CODE OF VIRGINIA

Title 38.2

Insurance

Title 38.2 - Insurance

Chapter 1 - GENERAL PROVISIONS

Article 1 - Definitions

§ 38.2-100. Definitions.

As used in this title:

"Alien company" means a company incorporated or organized under the laws of any country other than the United States.

"Bureau" or "Bureau of Insurance" means the division of the Commission established to administer the insurance laws of the Commonwealth.

"Commission" means the State Corporation Commission.

"Commissioner" or "Commissioner of Insurance" means the administrative or executive officer of the Bureau.

"Company" means any association, aggregate of individuals, business, corporation, individual, joint-stock company, Lloyds type of organization, organization, partnership, receiver, reciprocal or inter-insurance exchange, trustee or society.

"Domestic company" means a company incorporated or organized under the laws of the Commonwealth.

"Foreign company" means a company incorporated or organized under the laws of the United States, or of any state other than the Commonwealth.

"Health services plan" means any arrangement for offering or administering health services or similar or related services by a corporation licensed under Chapter 42 (§ 38.2-4200 et seq.).

"Insurance" means the business of transferring risk by contract wherein a person, for a consideration, undertakes (i) to indemnify another person, (ii) to pay or provide a specified or ascertainable amount of money, or (iii) to provide a benefit or service upon the occurrence of a determinable risk contingency. Without limiting the foregoing, "insurance" shall include (i) each of the classifications of insurance set forth in Article 2 (§ 38.2-101 et seq.) of this chapter and (ii) the issuance of group and individual contracts, certificates, or evidences of coverage by any health services plan as provided for in Chapter 42 (§ 38.2-4200 et seq.), health maintenance organization as provided for in Chapter 43 (§ 38.2-4300 et seq.), legal services organization or legal services plan as provided for in Chapter 44 (§ 38.2-4400 et seq.), dental or optometric services plan as provided for in Chapter 45 (§ 38.2-4500 et seq.), and dental plan organization as provided for in Chapter 61 (§ 38.2-6100 et seq.). "Insurance" shall not include any activity involving a home service contract that is subject to regulation pursuant to Chapter 33.1 (§ 59.1-434.1 et seq.) of Title 59.1; an extended service contract that is subject to regulation

pursuant to Chapter 34 (§ 59.1-435 et seq.) of Title 59.1; a warranty made by a manufacturer, seller, lessor, or builder of a product or service; or a service agreement offered by an automobile club as defined in subsection E of § 38.2-514.1.

"Insurance company" means any company engaged in the business of making contracts of insurance.

"Insurance transaction," "insurance business," and "business of insurance" include solicitation, negotiations preliminary to execution, execution of an insurance contract, and the transaction of matters subsequent to execution of the contract and arising out of it.

"Insurer" means an insurance company.

"Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendment of 1965, as amended.

"Person" means any association, aggregate of individuals, business, company, corporation, individual, joint-stock company, Lloyds type of organization, organization, partnership, receiver, reciprocal or interinsurance exchange, trustee or society.

"Rate" or "rates" means any rate of premium, policy fee, membership fee or any other charge made by an insurer for or in connection with a contract or policy of insurance. The terms "rate" or "rates" shall not include a membership fee paid to become a member of an organization or association, one of the benefits of which is the purchasing of insurance coverage.

"Rate service organization" means any organization or person, other than a joint underwriting association under § 38.2-1915 or any employee of an insurer including those insurers under common control or management, who assists insurers in ratemaking or filing by:

(a) Collecting, compiling, and furnishing loss or expense statistics;

(b) Recommending, making or filing rates or supplementary rate information; or

(c) Advising about rate questions, except as an attorney giving legal advice.

"State" means any commonwealth, state, territory, district or insular possession of the United States.

"Surplus to policyholders" means the excess of total admitted assets over the liabilities of an insurer, and shall be the sum of all capital and surplus accounts, including any voluntary reserves, minus any impairment of all capital and surplus accounts.

Without otherwise limiting the meaning of or defining the following terms, "insurance contracts" or "insurance policies" shall include contracts of fidelity, indemnity, guaranty and suretyship.

Code 1950, §§ 38-1, 38-194, 38-253.20, 38-253.67; 1952, c. 317, §§ 38.1-1, 38.1-219; 1973, c. 504, § 38.1-279.30; 1980, c. 204, § 38.1-362.12; 1986, c. 562; 2001, c. 707; 2004, c. 668; 2017, cc. 653, 727; 2020, c. 264.

§ 38.2-100.1. Certified mail; subsequent mail or notices may be sent by regular mail.

Whenever in this title the Commissioner or the Commission is required to send any mail or notice by certified mail and such mail or notice is sent certified mail, return receipt requested, then any subsequent, identical mail or notice that is sent by the Commissioner or the Commission may be sent by regular mail.

2011, c. 566.

Article 2 - INSURANCE CLASSIFIED AND DEFINED

§ 38.2-101. Classification of insurance.

Insurance is classified and defined as set out in subsequent sections of this article.

1952, c. 317, § 38.1-2; 1986, c. 562.

§ 38.2-102. Life.

