

**West Virginia Offices of the Insurance Commissioner  
REVIEW REQUIREMENTS CHECKLIST**

**INDIVIDUAL ACCIDENT & SICKNESS INSURANCE**

REVIEW REQUIREMENTS	REFERENCE	COMMENTS
<b>FORMS</b>		
<b>General Requirements</b>		
Fees	§33-6-34	The fee for a Form Filing is \$50.00 per filing.
Submission	Informational Letter No 163	All filings must be submitted through SERFF. Filing fees must be remitted via EFT through SERFF.
	§33-3-7	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.
Prohibited Provision Or Practice	§33-6-14 §33-4-20(b)(3)	The policy must be construed under the laws of this state. No entity providing life or health insurance may deny, refuse to issue, refuse to reissue, cancel or otherwise terminate an insurance policy or restrict coverage on any individual because that individual is, has been or may be the victim of abuse.
Policy Contents	§ 33-6-11	The policy shall specify the names of the parties to the contract, the insurer's name, the subject of the insurance, the risks insured against, the time the insurance coverage becomes effective and the term during which such coverage continues, the premium (or sufficient information to determine the premium), and the conditions pertaining to the insurance.
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.
Execution of Policies	§33-6-15	Every insurance policy shall be executed in the name of and on behalf of the insurer by its officer, attorney-in-fact, employee, or representative duly authorized by the insurer. A facsimile signature of any such executing individual may be used in lieu of an original signature, except that in all policies other than those approved for machine vending the countersignature shall be in original handwriting.
Compliance	33-15 33-15A Reg. 114-10 Reg. 114-17	The <u>Certification of Compliance</u> should reference the Chapter and Article for Individual Accident and Sickness policies. <u>Individual Accident and Sickness</u> policy forms must comply with Chapter 33, Article 15 of the WV Code. <u>Long Term Care</u> policy forms must comply with Chapter 33, Article 15A of the WV Code. <u>Advertising</u> -Require advertising filing on all Accident & Sickness products. <u>Medicare Supplements</u>
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 , <b>For Company Use Only</b> , 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.
<b>Required Disclosure Provisions</b>		
(1) Insuring Clause	§33-6-11	<u>On the First Page</u> of the health policy, there should be a broad statement stipulating the conditions under which benefits are to be paid for losses resulting from sickness or accidents.
(2) Renewal, Continuation or Non-renewal	Reg. §114-12-6.6.1	<u>On the First Page</u> of the policy, there must be an appropriately captioned provision for <u>Renewal, Continuation or Non-renewal</u> which clearly states the duration (where limited) of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.
(3) Preexisting Conditions	Reg. §114-12-6.6.5	<u>On the First Page</u> of the policy, any provisions limiting or excluding coverage of preexisting conditions must appear in a separate paragraph labeled " <u>Preexisting Condition Limitations</u> " and must also be included in the Outline of Coverage. Preexisting conditions MAY NOT be written into Major Medical Health Coverage.

