WEST VIRGINIA LEGISLATURE
REGULAR SESSION, 1974

ENROLLED
SENATE BILL NO. 403

(By Mr. Kusic)

PASSED March 5, 1974

In Effect ninety days from Passage

FILED IN THE OFFICE
EDGAR F. HEISKELL III
SECRETARY OF STATE
THIS DATE 3-18-74
ENROLLED

Senate Bill No. 403
(By Mr. Kusic)

[Passed March 5, 1974; in effect ninety days from passage.]

AN ACT to amend and reenact section four, article twenty-four, chapter thirty-three of the code of West Virginia, one thousand nine hundred thirty-one, as amended; and to further amend said chapter thirty-three by adding thereto a new article, designated article twenty-eight, relating to insurance; individual accident and sickness insurance minimum standards; short title; purpose; definitions; standards for policy provisions; minimum standards for benefits; outline of coverage; pre-existing conditions.

Be it enacted by the Legislature of West Virginia:

That section four, article twenty-four, chapter thirty-three of the code of West Virginia, one thousand nine hundred thirty-one, as amended, be amended and reenacted; and that said chapter thirty-three be further amended by adding thereto a new article, designated article twenty-eight, all to read as follows:

ARTICLE 24. HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS AND DENTAL SERVICE CORPORATIONS.

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

1 Every such corporation is hereby declared to be a scientific, nonprofit institution and as such exempt from the payment of all property and other taxes. Every such corporation, to the same extent such provisions are applicable to insurers transacting similar kinds of insurance and not inconsistent with the provisions of this article,
shall be governed by and be subject to the provisions of
the following articles of this chapter: Article two (insur-
ance commissioner) except that under section nine of
article two examinations shall be conducted at least once
every four years, article four (general provisions) except
that section sixteen of article four shall not be applicable
thereo, article ten (rehabilitation and liquidation), article
eleven (unfair practices and frauds), article twelve
(agents, brokers and solicitors) except that the agent's
license fee shall be one dollar and article twenty-eight (in-
dividual accident and sickness insurance minimum stand-
ard); and no other provision of this chapter shall apply to
such corporations unless specifically made applicable by
the provisions of this article. If, however, any such cor-
poration shall be converted into a corporation organized for
a pecuniary profit, or if it shall transact business without
having obtained a license as required by section five of
this article, it shall thereupon forfeit its right to these
exemptions.

ARTICLE 28. INDIVIDUAL ACCIDENT AND SICKNESS INSUR-
ANCE MINIMUM STANDARDS.

§33-28-1. Short title.

This article shall be known and cited as the "West Vir-
ginia Individual Accident and Sickness Insurance Mini-
mum Standards Act."

§33-28-2. Purpose of article.

The purpose of this article is to provide reasonable
standardization and simplification of terms and coverages
of individual accident and sickness insurance policies and
subscriber contracts of hospital and medical service cor-
porations in order to facilitate public understanding and
comparison and to eliminate provisions contained in in-
dividual accident and sickness insurance policies and sub-
scriber contracts of hospital and medical service corpora-
tions which may be misleading or confusing in connection
either with the purchase of such coverages or with the
settlement of claims and to provide for full disclosure in
the sale of such coverages.
§33-28-3. Definition of terms used in article.

1 As used in this article, unless used in a context that clearly requires a different meaning, the term:

3 (a) "Form" means a policy, contract, rider, endorsement or application as provided in section eight, article six of this chapter when used to describe an individual accident and sickness policy form, and means a contract, application, rider or endorsement as provided in section six, article twenty-four of this chapter when used to describe a hospital or medical service corporation subscriber's contract.

5 (b) "Accident and sickness insurance" means insurance written under article fifteen of this chapter, other than credit accident and sickness insurance, and coverages written under article twenty-four of this chapter. For purposes of this article, hospital, medical and dental service corporations shall be deemed to be engaged in the business of insurance.

7 (c) "Policy" means the entire contract between an insurer and an individual insured, including the policy, riders, endorsements and the application, if attached. The term "policy" shall not include coverages issued pursuant to a conversion privilege under a policy or contract of group insurance.

9 (d) "Subscriber contract" means the entire subscriber contract issued by a hospital, medical or dental service corporation to an individual subscriber, including the contract, riders, endorsements and the application, if attached. The term "subscriber contract" shall not include coverages issued pursuant to a conversion privilege under a policy or contract of group insurance.

11 (e) "Direct response insurance product" means an individual policy of accident and sickness insurance or a subscriber contract of a hospital, medical or dental service corporation, the sale of which is effected through direct contact between an insurer and an individual insured or between a hospital, medical or dental service corporation and a subscriber, without employing the intermediary services of an agent, broker or solicitor.

(a) The commissioner shall promulgate rules and regulations, in accordance with chapter twenty-nine-a of the code, to establish specific standards, including standards of full and fair disclosure, that set forth the manner, content and required disclosure for the sale of individual policies of accident and sickness insurance and subscriber contracts of hospital, medical and dental service corporations which shall be in addition to, and in accordance with, applicable laws of this state. Such rules and regulations may cover, but shall not be limited to:

1. Terms of renewability;
2. Initial and subsequent conditions of eligibility;
3. Nonduplication of coverage provisions;
4. Coverage of dependents;
5. Pre-existing conditions;
6. Termination of insurance;
7. Probationary periods;
8. Limitations;
9. Exceptions;
10. Reductions;
11. Elimination periods;
12. Requirements for replacement;
13. Recurrent conditions; and
14. The definition of terms including, but not limited to, hospital, accident, sickness, injury, physician, accidental means, total disability, permanent disability, partial disability, nervous disorder, guaranteed renewable and noncancellable.