A. "Life insurance" means insurance upon the lives of human beings. "Life insurance" includes policies that also provide (i) endowment benefits; (ii) additional benefits incidental to a loss in the event of death, dismemberment, or loss by accident or accidental means; (iii) additional benefits to safeguard the contract from lapse or to provide a special surrender value, a special benefit or an annuity, in the event of total and permanent disability of the insured; and (iv) optional modes of settlement of proceeds. As used in this title, unless the context requires otherwise, "life insurance" shall be deemed to include "credit life insurance," "industrial life insurance," "variable life insurance" and "modified guaranteed life insurance."

B. "Life insurance" also includes additional benefits to provide for educational loans, subject to the provisions of § 38.2-3113.3.

C. "Life insurance" also includes additional benefits providing specified disease coverage or limited benefit health coverage, subject to compliance with the minimum standards established by the Commission for such benefits pursuant to § 38.2-3519. Such additional benefits may be combined in an individual policy, or added as a rider to the policy, provided that the insurer offering such additional benefits is licensed to transact the business of accident and sickness insurance and complies with the rate and form filing requirements of the Commission's rules governing the filing of rates for individual and certain group accident and sickness insurance policy forms (14VAC5-130-10 et seq.), as amended.

1952, c. 317, § 38.1-3; 1976, c. 562; 1986, c. 562; 1992, c. 210; 2000, c. 173; 2011, c. 186; 2012, c. 673.

§ 38.2-103. Credit life.

"Credit life insurance" means insurance on the life of a debtor pursuant to or in connection with a specific loan or other credit transaction.

1960, c. 67, § 38.1-482.2; 1982, c. 223; 1986, c. 562.

§ 38.2-104. Industrial life.

"Industrial life insurance" means life insurance provided by an individual insurance contract (i) under which premiums are payable at least monthly and (ii) that has the words "industrial policy" printed upon the policy as a part of the descriptive matter.

Code 1950, § 38-433; 1952, c. 317, § 38.1-409; 1986, c. 562.

§ 38.2-105. Variable life.

"Variable life insurance" means any policy or contract of life insurance in which the amount or duration of benefits may vary according to the investment experience of any separate account maintained by the insurer for the policy or contract, as provided for in § 38.2-3113.

1986, c. 562.

§ 38.2-105.1. Modified guaranteed life insurance.

"Modified guaranteed life insurance" means any policy or contract of life insurance in which the benefits are guaranteed if held for specified periods and nonforfeiture values are based upon a market-value adjustment formula if held for shorter periods. The formula may or may not reflect the investment experience of any separate account which may be maintained by the insurer for the policy or contract as provided for in § 38.2-3113.1.

1992, c. 210.

§ 38.2-106. Annuities.

"Annuities" means all agreements to make periodic payments in specified or calculable sums pursuant to the terms of a contract for a stated period of time or for the life of the person or persons specified in the contract. "Annuities" does not include contracts defined in § 38.2-102 and qualified charitable gift annuities as defined in § 38.2-106.1.

As used in this title, unless the context requires otherwise, "annuity" shall be deemed to include "variable annuity" and "modified guaranteed annuity," and shall be deemed to include a contract under which a lump sum cash settlement is an alternative to the option of periodic payments.

1952, c. 317, § 38.1-4; 1966, c. 289; 1970, c. 532; 1985, c. 312; 1986, c. 562; 1992, c. 210; 1993, c. 764; 1996, c. 425; 2001, c. 64.

§ 38.2-106.1. Charitable gift annuities.

For purposes of this title:

"Charitable gift annuity" means an agreement by a charitable organization to make periodic payments in fixed dollar amounts payable over one or two lives, under which the actuarial value of the annuity, as determined for federal tax purposes, is less than the value of the cash or other property transferred by the donor in return therefor and the difference in value constitutes a charitable contribution for federal tax purposes.

"Charitable organization" means an entity described in:

1. § 501(c) (3) of the Internal Revenue Code of 1986 (26 U.S.C. § 501(c) (3)); or

2. § 170 (c) of the Internal Revenue Code of 1986 (26 U.S.C. § 170 (c)).

"Qualified charitable gift annuity" means a charitable gift annuity that conforms to the requirements of § 501 (m) (5) of the Internal Revenue Code of 1986 (26 U.S.C. § 501 (m) (5)) and § 514 (c) (5) of the Internal Revenue Code of 1986 (26 U.S.C. § 514 (c) (5)) and that is issued by a charitable organization that on the date of the annuity agreement:

1. Has a minimum of $100,000 in unrestricted cash, cash equivalents, or publicly traded securities, exclusive of the assets contributed by the donor in return for the annuity agreement; and

2. Has been in continuous operation as a charitable organization for at least three years or is a successor or affiliate of a charitable organization that has been in continuous operation as such for at least three years.

1996, c. 425.

§ 38.2-107. Variable annuity.

"Variable annuity" means any agreement or contract for an annuity in which the amount or duration of benefits or optional lump sum cash settlement may vary according to the investment experience of any separate account maintained by the insurer for the policy or contract as provided for in § 38.2-3113. Pursuant to the terms of the contract, payments may be made for a stated period of time or for the life of the person or persons specified in the contract.

1986, c. 562; 1993, c. 764.

§ 38.2-107.1. Modified guaranteed annuity.