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(4) Accident Only Policies	Reg. §114-12-6.6.6	<p>All <u>accident only policies</u> must contain as an overlay on the first page of the policy, in contrasting shade, a prominent statement as follows: <i>This is an accident only policy and it does not pay benefits for loss from sickness.</i> Any accident only policy providing benefits which vary according to the type of accidental cause must prominently state in the Outline of Coverage the circumstances under which benefits are payable that are less than the maximum amount payable under the policy.</p> <p>It is Departmental Policy to require an ACA disclosure statement on the front page of all limited benefit Accident and Sickness policies.</p>
(5) Free Look Provision (Right of Return)	Reg. §114-12-6.6.8	<p><u>On the First Page</u> of all policies, there must be a prominently displayed notice, stating that the policyholder has the right to return the policy within 10 days of its delivery and to have the premium refunded if after examination of the policy the policyholder is not satisfied for any reason.</p>
(6) Specified Disease Policies	Reg. §114-12-6.6.12	<p><u>On the First Page</u> of the policy, there must be a statement in either contrasting shade or boldface type, a prominent statement as follows: <u>"Caution: This is a limited benefits policy. Read it carefully with the Outline of Coverage."</u></p> <p>It is Departmental Policy to require an ACA disclosure statement on the front page of all limited benefit Accident and Sickness policies.</p>
(7) Signed Acceptance	Reg. §114-12-6.6.2	<p>All riders or endorsements added to a policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the policyholder. Any rider or endorsement which increases benefits or coverage and also increases the premium during the policy term shall be agreed to in writing signed by the policyholder, except if the increased coverage or benefits are required by law.</p>
Changes in Premium	Reg. §114-12-6.6.3	<p>Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy.</p>
Definition of Special Terms	Reg. §114-12-6.6.4	<p>A policy which provides for the payment of benefits based on standards described as usual and customary, reasonable and customary, or similar words must include a definition of those terms in both the policy and the Outline of Coverage.</p>
(8) Conversion Privilege	Reg. §114-12-6.6.10	<p>An individual health policy may insure one person or more than one if the applicant is an adult family member and the others to be covered are members of his/her family. Additional persons who may be insured include the husband, wife, dependent children or others dependent upon the adult applicant. To be eligible, children must meet certain age requirements, usually to age 19; if a full time unmarried student in a college or university the age is increased to age 23. If a policy contains a conversion privilege, it must comply with the following: The caption of the provision must be "Conversion Privilege," or similar words. The provision must indicate the persons eligible for conversion and the circumstances under which the conversion privilege may be exercised, including any limitation. The provision must specify the benefits to be provided on conversion or may state that the converted coverage will be as provided on a policy form then being used by the insurer for that purpose.</p>
(9) Outline of Coverage	Reg. §114-12-6.6.11	<p>No policy or certificate for individual health insurance may be delivered or issued for delivery in West Virginia unless an <u>Outline of Coverage</u> is completed for that policy. Outlines of Coverage delivered with policies for hospital confinement indemnity, specified disease or limited benefits health insurance coverages to persons eligible for Medicare must also contain the following language which must be printed on or attached to the first page of the Outline of Coverage: "This policy is not a Medicare Supplement policy. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurer." If age is to be used as a factor in reducing the maximum aggregate benefits made available in the policy as originally issued, such fact must be prominently set out in the Outline of Coverage. The Outline of Coverage warns the applicant to read the policy carefully. It provides a brief description of the important features and states that only the actual policy provisions set out the rights and obligations.</p>
Prescribed Forms for Outlines of Coverage	Reg. §114-12-6.6.14 thru 6.6.22	<p>Appendix A – Basic Hospital Expense Coverage; Appendix B – Basic Medical-Surgical Expense Coverage; Appendix C – Basic Hospital and Medical-Surgical Expense Coverage; Appendix D – Hospital Confinement Indemnity Coverage; Appendix E – Major Medical Expense Coverage; Appendix F – Disability Income Protection Coverage; Appendix G – Accident-Only Coverage; Appendix H – Specified Disease or Specified Accident Coverage; Appendix I – Limited Benefits Health Coverage.</p>

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Form and Content Requirements For Accident & Sickness Policies	§33-15-2	(a) The entire money and considerations must be expressed; (b) The effective date and the termination date of the policy must be expressed; (c) The policy purports to insure only one person, except for family members of the adult policyholder; (d) The policy is guaranteed renewable at the option of the insured; (e) Specifications for style, arrangement, over-all appearance, print size must be met; (f) The exceptions and reductions of indemnity must be set forth as specified; (g) Each policy form, including riders and endorsements must be identified by a form number in the lower left hand corner of the first part. . .(each page preferably); (h) There must be no provision purporting to make any portion of the insurer's charter, rules, constitution, by-laws a part of the policy. . . (i) The insurer must offer and accept for enrollment every eligible individual who applies for coverage within 63 days after termination of the individual's prior creditable coverage.
