OFFICES OF THE INSURANCE COMMISSIONER
STATE OF WEST VIRGINIA
REVIEW REQUIREMENTS CHECKLIST

GROUP ACCIDENT & SICKNESS INSURANCE

REVIEW REQUIREMENTS	REFERENCE	COMMENTS
FORMS		
GENERAL REQUIREMENTS		SERFF filings are submitted in accordance with SERFF procedures.
Fees	§33-6-34	The fee for a Form Filing is $50.00. Fee Revisions are Effective 6/30/2002.
Submission	Informational Letter No 163 §33-3-7	All filings must be submitted through SERFF (System for Electronic Rate and Form Filing). Filing fees must be remitted via EFT (Electronic Funds Transfer) through SERFF. The company transacting insurance in this State must be licensed by the Insurance Commissioner and authorized to conduct the appropriate lines of business for the filing submitted.
Certifications		
Readability	§33-29-5 (a)(1)	The Certification of Readability must show a Test Score of 40 or better according to the Flesch Score reading ease Method or by any other comparable method.
Compliance	33-16 33-16A 114-10 114-24 114-26 114-27 114-28 114-29	Group Accident and Sickness policy forms must comply with Chapter 16 of the WV Code. The Required provisions are found in 33-16-3. Group Health – Conversions: This Chapter sets forth the requirements for group policy conversions. Advertising Medicare Supplements Rate Filing Accident and Sickness AIDS Regulation Coordination of Benefits Temporo/Craniomandibular Disorders
Applications		
		The Application, when attached to the policy, and all its attachments become part of the Entire Contract. Statements are binding only if an application is attached. Only the applicant can alter statements on the application. This Division does not permit a box on the Application, **For Company Use Only**, because no changes are to be made to the Entire Contract after the application has been signed by the applicant. False statements may bar recovery.
General Characteristics		
Group Acceptance		Acceptance of all members of the group, regardless of any individual's physical condition.
Master Contract		Issuance of a master contract to the administrator of the group and individual certificates of insurance (outlines of coverage) to the members.
Coordination of Benefits		Coordination of benefits with other available coverages (such as workers compensation benefits)
Conversion Clause		Permits an individual insured under the group plan to convert to individual coverage upon termination of employment or membership in the group (usually within 31 days of termination). The individual must have participated in the group plan for a given period of time before the conversion privilege applies.
Benefits		Benefits are automatically determined by some preset formula which excludes individual benefit selection and thereby precludes adverse selection by not allowing poor risks to purchase higher amounts of insurance.
Legal Requirements		
Eligible Groups	§33-16-2	Group policies must come within any of the following classifications: (1) A policy issued to an employer, who shall be considered the policyholder, insuring at least two employees of the employer, for the benefit of persons other than the employer, and conforming to the following requirements: (A) If the premium is paid by the employer the group shall comprise all employees or all of any class or classes thereof determined by conditions pertaining to the employment; or (B) If the premium is paid by the employer and the employees jointly, or by the employees, there shall be no employee participation requirement. The term "employee" as used herein is considered to include the officers, managers and employees of the employer,