"Modified guaranteed annuity" means any agreement or contract for an annuity in which the benefits are guaranteed if held for specified periods and nonforfeiture values are based upon a market-value adjustment formula if held for shorter periods. The formula may or may not reflect the investment experience of any separate account which may be maintained by the insurer for the agreement or contract as provided for in § 38.2-3113.1.

1992, c. 210.

§ 38.2-107.2. Private family leave insurance.

"Family leave insurance" means an insurance policy issued to an employer related to a benefit program provided to an employee to pay for a percentage or portion of the employee's income loss due to (i) the birth of a child or adoption of a child by the employee; (ii) placement of a child with the employee for foster care; (iii) care of a family member of the employee who has a serious health condition; or (iv) circumstances arising out of the fact that the employee's family member who is a service member is on active duty or has been notified of an impending call or order to active duty. Family leave insurance may be written as an amendment or rider to a group disability income policy, included in a group disability income policy, or written as a separate group insurance policy purchased by an employer.

2022, cc. 131, 132.

§ 38.2-108. Credit accident and sickness.

"Credit accident and sickness insurance" means insurance on a debtor to provide for payments on a specific loan or other credit transaction while the debtor is disabled as defined in the policy.

1960, c. 67, § 38.1-482.2; 1982, c. 223; 1986, c. 562.

§ 38.2-109. Accident and sickness.

A. "Accident and sickness insurance" means insurance against loss resulting from sickness, or from bodily injury or death by accident or accidental means, or from a combination of any or all of these perils. As used in this title, unless the context requires otherwise, the term "accident and sickness insurance" shall be deemed to include "credit accident and sickness insurance."

B. The term "accident and sickness insurance" shall also include agreements insuring against losses resulting from health care claims or expenses of health care in excess of a specific or aggregate dollar amount, when such agreements are used to provide coverage to (i) an employee welfare benefit plan or any other plan providing accident and sickness benefits, (ii) a health maintenance organization, or (iii) a provider associated with a managed care network, provided:

1. The agreement clearly discloses the extent and duration of the liability assumed by the insurer once the policyholder's liability has been exceeded; and

2. The insurer maintains reserves in accordance with § 38.2-1314 for the liability it assumes under the agreement.

Such agreements shall not be subject to the requirements of Chapters 34 (§ 38.2-3400 et seq.) and 35 (§ 38.2-3500 et seq.) of this title.

1952, c. 317, § 38.1-5; 1986, c. 562; 1997, c. 28.

§ 38.2-110. Fire.

"Fire insurance" means insurance against loss of or damage to any property resulting from fire, including loss or damage incident (i) to extinguishing a fire, or (ii) to the salvaging of property in connection with a fire.

1952, c. 317, § 38.1-6; 1986, c. 562.

§ 38.2-111. Miscellaneous property and casualty.

A. "Miscellaneous property insurance" means insurance against loss of or damage to property resulting from:

1. Lightning, smoke or smudge, windstorm, tornado, cyclone, earthquake, volcanic eruption, rain, hail, frost and freeze, weather or climatic conditions, excess or deficiency of moisture, flood, the rising of the waters of the ocean or its tributaries; or

2. Insects, blights, or disease of such property other than animals; or

3. Electrical disturbance causing or concomitant with a fire or an explosion; or

4. The ownership, maintenance or use of elevators, except loss or damage by fire. This class of insurance includes the incidental power to make inspections of and to issue certificates of inspection upon any such elevator; or

5. Bombardment, invasion, insurrection, riot, civil war or commotion, military or usurped power, any order of a civil authority made to prevent the spread of a conflagration, epidemic or catastrophe, vandalism or malicious mischief, strike or lockout, collapse from any cause, or explosion; but not including any kind of insurance specified in § 38.2-115, except insurance against loss or damage to property resulting from:

a. Explosion of pressure vessels, except steam boilers of more than fifteen pounds pressure, in buildings designed and used solely for residential purposes by not more than four families;

b. Explosion of any kind originating outside of the insured building or outside of the building containing the insured property;

c. Explosion of pressure vessels not containing steam; or

d. Electrical disturbance causing or concomitant with an explosion; or

6. Any other cause or hazard which may result in a loss or damage to property, if the insurance is not contrary to law or public policy.

B. "Miscellaneous casualty insurance" means insurance against liability, and against loss, damage, or expense arising out of injury to the economic interests of any person, but not including any class of insurance otherwise specified in this title, provided that such insurance is not contrary to law or public policy, except that any policy of miscellaneous casualty insurance may include appropriate provisions obligating the insurer to pay medical, hospital, surgical, and funeral expenses arising out of the death, dismemberment, sickness, or injury of any person, and death and dismemberment benefits in the event of death or dismemberment, if the death, dismemberment, sickness, or injury is caused by or is incidental to a cause of loss insured under the policy.

1952, c. 317, §§ 38.1-7, 38.1-12; 1986, c. 562; 2004, c. 182; 2007, c. 762.

§ 38.2-112. Water damage.

