facility;

(5) "Medical screening examination" means an appropriate examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists; and

(6) "Emergency medical condition" means a condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health, or, with respect to a pregnant woman, the health of the unborn child, serious impairment to bodily functions, or serious dysfunction of any bodily part or organ.

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§33-15-22. Assignment of certain benefits in dental care insurance coverage.

(a) Any entity regulated under this article that provides dental care coverage to a covered person shall honor an assignment, made in writing by the person covered under the policy, of payments due under the policy to a dentist or a dental corporation for services provided to the covered person that are covered under the policy. Upon notice of the assignment, the entity shall make payments directly to the provider of the covered services. A dentist or dental corporation with a valid assignment may bill the entity and notify the entity of the assignment. Upon request of the entity, the dentist or dental corporation shall provide a copy of the assignment to the entity.

(b) A covered person may revoke an assignment made pursuant to subsection (a) of this section with or without the consent of the provider. The revocation shall be in writing. The covered person shall provide notice of the revocation to the entity. The entity shall send a copy of the revocation notice to the dentist or dental corporation subject to the assignment. The revocation is effective when both the entity and the provider have received a copy of the revocation notice. The revocation is only effective for any charges incurred after both parties have received the revocation notice.

(c) If, under an assignment authorized in subsection (a) of this section, a dentist or dental corporation collects payment from a covered person and subsequently receives payment from the entity, the dentist or dental corporation shall reimburse the covered person, less any applicable copayments, deductibles, or coinsurance amounts, within 45 days.

(d) Nothing in this section limits an entity’s ability to determine the scope of the entity’s benefits, services, or any other terms of the entity’s policies or to negotiate any contract with a licensed health care provider regarding reimbursement rates or any other lawful provisions.

(e) Any entity providing dental care shall provide conspicuous notice to the covered person that the assignment of benefits is optional, and that additional payments may be required if the assigned benefits are not sufficient to pay for received services.

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§33-15-23. Copayments for certain services.

(a) A policy, provision, contract, plan, or agreement subject to this article may not impose a copayment, coinsurance, or office visit deductible amount charged to the insured for services rendered for each date of service by a licensed occupational therapist, licensed occupational therapist assistant, licensed speech-language pathologist, licensed speech-language pathologist assistant, licensed physical therapist, or a licensed physical therapist assistant that is greater than the copayment, coinsurance, or office visit deductible amount charged to the insured for the services of a primary care physician or an osteopathic physician.

(b) The policy, provision, contract, plan, or agreement shall clearly state the availability of occupational therapy, speech-language therapy, and physical therapy coverage and all related limitations, conditions, and exclusions.

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§33-15-24. Prohibiting surprise billing of ground emergency medical services by nonparticipating providers.

For a health insurance policy issued by an insurer on or after January 1, 2027:

(1) Payment by an insurer to a non-participating emergency medical services agency for covered ambulance services provided under the provisions of §16-4C-1 *et seq*. of this code, excluding air ambulance services as defined in §16-4C-3(a) of this code, to a covered enrollee in accordance with subdivision (2) of this section:

(A) Shall be considered payment in full for the ambulance services provided, except for any copayment, coinsurance, deductible, and other cost-sharing amounts that the insurer requires the covered enrollee to pay; and

(B) The non-participating emergency medical services agency is prohibited from billing the covered individual for any additional amount for the ambulance services provided, except for any copayment, coinsurance, deductible, and other cost-sharing amounts that the insurer requires the covered enrollee to pay.

(2) The insurer shall provide direct payment to a non-participating emergency medical services agency for covered ground ambulance services provided to a covered individual:

(A) At the rate of 200 percent of the current published rate for ambulance services as established by the Centers for Medicare and Medicaid Services under Title XVIII of the federal Social Security Act, 42 U.S.C. 1395 *et seq*., for the same ambulance services provided in the same geographic area; or

E(B) According to the non-participating emergency medical services agency's billed charges, whichever is less.

(3) The copayment, coinsurance, deductible, and other cost-sharing amounts that an insurer requires a covered individual to pay in connection with ground ambulance services provided to the covered individual by a non-participating emergency medical services agency shall not exceed the copayment, coinsurance, deductible, and other cost-sharing amounts that the covered individual would be required to pay if the ambulance services had been provided to the covered individual by a participating emergency medical services agency.

(4) If an insurer receives a clean claim for ground ambulance services provided to a covered individual by a non-participating emergency medical services agency, the insurer shall remit payment for the ambulance services directly to the non-participating emergency medical services agency not more than 30 days after receiving a clean claim and shall not send payment to the covered individual.

(5) An insurer shall either pay or deny a clean claim for ground ambulance services provided to a covered individual by a non-participating emergency medical services agency within 30 days of receipt of the claim, except in the following circumstances:

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(A) Another payor or party is responsible for the claim;

(B) The insurer is coordinating benefits with another payor;

(C) The provider has already been paid for the claim;

(D) The claim was submitted fraudulently; or

(E) There was a material misrepresentation in the claim.

(6) If an insurer denies a claim for ground ambulance services provided to a covered individual by a non-participating emergency medical services agency, the insurer shall provide written notice that:

(A) Acknowledges the date of the receipt of the claim; and

(B) States that the insurer is declining to pay all or part of the claim and sets forth the specific reason or reasons for declining to pay the claim in full; or

(C) States that additional information is needed to determine whether all or part of the claim is payable and specifically describes the additional information that is needed.

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