		the partners, if the employer is a partnership, the officers, managers and employees of subsidiary or affiliated corporations of a corporate employer, and the individual proprietors, partners and employees of individuals and firms, the business of which is controlled by the insured employer through stock ownership, contract or otherwise. The term "employer" as used herein may include any municipal or governmental corporation, unit, agency or department and the proper officers of any unincorporated municipality or department, as well as private individuals, partnerships and corporations. (2) A policy issued to an association or to a trust or to the trustees of a fund established, created or maintained for the benefit of members of one or more associations. The association or associations shall have at the issuance of the policy a minimum of one hundred persons and have been organized and maintained in good faith for purposes other than that of obtaining insurance; shall have been in active existence for at least one year; and shall have a constitution and bylaws that provide that: The association or associations hold regular meetings not less than annually to further the purposes of the members; except for credit unions, the association or associations collect dues or solicit contributions from members; and the members have voting privileges and representation on the governing board and committees. The policy is subject to the following requirements: (A) The policy may insure members of the association or associations, employees thereof or employees of members or one or more of the preceding or all of any class or classes for the benefit of persons other than the employee's employer. (B) The premium for the policy shall be paid from: (i) Funds contributed by the association or associations; (ii) Funds contributed by covered employer members; (iii) Funds contributed by both covered employer members and the association or associations; (iv) Funds contributed by the covered persons; or (v) Funds contributed by both the covered persons and the association, associations or employer members. (C) Except as provided in paragraph (D) of this subdivision, a policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for their insurance must insure all eligible persons, except those who reject coverage in writing. (D) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer. (E) A small employer, as defined in subdivision (r), section two, article sixteen-d of this chapter, insured under an eligible group policy provided in this subdivision shall also be subject to the marketing and rate practices provisions in article sixteen-d of this chapter. (3) A policy issued to a bona fide association; (4) A policy issued to a college, school or other institution of learning or to the head or principal thereof, insuring at least ten students, or students and employees, of the institution; (5) A policy issued to or in the name of any volunteer fire department, insuring all of the members of the department or all of any class or classes thereof against any one or more of the hazards to which they are exposed by reason of the membership but in each case not less than ten members; (6) A policy issued to any person or organization to which a policy of group life insurance may be issued or delivered in this state, to insure any class or classes of individuals that could be insured under the group life policy; and (7) A policy issued to cover any other substantially similar group which in the discretion of the commissioner may be subject to the issuance of a group accident and sickness policy or contract.
REQUIRED POLICY PROVISIONS		Group policies must contain the following:
Entire Contract	§33-16-3(a)	A provision that the policy, application of the policyholder, and the individual applications submitted shall constitute the entire contract between the parties, and that all statements made by any applicant(s) shall be deemed representations and not warranties, and that no such statement shall void the insurance or reduce benefits thereunder unless contained in a written application.
Individual Certificates	§33-16-3(b)	A provision that the insurer will provide an individual certificate for each member of the group setting forth in substance the essential

		features of the coverage and to whom benefits are payable. If dependents are included, only one certificate need be issued for each family unit.
New Members	§33-16-3(c)	A provision that all new employees or members, in the groups or classes eligible for insurance, shall from time to time be added to such groups or classes eligible to obtain such insurance in accordance with the terms of the policy.
Prohibited Provisions	§33-16-3(d)	No provision relative to notice or proof of loss or the time for paying benefits or the time within which suit may be brought upon the policy shall be less favorable to the insured than would be permitted in the case of an individual policy by the provisions set forth in §§33-15-1 et seq.
Layoff Provision	§33-16-3(e)	A provision that all members shall be permitted to pay the premiums at the same group rate and receive the same coverages for a period not to exceed 18 months when they are involuntarily laid off from work.
Other Provisions	§33-16-3(f)	Further provisions as the commissioner shall promulgate by rule.
MANDATORY BENEFITS		
Mental Health	§33-16-3a	Any health benefit plan issued or renewed in this state shall provide benefits to all individual subscribers and members and to all group members for expenses arising from treatment of serious mental illness. The expenses do not include custodial care, residential care or schooling. For purposes of this section, "serious mental illness" means an illness included in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, as periodically revised, under the diagnostic categories or subclassifications of: (A) Schizophrenia and other psychotic disorders; (B) bipolar disorders; (C) depressive disorders; (D) substance-related disorders with the exception of caffeine-related disorders and nicotine-related disorders; (E) anxiety disorders; and (F) anorexia and bulimia. a. Mental health benefits furnished to an enrollee of a plan offered in connection with a group health plan: 1. Aggregate Lifetime Limits: A. If the health benefit plan does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan may not impose any aggregate lifetime limit on mental health benefits. B. If the plan limits the total amount that may be paid with respect to an individual (or other coverage unit) for substantially all medical and surgical benefits, the plan shall either apply the applicable lifetime limit to medical and surgical benefits and to mental health benefits or not include any aggregate lifetime limit on mental health benefits that is less than the applicable lifetime limit. 2. Annual Limits: A. If a plan does not include an annual limit on substantially all medical and surgical benefits, the plan may not impose any annual limit on mental health benefits. B. If the plan places an annual limit on the amount paid with respect to an individual (or other coverage unit) for substantially all medical and surgical benefits, the plan shall either apply the applicable annual limit to medical and surgical benefits and to mental health benefits or not include any annual limit on mental health benefits that is less than the applicable annual limit.
Home Health Care Coverage	§33-16-3b	Any insurer who delivers or issues for delivery in West Virginia group basic hospital expense or major medical expense coverage shall make available to the policyholder home health care coverage consistent with the provisions of this section. Home health care coverage offered shall include: 1. Services provided by a registered nurse or a licensed practical nurse. 2. Health services provided by a physical, occupational, respiratory and speech therapists. 3. Health services provided by a home health aide to the extent that such services would be covered if provided on an inpatient basis. 4. Medical supplies, drugs, medicines and laboratory services to the extent that they would be covered if provided on an inpatient basis. 5. Services provided by a licensed midwife or a licensed nurse midwife. Home health care coverage may be limited to:

		1. Services provided on the written order of a licensed physician, provided such order is renewed at least every sixty days. 2. Services provided by a home health agency certified in the state in which the services are rendered or under Title XVIII [42 U.S.C. §§ 1395 et seq.] of the Social Security Act. 3. Services as set forth above without which the insured would have to be hospitalized. Coverage shall be provided for at least 100 home visits per insured per policy year, with each home visit by a member of a home health care team to be considered as one visit including up to four hours of home health care services. No such policy need provide such coverage to persons eligible for Medicare.
Medicare Supplement Insurance	§33-16-3d, §114-24-5, §114-24-6, §114-24-6A, §114-24-7, §114-24-7A	Standards for Medicare Supplement Insurance are found in §33-16-3d, §114-24-5, §114-24-6, §114-24-6A, §114-24-7, and §114-24-7A .
Policies to Cover Nursing Services	§33-16-3e	Group policies must make available as benefits coverage for primary health care nursing services 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 nurse and other health providers.
TMD/CMD	§33-16-3f, §114-29-4	All accident and sickness coverage which provides hospital, surgical, or major medical coverage must provide benefits for the diagnosis and treatment of temporomandibular disorders (TMD) and craniomandibular disorders (CMD). An insured shall be given the option of declining coverage for temporomandibular disorders (TMD) and craniomandibular disorders (CMD) and the insurer must provide an appropriate waiver form or incorporate such waiver form into the insurance policy or other evidence of coverage.
Mammograms, Pap Smears and Human Papilloma Virus Test	§33-16-3g	Whenever reimbursement or indemnity for laboratory or X-ray services are covered, reimbursement or indemnification shall not be denied for mammograms, pap smears or human papilloma virus test 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.
Rehabilitation Services	§33-16-3h	Insurers shall provide as benefits coverage for rehabilitation services (as defined in §33-16-3h), unless rejected by the insured.
Emergency Services	§33-16-3i	Insurers shall provide as benefits coverage for emergency services. A policy, provision, contract, plan or agreement may apply to emergency services the same deductibles, coinsurance and other limitations ass apply to other covered services, provided that preauthorization or precertification shall not be required. Every insurer shall provide coverage for emergency medical 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. 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. Coverage of emergency services shall be subject to coinsurance, copayments and deductibles applicable under the health benefit plan. The emergency department and the insurer shall make a good faith effort to communicate with each other in a timely fashion to expedite postevaluation or poststabilization services in order to avoid material deterioration of the covered person's condition.
Postpartum Hospital Stay 48 Hours Normal Delivery 96 Hours C-Section	§33-16-3j	If a health plan provides inpatient benefits in connection with child birth for a mother or her newborn child: The plan may not restrict benefits for any hospital stay following a normal vaginal delivery to less than forty-eight hours or following a cesarean section to less than ninety-six hours, or require a provider to obtain authorization for such length hospital stays.
Pre-Existing Conditions Limitations	§33-16-3k	a health benefit plan issued in connection with a group health plan may not impose a preexisting condition exclusion with respect to an employee or a dependent of an employee for losses incurred by the employee or dependent more than twelve months (or eighteen months for a late enrollee) after the earlier of the individual's date of enrollment in the health benefit plan or the first day of a waiting period for enrollment in the plan.
Colorectal Cancer Examination and Laboratory Testing	§33-16-3o	Reimbursement or indemnification for colorectal cancer examinations and laboratory testing may not be denied for any nonsymptomatic person 50 years of age or older, or a symptomatic person under 50 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.