<b>Required Policy Provisions</b>		
(1) Entire Contract	§33-15-4(a)	The Entire Contract includes the policy, all endorsements and any attached papers, such as the application and any riders. Nothing outside of the contract and its attachments is considered part of the entire contract. This Entire Contract assures the policy owner that no changes will be made to the contract after it has been issued. Only an executive Officer of the insurance company and not the agent can make changes to the policy.
(2) Time Limit on Certain Defenses	§33-15-4(b)	There is a limit to the period of time in which an insurer may challenge the contract or deny a claim on grounds of material misrepresentation in the application. There are two provisions: 1) After two (2) years has expired from the policy date of issue, no material non disclosures or misstatements made by the applicant may be used to void the policy or deny a claim except in case of fraudulent misstatements. 2) After two (2) years has expired, the insurer cannot deny a claim on the basis of preexisting conditions, unless the condition was excluded from coverage under the policy by name or specific description.
(3) Grace Period	§33-15-4(c)	A certain number of days are allowed after the premium due date during which a premium may be paid without penalty or lapse of the policy for non-payment of premium. The number of days depends on how the premiums are paid: a) 7 days if premiums are paid weekly; b) 10 days if premiums are paid monthly; c) 31 days for all other modes of premium payment.
(4) Reinstatement	§33-15-4(d)	A policy which has lapsed due to non payment of premium may be put back in force. a) If an application is required, and a conditional receipt for the premium is issued, the policy will be reinstated upon the insurer's approval of the application, or lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the applicant in writing of the disapproval of such application.
(5) Notice of Claim	§33-15-4(e)	A Policyholder must give the insurer written notice of claim within 20 days or as soon as reasonably possible. This notice can be given to either the agent or directly to the insurance company. In loss of time contracts, notice of continuation of disability is required at least every six months except in the absence of legal incapacity.
(6) Claim Forms	§33-15-4(f)	Upon receipt of a notice of claim, the insurer will furnish the claimant within fifteen (15) days the appropriate forms upon which the claimant is to file proofs of loss. The proof of loss must cover the occurrence, the character and the extent of the loss for which claim is made.
(7) Proof of Loss	§33-15-4(g)	The claimant must provide the insurer with the written proof of loss within 90 days of the loss or, in the case of a continuing loss, within 90 days after the end of a period for which the insurer is liable. A proof of loss is a formal statement given to the carrier regarding the loss. If the claimant is unable to file within 90 days, the proof of loss must be filed within a reasonable time not exceeding one year, except in the case of legal incapacity.
(8) Time of Payment of Claims	§33-15-4(h)	Claims are due and payable immediately upon the insurer's receipt of proof of loss, except when periodic payments, at least on a monthly basis, are to be made as specified in the policy. Balances unpaid when the policy terminates shall be paid immediately upon receipt of due proof of loss.

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(9) Payment of Claims	§33-15-4(l)	Death benefits from any group policy or individual accident policy are paid to a named beneficiary otherwise to the estate of the insured. If the beneficiary is a minor or legally incapable of receiving proceeds, a facility of payment provision may be included for payments up to one thousand dollars (\$1,000.00). All other benefits are payable to the insured unless assigned to a healthcare provider. The insurer may have the option of making payments directly to the person or hospital rendering services.
(10) Physical Exams & Autopsy	§33-15-4(j)	The insurer at its own expense has the right to examine the person insured when and as often as it is reasonably required while a claim under the policy is pending and to make an autopsy in case of death where it is not prohibited by law.
(11) Legal Actions	§33-15-4(k)	No legal action shall be brought against the company prior to sixty (60) days after proof of loss has been submitted and not later than three years after proof of loss has been submitted.
(12) Change of Beneficiary	§33-15-4(l)	Unless the insured makes an irrevocable designation of beneficiary, the insured has the right to change the beneficiary and the consent of the beneficiary is not required for the surrender or assignment or other changes in this policy.