"Water damage insurance" means insurance against loss or damage to any property by water or other fluid or substance resulting from (i) the breakage or leakage of sprinklers, pumps or other apparatus erected for extinguishing fires or of water pipes or other conduits or containers, or (ii) casual water entering through leaks or openings in buildings or by seepage through building walls, but not including loss or damage resulting from flood or the rising of the waters of the ocean or its tributaries. This class of insurance includes insurance against accidental injury of such sprinklers, pumps, fire apparatus, conduits or containers.

1952, c. 317, § 38.1-8; 1986, c. 562.

§ 38.2-113. Burglary and theft.

"Burglary and theft insurance" means insurance against:

1. Loss of or damage to any property resulting from actual or attempted burglary, theft, larceny, robbery, forgery, fraud, vandalism, malicious mischief, wrongful confiscation or wrongful conversion, disposal or concealment by any person or persons;

2. Loss of or damage to moneys, coins, bullion, securities, notes, drafts, acceptances or any other valuable papers or documents, resulting from any cause, except while in the custody or possession of and being transported by any carrier for hire or in the mail; or

3. The loss of property actually surrendered due to extortion, threat, or demand, involving the actual, alleged or threatened kidnapping of any individual or the threat to do bodily injury to or damage to property of or to wrongfully abduct or detain any individual.

Any policy of burglary and theft insurance may include appropriate provisions obligating the insurer to pay medical, hospital, surgical, and funeral expenses arising out of the death, dismemberment, sickness, or injury of any person, and death and dismemberment benefits in the event of death or dismemberment, if the death, dismemberment, sickness, or injury is caused by or is incidental to a cause of loss insured under the policy.

1952, c. 317, § 38.1-9; 1986, c. 562; 2007, c. 762.

§ 38.2-114. Glass insurance.

"Glass insurance" means insurance against loss of or damage to glass and its appurtenances resulting from any cause.

1952, c. 317, § 38.1-10; 1986, c. 562.

§ 38.2-115. Boiler and machinery.

"Boiler and machinery insurance" means insurance against any liability of the insured and against loss of or damage to any property of the insured resulting from the explosion of or injury to (i) any boiler, heater or other fired pressure vessel; (ii) any unfired pressure vessel; (iii) any pipes or containers connected with any of the boilers or vessels; (iv) any engine, turbine, compressor, pump or wheel; (v) any apparatus generating, transmitting or using electricity; or (vi) any other machinery or apparatus connected with or operated by any of the previously named boilers, vessels or machines. Boiler and machinery insurance includes the incidental power to inspect and to issue certificates of inspection upon any such boilers, pressure vessels, apparatus, and machinery.

1952, c. 317, § 38.1-11; 1986, c. 562.

§ 38.2-116. Animal.

"Animal insurance" means insurance against loss of or damage to any animal resulting from any cause.

1952, c. 317, § 38.1-13; 1986, c. 562.

§ 38.2-117. Personal injury liability.

"Personal injury liability insurance" means insurance against legal liability of the insured, and against loss, damage or expense incident to a claim of such liability, arising out of the death or injury of any

person, or arising out of injury to the economic interests of any person as the result of negligence in rendering expert, fiduciary or professional service, but not including any class of insurance specified in § 38.2-119.

Any policy of personal injury liability insurance may include appropriate provisions obligating the insurer to pay medical, hospital, surgical, and funeral expenses arising out of the death or injury of any person, regardless of any legal liability of the insured.

Code 1950, § 38-239; 1952, c. 317, § 38.1-15; 1986, c. 562.

§ 38.2-118. Property damage liability.

"Property damage liability insurance" means insurance against legal liability of the insured, and against loss, damage or expense incident to a claim of such liability, arising out of the loss or destruction of, or damage to, the property of any other person, but not including any class of insurance specified in § 38.2-117 or § 38.2-119.

1952, c. 317, § 38.1-16; 1986, c. 562.

§ 38.2-119. Workers' compensation and employers' liability.

"Workers' compensation and employers' liability insurance" means insurance against the legal liability of any employer for the death or disablement of, or injury to, his or its employee whether imposed by common law or by statute, or assumed by contract.

Employers' liability insurance may include appropriate provisions obligating the insurer to pay medical, chiropractic, hospital, surgical, and funeral expenses arising out of the death or injury of an employee, regardless of any legal liability of the insured.

1952, c. 317, § 38.1-17; 1986, c. 562.

§ 38.2-120. Fidelity.

"Fidelity insurance" means:

1. Indemnifying any person against loss through counterfeit, forgery or alteration of, on, or in any security obligation or other written instrument; or

2. Indemnifying banks, bankers, brokers, financial or moneyed corporations or associations against loss resulting from any cause, of personal property, including fixtures, equipment, safes and vaults on the insured's premises.

1952, c. 317, § 38.1-18; 1986, c. 562.

§ 38.2-121. Surety.

"Surety insurance" means:

1. Becoming surety or guarantor for any person, in any public or private position or place of trust, whether the guarantee is in an individual, schedule or blanket form; or

2. Becoming surety on or guaranteeing the performance of any lawful obligation, undertaking, agreement, or contract, including reinsurance contracts connected therewith, except policies of insurance; or

3. Becoming surety on or guaranteeing the performance of bonds and undertakings required or permitted in all judicial proceedings or otherwise allowed by law, including surety bonds accepted by state and municipal authorities in lieu of deposits as security for the performance of insurance contracts.