Reconstructive Surgery Following Mastectomy	§33-16-3p	Any policy of insurance which provides medical and surgical benefits with respect to a mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy
Clinical Trials under §33-25F-1	§33-16-3r	The provisions relating to clinical trials established in article twenty-five-f of Chapter 33 shall apply to the health benefit plans regulated by Article 16 of Chapter 33.
Third-party reimbursement for kidney disease screening	§33-16-3s	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. 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.
Required coverage for dental anesthesia services	§33-16-3t	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: (1) 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 (2) 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. (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.
AIDS Regulation	§33-16-9, §114-27	No insurer may cancel or nonrenew a policy of any insured because of diagnosis or treatment of acquired immune deficiency syndrome. See West Virginia Regulation §114-27 for more details.
Women's Access to Health Care Act	33-42-1, et seq.	No health benefits policy may require as a condition to the coverage of basic primary and preventative obstetrical and gynecological services that a woman first obtain a referral from a primary care physician. No health benefits policy may require as a condition to the coverage of prenatal or obstetrical care that a woman first obtain a referral for those services by a primary care physician.
Newly Born Children	§33-6-32	All health insurance policies shall provide that the health insurance benefits applicable for children shall be payable with respect to a newly born child of the insured or subscriber from the moment of birth. The coverage for newly born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that

		notification of birth of a newly born child and payment of the required premium or fees must be furnished to the insurer within 31 days after the date of birth in order to have the coverage continue beyond such 31 day period.
Newborn Screenings (Applies to policies that cover pregnancy benefits)	§16-22-3(c)	Newborn screenings shall be considered a covered benefit reimbursed to the birthing facilities by Public Employees Insurance Agency, the State Children's Health Insurance Program, the Medicaid program and all health insurers whose benefit package includes pregnancy coverage and who are licensed under chapter thirty-three of this code.
Child Immunization Services Coverage	§33-16-12	All policies shall cover the cost of child immunization services as described in W. Va. Code §16-3-5, 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 does not require that other health care services provided at the time of immunization be exempt from any deductible and/or copayment provisions.
Diabetes Coverage	§33-16-16 §33-15C-1	Except as provided in W. Va. Code §33-15-6, any policy shall include coverage for equipment and supplies listed in W. Va. Code §33-16-16(a) for treatment and/or management of diabetes for both insulin dependent and noninsulin dependent persons with diabetes and those with gestational diabetes, if medically necessary and prescribed by a licensed physician. All policies shall also include coverage for diabetes self-management education to ensure that persons with diabetes are educated as toe the proper self-management and treatment of their diabetes, including information on proper diets. Coverage for this education shall be limited to visits medically necessary upon diagnosis, visits under circumstances whereby a physician diagnoses a significant change in symptoms or conditions that necessitate changes in self-management, and where a new medication or therapeutic process has been identified as medically necessary by a licensed physician. The education may be provided by the physician as part of an office visit, or by a certified diabetes educator certified by a national diabetes educator certification program, or registered dietitian registered by a nationally recognized professional association of dietitians upon the referral of a physician. Provided that such national program has been certified to the commissioner by the commissioner of the bureau of public health. Any deductible or coinsurance billed for any service shall apply on an equal basis with all other coverages provided by the insurer.
Contraceptive Coverage (Applies to policies which include a prescription drug plan)	§33-16E-3	Health insurance plans that provide benefits for prescription drugs or prescription devices in prescription drug plans may not exclude or restrict benefits to covered persons for any prescription contraceptive drug or prescription contraceptive device approved by the federal Food and Drug Administration.
Conversion Privileges		
Right to Convert	§33-16A-1	A group policy or group subscriber contract which provides hospital, surgical or major medical expense insurance, or any combination of these, on an expense incurred basis, but not a policy which provides benefits for specific diseases or for accidental injuries only, shall provide that an employee or member whose insurance under the group policy or contract has been terminated for any reason, who has been continuously insured under the policy, or under any group policy providing similar benefits which it replaces, for at least three months immediately prior to termination, shall be entitled to have issued to him by the insurer a converted policy of health insurance. An employee or member is not entitled to this if termination occurred due to nonpayment, or the discontinued group coverage was replaced by similar group coverage within 31 days.
Standards for Converted Policies	§33-16A-3 §33-16A-4 §33-16A-8 §33-16A-2(b)	The following are standards for converted policies: 1. The converted policy must become effective upon termination of insurance coverage under the group policy. 2. The converted policy must cover the employee or member or his dependents, or both, who are covered by the group policy on the date of termination of insurance. At the option of the insurer, a separate converted policy may be issued to cover any dependent. 3. The converted policy may not contain exclusions for preexisting conditions, except to the extent that a condition was excluded from the group policy from which conversion was made. Benefits for pregnancy and childbirth may not be excluded from the converted policy if benefits for these conditions were provided under the group policy. 4. The converted policy must be offered without evidence of insurability.