(13) Limited Benefits	26 US Code 5000 A(f)(4)(B) §148.220(b)(4)(iv)  Informational Letter 192	<b><u>Disclosure Statement</u></b> A notice must be displayed prominently in the plan materials in at least 14 point type that has the following language:  "THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES."  <b><u>Attestation</u></b> Carriers selling individual fixed indemnity plans with plan years beginning on or after January 1, 2015, must include in the application a written attestation that the purchaser has minimum essential coverage. This is a one-time attestation and the carrier is not required to confirm continued enrollment in a plan.
AIDS Regulation	Reg. §114-27-2.2.1  Reg. §114-27-4.4.1 b -4.4.2 a -4.4.2 b  -4.4.2 c	All insurers who deliver or issue for delivery in this state any policies for life or accident and sickness insurance are subject to this regulation.  Sexual orientation may not be used in the underwriting process or in the determination of insurability. No question shall be used which is designed to establish the sexual orientation of the proposed insured. Questions relating to the proposed insured having or having been diagnosed as having AIDS or ARC are permissible if they are factual and designed to establish the existence of the condition. Questions inquiring as to whether the proposed insured has ever tested positive for the presence of the HIV virus or HIV virus antibodies are permissible; however, questions inquiring as to whether the proposed insured has ever been tested for the presence of the HIV virus or HIV antibodies are prohibited.
Medicare	Reg. §114-17-4	No Medicare Supplement or Limited Benefit Medicare Supplement policy or contract shall be delivered or issued for delivery in this State which does not meet the requirements of this section. These are minimum standards and do not preclude the inclusion of other provisions or benefits in addition to, and which are not inconsistent with, these standards. (For Group see Reg. 114-24-5)
<b>Mandatory Benefits</b>		
Rehabilitation Therapy Benefits	§33-15-4d	<b><u>Rehabilitation Therapy Benefits</u></b> – Any entity regulated by Article 15 of Chapter 33 shall provide benefits to all subscribers and members for coverage for rehabilitation services. "Rehabilitation Services" includes those services designed to remediate patient's condition or restore patients to their optimal physical, medical, psychological, social, emotional, vocational and economic status. These services include, but are not limited to, diagnostic testing, assessment, monitoring or treatment of conditions as described in 33-15-4d (b), (c) and (d). . . Stroke; Spinal cord injury; Amputation; Brain injury. . .
Postpartum Hospital Stay Coverage	§33-15-4e	An insurer offering accident and sickness coverage under Article 15 may not restrict 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. . . The mother and her newborn child may be discharged prior to the expiration of the minimum length of stay in those cases in which the decision to discharge is made by an attending provider in consultation with the mother.

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<p align="center">ACA</p> <p>Required coverage for dental anesthesia services</p>	<p align="center">§33-15-4j</p>	<p>All Provisions of the Patient Protection and Affordable Care Act must be followed.</p> <p>Required coverage for dental anesthesia services.</p> <p>(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.</p> <p>(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:</p> <p>(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</p> <p>(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.</p> <p>(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.</p> <p>(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:</p> <p>(1) A fully accredited specialist in pediatric dentistry;</p> <p>(2) A fully accredited specialist in oral and maxillofacial surgery; and</p> <p>(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.</p> <p>(f) Temporal mandibular joint disorders. -- The provisions of this section do not apply to dental care rendered for temporal mandibular joint disorders.</p> <p>(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.</p>
<p>Child Immunization Services Coverage</p>	<p align="center">§33-15-17</p>	<p>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.</p>
<p>Emergency Services</p>	<p align="center">§33-15-21</p>	<p>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 as apply to other covered services, provided that preauthorization or precertification shall not be required.</p> <p>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.</p> <p>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.</p> <p>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.</p>
<p>Contraceptive Coverage (Applies to policies which include a prescription drug plan)</p>	<p align="center">§33-16E-3</p>	<p>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.</p>

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Optional Policy Provisions Individual Accident and Sickness Policies		
(1) Change of Occupation	§33-15-5(a)	<u>"Change of Occupation"</u> – The provision must be captioned. If the insured changes his occupation to one classified by the insurer as more hazardous or to one less hazardous, this provision must state the changes that may be made in premium rates or benefits payable. a) A change to a more hazardous occupation by the insured, upon claim, benefits will be reduced to that which the premium paid would have purchased. B) A change to a less hazardous occupation by the insured, the insured may apply for a rate reduction.