1952, c. 317, § 38.1-18; 1986, c. 562.

§ 38.2-122. Credit.

"Credit insurance" means indemnifying merchants or other persons extending credit against loss or damage resulting from the nonpayment of debts owed to them. "Credit insurance" includes the incidental power to acquire and dispose of debts so insured and to collect any debts owed to the insurer or to any persons so insured by the insurer. "Credit insurance" does not include any insurance defined in §§ 38.2-103, 38.2-108, 38.2-122.1, 38.2-122.2 or § 38.2-128.

1952, c. 317, § 38.1-19; 1986, c. 562; 2000, c. 526.

§ 38.2-122.1. Credit involuntary unemployment insurance.

"Credit involuntary unemployment insurance" means insurance on a debtor in connection with a specified loan or other credit transaction to provide payment to a creditor for the installment payments or other periodic payments becoming due (i) while the debtor is involuntarily unemployed, or (ii) while the debtor is on an unpaid leave of absence during which employment does not terminate. Such term shall not mean any insurance defined in §§ 38.2-108, 38.2-109 or § 38.2-122.

1993, c. 774; 2000, c. 526.

§ 38.2-122.2. Credit property insurance.

"Credit property insurance" means insurance against direct physical damage to personal household property used as security for a loan or other credit transaction. Such insurance may insure the creditor as sole beneficiary or may insure both the creditor and the debtor with the creditor as primary beneficiary and the debtor as beneficiary of proceeds not paid to the creditor. For purposes of this definition, "personal household property" does not include motor vehicles, mobile homes, or watercraft. The term "credit property insurance" shall not mean any insurance defined in § 38.2-122.

2000, c. 526.

§ 38.2-123. Title.

"Title insurance" means insurance against loss by reason of liens and encumbrances upon property, defects in the title to property, and other matters affecting the title to property or the right to the use and enjoyment of property. "Title insurance" includes insurance of the condition of the title to property and the status of any lien on property.

Code 1950, § 38-233; 1952, c. 317, § 38.1-20; 1986, c. 562.

§ 38.2-124. Motor vehicle.

A. "Motor vehicle insurance" means insurance against:

1. Loss of or damage to motor vehicles, including trailers, semitrailers or other attachments designed for use in connection with motor vehicles, resulting from any cause, and against legal liability of the insured for loss or damage to the property of another resulting from the ownership, maintenance or use of motor vehicles and against loss, damage or expense incident to a claim of such liability; or

2. Legal liability of the insured, and liability arising under subsection A of § 38.2-2206 and against loss, damage, or expense incident to a claim of such liability, arising out of the death or injury of any person resulting from the ownership, maintenance or use of motor vehicles. Motor vehicle insurance does not include any class of insurance specified in § 38.2-119.

B. Any policy of "motor vehicle insurance" covering legal liability of the insured under subdivision 2 of subsection A and covering liability arising under subsection A of § 38.2-2206 may include appropriate provisions obligating the insurer to pay to the covered injured person medical expense and loss of income benefits arising out of the death or injury of any person, as set forth in subsection A of § 38.2-2201. Any such policy of motor vehicle insurance may include appropriate provisions obligating the insurer to pay weekly indemnity or other specific benefits to persons who are injured and specific death benefits to dependents, beneficiaries or personal representatives of persons who are killed, if the injury or death is caused by accident and sustained while in or upon, entering or alighting from, or through being struck by a motor vehicle while not occupying a motor vehicle. These provisions shall obligate the insurer to make payment regardless of any legal liability of the insured or any other person.

1952, c. 317, § 38.1-21; 1956, c. 678; 1962, c. 253; 1983, c. 448; 1984, c. 311; 1986, c. 562; 1991, c. 4; 1996, c. 276.

§ 38.2-125. Aircraft.

"Aircraft insurance" means insurance against:

1. Loss of or damage to aircraft and its equipment, resulting from any cause, and against legal liability of the insured for loss of or damage to the property of another resulting from the ownership, maintenance or use of aircraft and against loss, damage or expense incident to a claim of liability; or

2. Legal liability of the insured, and against loss, damage, or expense incident to a claim of liability, arising out of the death or injury of any person resulting from the ownership, maintenance or use of aircraft.

Any policy of "aircraft insurance" covering legal liability of the insured under subdivision 2 of this section may include appropriate provisions obligating the insurer to pay medical, chiropractic, hospital, surgical, and funeral expenses arising out of the death or injury of any person.

1952, c. 317, § 38.1-21; 1956, c. 678; 1962, c. 253; 1983, c. 448; 1984, c. 311; 1986, c. 562.

§ 38.2-126. Marine.