Issuance of Converted Policy	§33-16A-2	Issuance of a converted policy shall be subject to the following conditions: 1. Written application for the converted policy shall be made and the first premium paid to the insurer not later than 31 days after termination. 2. The initial premium for the first 12 months and subsequent renewal premiums shall be determined in accordance with premium rates applicable to individually underwritten standard risks, to the age and class of risk of each person to be covered under the converted policy and to the type and amount of insurance provided. The experience under converted policies shall not be an acceptable basis for establishing rates. If an insurer experiences or incurs losses for a period of two years on conversion policies which exceed earned premiums by more than 20%, the insurer may file with the commissioner amended renewal rates which will produce a loss ratio of not less than 120%. Conditions pertaining to health shall not be an acceptable basis for classification. The frequency of premium payment shall be the frequency customarily required by the insurer for the policy form and plan selected, provided that the insurer shall not require premium payments less frequently than quarterly.
Coordination of Benefits		
COB Contract Provision	§114-28-3.1	Appendix A of §114-28 contains a model COB provision.
Flexibility	§114-28-3.2	A group contract's COB provision does not have to use the words and format of the model. Changes may be made to fit the language and style of the rest of the group contract or to reflect the difference amount plans which provide services, which pay benefits for expenses incurred, and which indemnify. No other substantive changes are allowed.
Cost Containment Provisions		
Mandatory Second Surgical Opinion		Company won't pay 100% of scheduled charges unless another physician's opinion is sought – emergencies excepted.
Pre-Admission Certification		Company approves the admission to the hospital (emergencies excepted).
Concurrent Review		A review of an insured's medical care while that care is being administered. The purpose of concurrent review is to assure that the required care is being provided.
Retrospective Review		Company reviews all charges by the hospital and the physician and looks for duplicate or unreasonable fees.
Ambulatory Outpatient Services		Deductible waived and at 100%.
COBRA		
Basic Requirements		The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) requires employers with 20 employees or more on at least 50% or the working days in the previous calendar year to provide for continuation of health coverage at group rates (except group disability income benefits) for the dependents of all eligible employees with evidence of insurability.
		1. Qualified beneficiaries may elect to continue coverage identical to that covered under the original health plan. 2. Employers have an obligation to determine the specific rights of the beneficiaries and inform them of same through an initial general notice known as a summary plan description. 3. Employers must notify plan administrators within 30 days of an employee's death, termination, reduced hours, and/or Medicare entitlement. 4. Multi-employer plans may be given a longer period of time than 30 days. 5. Employees, retirees and family members must notify the plan administrator within 60 days of such qualifying events as divorce or legal separation or an individual losing "dependent child" status. 6. Once notified of a "qualifying event," plan administrators must notify employees and/or family members of their rights to elect benefits identical to those received immediately before the qualifying event. 7. Qualified beneficiaries have a 60 day period to elect whether or not to continue coverage. 8. Employer Penalties – Employers who fail to comply with COBRA regulations are subject to a fine of $100 per day per eligible insured. 9. Premiums – COBRA allows employers to change those who elect to continue coverage 102% of the premiums the employer (company) pays for each employee. The excess 2% covers administrative duties and paperwork required of the employer. A grace period exists for the failure to pay premiums. The grace period is the longest of 30 days, the period the plan allows employees for failure to pay premiums, and the period the insurance company allows the plan or the employer for failure to pay premiums.

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