(2) Misstatement of Age	§33-15-5(b)	<u>"Misstatement of Age"</u> – Caption the provision. "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."
(3) Other Insurance with This Insurer	§33-15-5(c)	<u>"Other Insurance With This Insurer"</u> – Caption the provision. This provision is designed to limit the problems of over-insurance. 1) If a policy or policies concurrently in force, issued by and insurer to an insured, make(s) the aggregate indemnity for the accident and sickness coverages excess of a maximum stated limit, the excess insurance shall be void and all premiums paid shall be returned to the insured. 2) The Liability of the insurer is limited to one policy selected by the insured and premiums for all others shall be refunded.
(4) Insurance with Other Insurers	§33-15-5(d)	<u>"Insurance With Other Insurers"</u> – Caption the provision. The essence of this provision: If an insured person has two or more policies that cover the same expenses with more than one insurer and the insurers were not notified that the other coverage existed, then each company shall pay a proportionate share of any claim. Each insurer's share of the claim shall be in proportion to the amount of the insurer's coverage involved in the claim. (This prevents the insured from receiving benefits greater than the loss.) The insurer may include in this provision a definition for "other valid coverage". Provision shall be made for the return of such portion of the premium paid as shall exceed the amount needed to pay for the company's portion of prorated benefits.
(5) Relation of Earnings to Insurance	§33-15-5(e)	<u>"Relation of Earnings to Insurance"</u> – Caption the provision. This provision may only be used in noncancellable and guaranteed renewable contracts. This provision essentially states that if at the time the disability begins, the insured's total disability income exceeds his/her earned income, or average income for the preceding two (2) years, the disability under all disability income policies will not be reduced to less than two-hundred dollars (\$200.00) per month. Premiums for the excess coverage will be returned to the insured. (This provision is concerned with over-insurance for disability income benefits so the insured will not receive more cash from disability insurance than he/she would receive from working.
(6) Unpaid Premiums	§33-15-5(f)	<u>"Unpaid Premiums"</u> – Caption the provision. If there is an unpaid premium or a premium is covered by a note at the time a claim becomes payable, the amount of the premium shall be deducted from the sum payable to the insured or to the beneficiary.
(7) Return of Premium on Cancellation	§33-15-5(g)	<u>"Return of Premium on Cancellation"</u> - After the initial term, the insured may cancel at any time with written notice to the company. If the insured cancels this policy, the earned premium shall be computed by the use of the short-rate table last filed with the Insurance Commission. Cancellation is effective upon the company's receipt of the written notice, but does not affect claims pending to the effective date of cancellation. The insurer is allowed to cancel the policy with written notice to the insured during the initial term. If the insurer cancels the policy, any unearned premium is refunded on a pro rata basis. The insurer must give the insured (7) days notice if the premium is paid weekly; (10) days notice if the premium is paid monthly; (31) days notice for any other mode of payment.
(8) Conformity with State Statutes	§33-15-5(h)	<u>"Conformity with State Statutes"</u> – Caption the provision. "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."
(9) Illegal Occupation	§33-15-5(l)	<u>"Illegal Occupation"</u> – Caption the provision. "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."