A. "Marine insurance" means insurance against any kind of loss or damage to:

1. Vessels, craft, aircraft, vehicles of every kind, excluding vehicles operating under their own power or while in storage not incidental to transportation, as well as all goods, freights, cargoes, merchandise, effects, disbursements, profits, moneys, bullion, precious stones, securities, choses in action, evidences of debt, valuable papers, bottomry and respondentia interests and all other kinds of property and interests therein in respect to any risks or perils of navigation, transit or transportation, including war risks, on or under any seas or other waters, on land or in the air, or while being assembled, packed, crated, baled, compressed or similarly prepared for shipment or while awaiting shipment, or during any delays, storage, transshipment, or reshipment incident to shipment, including marine builders' risks and all personal property floater risks;

2. Persons or property in connection with or appertaining to marine, inland marine, transit or transportation insurance, including liability for loss of or damage to either arising out of or in connection with the construction, repair, operation, maintenance, or use of the subject matter of the insurance. This class of insurance shall not include life insurance, surety bonds or insurance against loss by reason of bodily injury to the person arising out of the ownership, maintenance or use of automobiles;

3. Precious stones, jewels, jewelry, gold, silver and other precious metals used in business, trade, or otherwise and whether or not in transit. This class of insurance shall include jewelers' block insurance;

4. (i) Bridges, tunnels, and other instrumentalities of transportation and communication, excluding buildings, their furniture and furnishings, fixed contents and supplies held in storage, unless fire, tornado, sprinkler leakage, hail, explosion, earthquake, riot, and civil commotion are the only hazards to be covered; (ii) to piers, wharves, docks, and slips, excluding the risks of fire, tornado, sprinkler leakage, hail, explosion, earthquake, riot and civil commotion; and (iii) to other aids to navigation and transportation, including dry docks and marine railways, against all risks.

B. Marine insurance shall also include "marine protection and indemnity insurance," meaning insurance against loss, damage, or expense or against legal liability of the insured for loss, damage, or expense arising out of or incident to ownership, operation, chartering, maintenance, use, repair or construction of any vessel, craft or instrumentality in use in ocean or inland waterways, including liability of the insured for personal injury, illness or death or for loss of or damage to the property of another person.

C. Any policy of "marine insurance" as defined in this section providing protection against bodily injury, sickness or death of another person may include appropriate provisions obligating the insurer to pay medical, hospital, surgical, and funeral expenses arising out of the death or injury of any person, regardless of any legal liability of the insured.

D. Marine insurance shall also include "travel insurance" as defined in § 38.2-1887.

1952, c. 317, § 38.1-22; 1986, c. 562; 2019, cc. 266, 346.

§ 38.2-127. Legal services insurance.

"Legal services insurance" means the assumption of a contractual obligation to reimburse the insured against, or pay on behalf of the insured, all or a portion of his fees, costs, and expenses related to services performed by or under the supervision of an attorney licensed to practice in the jurisdiction where the services are performed.

1976, c. 636, § 38.1-22.1; 1978, c. 658; 1986, c. 562.

§ 38.2-128. Mortgage guaranty insurance.

"Mortgage guaranty insurance" means indemnifying lenders against financial loss arising from nonpayment of principal, interest, or other sums due under the terms of any evidence of indebtedness secured by a mortgage, deed of trust, or other instrument constituting a lien or charge on real property.

1986, c. 562.

§ 38.2-129. Home protection insurance.

"Home protection insurance" means any contract or agreement whereby a person undertakes for a specified period of time and for a predetermined fee to furnish, arrange for, or indemnify for service, repair, or replacement of any or all of the structural components, parts, appliances, or systems of any covered residential dwelling caused by wear and tear, deterioration, inherent defect, or by the failure of any inspection to detect the likelihood of failure.

1986, c. 562.

§ 38.2-130. Homeowners insurance.

"Homeowners insurance" is a combination multi-peril policy written under the provisions of § 38.2-1921 containing fire, miscellaneous property, and liability coverages, insuring primarily (i) owner-occupied residential real property pursuant to § 38.2-2108, (ii) personal property located in residential units, or (iii) any combination thereof.

1986, c. 562.

§ 38.2-131. Farmowners insurance.

"Farmowners insurance" is a combination multi-peril policy written under the provisions of § 38.2-1921 containing fire, miscellaneous property, and liability coverages, insuring primarily (i) farm and related residential property and improvements to real property owned, leased, or operated as a farm, (ii) personal property located in residential units, (iii) other real or personal property usual or incidental to the operation of a farm, or (iv) any combination thereof.

1986, c. 562.

§ 38.2-132. Commercial multi-peril insurance.

"Commercial multi-peril insurance" is a combination multi-peril policy written under the provisions of § 38.2-1921 insuring risks incident to a commercial enterprise containing any combination of the classes of insurance set forth in subsection A of § 38.2-1902, except insurance on or with respect to operating properties of railroads.

1986, c. 562.

§ 38.2-133. Contingent and consequential losses.

The definition of any class of insurance against loss of or damage to property enumerated in this article may include insurance against contingent, consequential and indirect losses resulting from any of the causes set out in this article. Coverage for these losses shall be included in the specific grouping of the class of insurance where the cause is specified. Insurance against loss of or damage to property may include insurance against loss or damage to all lawful interests in the property, and against loss of use and occupancy, rents, and profits resulting from the loss or damage.

1952, c. 317, § 38.1-23; 1986, c. 562.

§ 38.2-134. Definitions to include other insurance of same general kind.

The definition of any class of insurance enumerated in this article shall include insurance against other loss, damage or liability of the same general nature or character, or of a similar kind, if the insurance may reasonably and properly be included in the definition and is not specifically included in the definition of some other class of insurance.