(b) The commissioner may promulgate rules and regulations, in accordance with chapter twenty-nine-a of the code, specifying prohibited provisions of policies and subscriber contracts not otherwise specifically authorized by statute which in the opinion of the commissioner are unjust, unfair or unfairly discriminatory either to the policyholder, subscriber, beneficiary or any person insured under the policy.


(a) The commissioner shall promulgate rules and regulations, in accordance with chapter twenty-nine-a of the code, specifying minimum standards for benefits which may cover, but shall not be limited to:

1. Terms of renewability;
2. Initial and subsequent conditions of eligibility;
3. Nonduplication of coverage provisions;
4. Coverage of dependents;
5. Pre-existing conditions;
6. Termination of insurance;
7. Probationary periods;
8. Limitations;
9. Exceptions;
10. Reductions;
11. Elimination periods;
12. Requirements for replacement;
13. Recurrent conditions; and
14. The definition of terms including, but not limited to, hospital, accident, sickness, injury, physician, accidental means, total disability, permanent disability, partial disability, nervous disorder, guaranteed renewable and noncancellable.
code, to establish minimum standards for benefits under each of the following categories of coverage in individual policies of accident and sickness insurance and subscriber contracts of hospital, medical, dental and service corporations:

1. Basic hospital expense coverage;
2. Basic medical-surgical expense coverage;
3. Hospital confinement indemnity coverage;
4. Major medical expense coverage;
5. Disability income protection coverage;
6. Accident only coverage; and
7. Specified disease or specified accident coverage.

(b) Nothing in this section shall preclude the issuance of any policy or subscriber contract which combines two or more of the categories of coverage enumerated in subdivisions (1) through (6) of subsection (a) of this section.

(c) No policy or subscriber contract shall be delivered or issued for delivery in this state which does not meet the prescribed minimum standards for the categories of coverage listed in subdivisions (1) through (7) of subsection (a) of this section unless the commissioner finds that such policy or subscriber contract will be in the public interest and that such policy or subscriber contract contains benefits which are reasonable in relation to the premium charged.

(d) The commissioner shall prescribe the method of identification of policies and subscriber contracts based upon coverages provided.

§33-28-6. Outline of coverage.

(a) In order to provide for full and fair disclosure in the sale of individual accident and sickness insurance policies or subscriber contracts of hospital, medical and dental service corporations, no such policy or subscriber contract shall be delivered or issued for delivery in this state unless:

1. In the case of a direct response insurance product, the outline of coverage described in subsection (b) of this section accompanies the policy or subscriber contract; and
(2) In all other cases, the outline of coverage described in subsection (b) of this section is delivered to the applicant at the time application is made and an acknowledgment of receipt or certificate of delivery of such outline is provided the insurer or hospital, medical or dental service corporation with the application. In the event the policy or subscriber contract is issued on a basis other than that applied for, the outline of coverage properly describing the policy or subscriber contract must accompany the policy or subscriber contract when it is delivered and clearly state that it is not the policy or subscriber contract for which application was made.

(b) The commissioner shall, by promulgation of appropriate rules and regulations in accordance with chapter twenty-nine-a of the code, prescribe the format and content of the outline of coverage required by subsection (a) of this section. "Format" means style, arrangement and overall appearance, including such items as the size, color and prominence of type and the arrangement of text and captions. Such outline of coverage shall include:

(1) A statement identifying the applicable category or categories of coverage provided by the policy or subscriber contract as prescribed in section five of this article;

(2) A description of the principal benefits and coverage provided in the policy or subscriber contract;

(3) A statement of the exceptions, reductions and limitations contained in the policy or subscriber contract;

(4) A statement of the renewal provisions, including any reservation by the insurer or hospital, medical or dental service corporation of a right to change premiums; and

(5) A statement that the outline of coverage is a summary of the policy or subscriber contract issued or applied for and that the terms of the policy or subscriber contract should be consulted to determine governing contractual provisions.

§33-28-7. Pre-existing conditions.

Notwithstanding the provisions of section four-b, ar-
article fifteen of this chapter if an insurer or a hospital, medical or dental service corporation elects to use a simplified application form containing no questions concerning the applicant's health history or medical treatment history, the policy or contract applied for must cover any loss occurring after twelve months from the inception date of coverage which loss is traceable to a pre-existing condition not specifically excluded from coverage by the terms of the policy, and, except as so provided, the policy or contract shall not include wording which would permit a defense based upon pre-existing conditions.
The Joint Committee on Enrolled Bills hereby certifies that the foregoing bill is correctly enrolled.

H. Darril Darby
Chairman Senate Committee

Chairman House Committee

Originated in the Senate.

In effect ninety days from passage.

J. W. Carson
Clerk of the Senate

Clerk of the House of Delegates

H. P. Breckton, Jr.
President of the Senate

Lewis F. Manns
Speaker House of Delegates

The within approved this the 14th day of March, 1974.

Ann W. Davis, Jr.
Governor