(10) Intoxicants and Narcotics	§33-15-5(j)	<u>"Intoxicants and Narcotics"</u> – Caption the provision. "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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<b>Common Exclusions or Restrictions</b>		
Policy Exclusions Policy Exclusions cont.		Some common exclusions found in health insurance policies include: injuries due to war or an act of war, self-inflicted injuries, injuries incurred while the insured serves as a pilot or crew member of an aircraft. Other exclusions are losses resulting from suicide, riots or the use of drugs or narcotics. (This department does not permit the exclusion of hernia, as an accidental injury.) Losses due to injuries sustained while committing or attempting to commit a felony, may be excluded. Foreign travel may not be excluded in every instance and extended stays may cause a loss of benefits. If travel to specific countries is excluded, a list of the countries must be provided the insured, prior to purchase. Terrorism is excluded.
<b>Replacement of Health Insurance</b>		
The Application	Reg. §114-12-7 Reg. §114-12-7.7.1	The Application forms must include a question designed to elicit information as to whether the policy to be issued is intended to replace any other accident and sickness insurance presently in force. A supplementary application to be signed by the applicant containing such question may be used.
Notice to Applicant Regarding Replacement of Accident and Sickness Insurance	Reg. §114-12-7.7.2 APPENDIX J  APPENDIX K	Upon determining that a sale will involve replacement, the insurer (other than a Direct Response insurer) must furnish the applicant, prior to issuance or delivery of the policy, the notice prescribed in Appendix J. One copy of the notice shall be retained by the insurer. A Direct Response insurer must furnish the applicant, upon issuance of the policy, the notice prescribed in Appendix K. No notice is required in the solicitation of accident-only and single-premium nonrenewable policies.
<b>Health Insurance Riders</b>		
Impairment Rider		A rider is an endorsement or form used in health insurance to modify the underlying coverage of a particular policy. An Impairment Rider is used by an insurer to write health insurance on an individual with impaired health from a specific condition, such as diabetes or epilepsy, but who is otherwise in good health.
Guaranteed Insurability Rider		The Guaranteed Insurability Rider provides the insured with the right to purchase additional disability income benefits at regular, specified intervals without evidence of insurability up to a specified maximum age and specified benefit amount.
Multiple Indemnity Rider		The Multiple Indemnity Rider on a disability income policy provides a multiple of income benefits if the insured sustains injury or dies under certain specialized circumstances. Examples: 1) As a passenger on a common carrier; 2) As a passenger in a passenger elevator; 3) Injured in a building whose outer walls collapse; 4) Injured in a building that catches on fire; 5) Injured due to a Steam boiler explosion, due to a Hurricane, Tornado, or Lightning.
<b>Rights of Renewability</b>		
Cancellable Policies		Cancellable health insurance policies allow the insurer to cancel coverage at any time by giving the insured a specified number of days notice.
Noncancellable Policies		Noncancellable contracts cannot be cancelled by an insurer for any reason except nonpayment of premium. Noncancellable contracts provide the insured with a stated amount of coverage for a stated period of time (age 65 usually) at a guaranteed premium rate. They are expensive policies. Disability income policies are the only health policies today written on a noncancellable basis.
Guaranteed Renewable Policies		Guaranteed Renewable health insurance contracts are "guaranteed" (usually to age 65 or 70 at which time the insured is eligible for Medicare benefits). These contracts "guarantee" the continuation of health protection, but the premiums for classes of insureds may increase on premium due dates. As an individual ages and moves from one premium class to another, the cost of health protection will increase. Disability income policies and medical insurance policies are written on a guaranteed renewable basis.
Conditionally Renewable Policies		Conditionally Renewable health insurance policies allow the insurer to nonrenew coverage for certain conditions stated in the policy. These policy conditions might be the insurer's decision to discontinue a particular series of policies in the state or to discontinue writing a particular class of insureds. The policy condition for nonrenewal may be material misrepresentation of a covered person in filing a claim under the policy. To refuse to renew an individual solely on the basis of declining health is not permitted. Disability income policies and medical insurance policies are written on a conditionally renewable basis.