1952, c. 317, § 38.1-24; 1986, c. 562.

Article 3 - Classes of Insurance Companies May Write; Reinsurance

§ 38.2-135. Classes of insurance companies may be licensed to write.

Except as otherwise provided in this title and subject to any conditions and restrictions imposed therein, any insurer licensed to transact the business of insurance in the Commonwealth, other than life insurers and title insurers, may be licensed to write one or more of the classes of insurance enumerated in Article 2 (§ 38.2-101 et seq.) of this chapter that it is authorized under its charter to write, except life insurance, industrial life insurance, credit life insurance, variable life insurance, modified guaranteed life insurance, annuities, variable annuities, modified guaranteed annuities, and title insurance. An insurer licensed to write life insurance shall not be licensed to write any additional class of insurance except modified guaranteed life insurance, variable life insurance, annuities, modified guaranteed annuities, variable annuities, credit life insurance, credit accident and sickness insurance, accident and sickness insurance, industrial life insurance, and family leave insurance. An insurer licensed to write title insurance shall not be licensed to write any additional class of insurance. However, any life insurer that has been licensed to write and has been actively engaged in writing life insurance and any additional class of insurance set out in Article 2 (§ 38.2-101 et seq.) of this chapter continuously during a period of 20 years immediately preceding July 1, 1952, may continue to be licensed to write those classes of insurance. No company shall write any class of insurance unless it has a current annual license from the Commission to do so.

Code 1950, §§ 38-159, 38-504; 1952, c. 317, § 38.1-25; 1978, c. 20; 1986, c. 562; 1994, c. 316; 1995, c. 789; 2022, cc. 131, 132.

§ 38.2-136. Reinsurance.

A. Except as otherwise provided in this title, any insurer licensed to transact the business of insurance in this Commonwealth may, by policy, treaty or other agreement, cede to or accept from any insurer reinsurance upon the whole or any part of any risk, with or without contingent liability or participation, and, if a mutual insurer, with or without membership therein.

B. No insurer licensed in this Commonwealth shall cede or assume policy obligations on risks located in this Commonwealth whereby the assuming insurer assumes the policy obligations of the ceding insurer as direct obligations of the assuming insurer to the payees under the policies and in substitution for the obligations of the ceding insurer to the payees, unless: (i) the policyholder has consented to the assumption and (ii) the assuming insurer is licensed in this Commonwealth to write the class or classes of insurance applicable to the policy obligations assumed.

C. Notwithstanding the provisions of subsection B, the transfer of risk under any reinsurance agreement may be effected by entry of an order by the Commission approving the transaction whenever (i) the Commission finds a licensed insurer to be impaired or in hazardous financial condition, (ii) a delinquency proceeding has been instituted against the licensed insurer for the purpose of conserving, rehabilitating, or liquidating the insurer, or (iii) the Commission finds, after giving the insurer notice and an opportunity to be heard, that the transfer of the contracts is in the best interests of the policyholders. In granting any such approval, the Commission shall ensure that policyholders do not lose any rights or claims afforded under their original policies pursuant to Chapter 16 (§ 38.2-1600 et seq.) or 17 (§ 38.2-1700 et seq.) of this title. Prior to granting an approval under clause (iii), the Commission shall consider whether there is a reasonable expectation that the ceding insurer may not be able to meet its obligations to all policyholders; whether the ceding insurer's continued operation in this Commonwealth may become hazardous to policyholders, creditors and the public in this Commonwealth; or whether the ceding insurer may otherwise be unable to comply with the provisions of this title.

Code 1950, §§ 38-160, 38-519; 1952, c. 317, § 38.1-26; 1986, c. 562; 1993, c. 158.

§ 38.2-137. Flood insurance.

"Flood insurance" means insurance against loss or damage to any property caused by flooding or the rising of the waters of the ocean or its tributaries.

1990, c. 916.

Chapter 2 - Provisions of a General Nature

§ 38.2-200. General powers of the Commission relative to insurance.

A. The Commission is charged with the execution of all laws relating to insurance and insurers. All companies, domestic, foreign, and alien, transacting or licensed to transact the business of insurance in this Commonwealth are subject to inspection, supervision and regulation by the Commission.

B. All licenses granting the authority to transact the business of insurance in this Commonwealth shall be granted and issued by the Commission under its seal. The licenses shall be in addition to the certificates of authority required of foreign corporations under §§ 13.1-757 and 13.1-919.

C. During an emergency, public health or otherwise, which the Commission, in its discretion, determines may inhibit the Commission's ability to issue or renew licenses and registrations under this title, or which may hinder licensees' ability to meet licensure requirements, the Commission may temporarily suspend, authorize extensions of time for, or waive requirements for issuance or renewal of a license or registration under this title. The Commission may (i) issue temporary licenses and registrations, (ii) suspend examination requirements, or (iii) take other necessary measures to ensure that licensees and registrants under this title can continue to transact the business of insurance in the Commonwealth during the emergency.