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Optionally Renewable Policies		Optionally Renewable health insurance policies allow the insurer the option to renew or terminate an individual policy at the time of premium payment; cancellation cannot occur at any other time. The insurer is allowed the following options: 1) Refuse to renew; 2) Renew the policy but increase the premium for the particular class of insureds; 3) Renew the policy, but add restrictions to the particular class of insureds.
Period of Time		Health insurance policies written for a specified period of time are called term contracts or nonrenewable contracts. Term health insurance contracts usually are written to provide health benefits for insureds under a limited time frame such as: 1) Passengers on a regularly scheduled air flight; 2) Students at a school for a specific academic year. The "term" varies from one day to one year according to the purpose of the contract.
Newly Born Children	§33-6-32	All individual and group health insurance policies providing coverage on an expense incurred basis and individual and group service or indemnity type contracts issued by a nonprofit corporation which provide coverage for a family member of the insured or subscriber shall, as to such family members coverage, also 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. For the newly born child there shall be coverage for injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for a child, the policy may require that notice of the newborn child's birth and payment of the required premium must be furnished to the insurer or nonprofit service or indemnity corporation within 31 days in order to have the coverage continue beyond the 31-day period.
<b>Service Corporations</b>		
Hospital Service Corporation	§33-24-2 (b)	<u>Hospital Service Corporation</u> is a non-profit, non-stock corporation, organized for the sole purpose of contracting with the public and with hospitals and other health agencies for hospital or other health services to be furnished to subscribers under terms of their contract with the corporation. The corporation must have a controlling board of directors (not more than 20% of whom, or whose spouse, parent, child, brother or sister by blood or marriage) who are engaged in the providing of health care, and at least 80% of whom must be chosen as representatives of the interests of consumers, elderly persons, organized labor and business subscribers.
Medical Service Corporation	§33-24-2 (d)	<u>Medical Service Corporation</u> is a nonprofit, non-stock corporation, organized for the sole purpose of contracting with the public and with licensed physicians, dentists and podiatrists for medical or surgical services and with licensed chiropractors and other health agencies for other health services to be furnished to subscribers under terms of their contract with the corporation. The corporation must have a controlling board of directors (not more than 20% of whom, or whose spouse, parent, child, brother or sister by blood or marriage) who are engaged in the providing of health care, and at least 80% of whom must be chosen as representatives of the interest of consumers, elderly persons, organized labor and business subscribers.
Dental Service Corporation	§33-24-2 (f)	<u>A Dental Service Corporation</u> is a nonprofit, non-stock corporation, organized for the sole purpose of contracting with the public and with licensed dentists for dental services to be furnished to subscribers under terms of their contracts with the corporations. The corporation must have a board of directors as discussed with the previous corporation forms.
Health Service Corporation	§33-24-2 (h)	<u>A Health Service Corporation</u> is a nonprofit, non-stock corporation, organized for the sole purpose of contracting with the public and with hospitals and other health agencies for hospital or other health services to be furnished to subscribers, or for the purpose of contracting with the public and with licensed physicians, dentists and chiropodists-podiatrists for medical or surgical services and with chiropractors and other health agencies for other health services or for the purpose of contracting with the public and with duly licensed dentists for dental services to be furnished to subscribers, all under terms of their contract or contracts with the corporation. Must have a board of directors as previously described. Hospital Service, Medical Service and Dental Service Corporations may merge to form a Health Service Corporation. However, no merger may be made unless the plan, agreement and other supporting documents have been filed in advance and approved by the Insurance Commissioner. Examinations of such corporations are conducted by the Commissioner once every four years.

**West Virginia Offices of the Insurance Commissioner  
REVIEW REQUIREMENTS CHECKLIST**

**INDIVIDUAL ACCIDENT & SICKNESS INSURANCE**

<b>PPACA FILINGS</b>	Please refer to documentation in SERFF's Online Help section for instructions on completing the required PPACA fields. West Virginia <u>does</u> accept grandfathered and non-grandfathered related filings in one submission.
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