When temporarily suspending, authorizing extensions of time for, or waiving requirements for issuance or renewal of a license or registration pursuant to this subsection, the Commission shall issue an order specifying:

1. The nature and basis of the emergency;

2. Each line of insurance business to which the order applies, if applicable;

3. The requirements for temporary licensure or registration and other relief, if applicable;

4. The requirements for issuance or renewal of licenses or registrations that the Commission is suspending, authorizing extensions of time for, or waiving; and

5. The duration of the order, not to exceed 120 days unless renewed by the Commission.

Code 1950, § 38-2; 1952, c. 317, § 38.1-29; 1986, c. 562; 2021, Sp. Sess. I, c. 297.

§ 38.2-201. Recommendations by Commission to General Assembly.

The Commission shall make any recommendations to the General Assembly necessary for legislation governing and regulating the classes of companies placed under its supervision by this title.

Code 1950, § 38-128; 1952, c. 317, § 38.1-30; 1986, c. 562.

§ 38.2-202. Regulation of solicitation of proxies, consents and authorizations.

The Commission may adopt any rules and regulations regarding the voting equity securities of any domestic stock insurer. These rules and regulations shall cover (i) the solicitation of proxies, (ii) consents, (iii) authorizations, and (iv) any related financial reports. However, these rules and regulations shall not apply to any domestic stock insurer whose equity securities are registered, or required to be registered, pursuant to § 12 of the Securities Exchange Act of 1934, as amended.

1966, c. 262, § 38.1-30.1; 1986, c. 562.

§ 38.2-203. Management and exclusive agency contracts subject to approval by Commission.

A. For the purpose of this section, an insurer shall mean a stock or mutual insurer, cooperative nonprofit life benefit company, mutual assessment life, accident and sickness insurer, burial society, fraternal benefit society, mutual assessment property and casualty insurer, home protection company, health maintenance organization, premium finance company or a person licensed under Chapter 42

(§ 38.2-4200 et seq.), 44 (§ 38.2-4400 et seq.) or 45 (§ 38.2-4500 et seq.) of this title, incorporated or organized under the laws of this Commonwealth.

B. No insurer shall make or enter into any contract that provides for the control and management of the insurer, or the controlling or preemptive right to produce substantially all insurance business for the insurer, unless the contract has been filed with and approved by the Commission and approval has not been withdrawn by the Commission. Any approval, disapproval, or withdrawal of approval shall be delivered to the insurer in writing. The notice of disapproval or withdrawal of approval shall state the grounds of such action and shall be delivered to the insurer at least fifteen days before the effective date.

C. The Commission may disapprove or withdraw approval of any contract referred to in this section that:

1. Subjects the insurer to excessive charges for expenses or commissions;

2. Does not contain fair and adequate standards of performance;

3. Extends for an unreasonable length of time; or

4. Contains other inequitable provisions or provisions that may jeopardize the security of policyholders.

D. The provisions of this section shall not affect contracts made before June 30, 1954, but shall apply to all renewals of those contracts made after that date.

E. Any insurer aggrieved by a disapproval or withdrawal of approval under this section may proceed under the provisions of § 38.2-222.

1954, c. 363, § 38.1-29.1; 1986, c. 562; 1998, c. 42.

§§ 38.2-204, 38.2-205. Repealed.

Repealed by Acts 1991, c. 620.

§ 38.2-205.1. Temporary contracts of insurance permitted.

A lender engaged in making or servicing real estate mortgage or deed of trust loans on one to four family residences shall accept as evidence of insurance a temporary written contract of insurance meeting the requirements of § 38.2-2112 and issued by any duly licensed agent, broker, or insurance company. Nothing herein prohibits the lender from disapproving such insurer provided such disapproval is reasonable. Such lender need not accept a binder unless such binder (i) includes the name and address of the insured, name and address of the mortgagee, a description of the insured collateral, and a provision that it may not be cancelled within the term of the binder except upon ten days' written notice to the mortgagee; (ii) is accompanied by a paid receipt for one year's premium, except in the case of the renewal of a policy subsequent to the closing of a loan; and (iii) includes an undertaking of agent to use his best efforts to have the company issue a policy within forty-five days, unless the binder is cancelled. The Bureau of Insurance may by administrative letter require binders to contain such additional information as may be necessary to permit such binders to comply with the

reasonable requirements of the Federal National Mortgage Association or Federal Home Loan Mortgage Corporation for purchase of mortgage loans.

1987, c. 10.

§ 38.2-206. Corporations as members of mutual insurers.

Any public or private corporation in this Commonwealth or elsewhere may apply and enter into agreements for, hold policies in, and be a member of any mutual insurer.

Code 1950, § 38-506; 1952, c. 317, § 38.1-31.1; 1986, c. 562.

§ 38.2-207. Enforcement of right of subrogation in name of insured.

Except for contracts or plans subject to § 38.2-3405 or § 38.2-2209, when any insurer pays an insured under a contract of insurance which provides that the insurer becomes subrogated to the rights of the insured against any other party the insurer may enforce the legal liability of the other party. This action may be brought in its own name or in the name of the insured or the insured's personal representative.

1952, c. 476, § 38.1-31.2; 1973, c. 28; 1986, c. 562.

§ 38.2-208. Limitation of risks generally.

A. Except as otherwise provided in this title, no insurer transacting business in this Commonwealth shall expose itself to any loss on any one risk or hazard in an amount exceeding ten percent of its surplus to policyholders. Any risk or portion of any risk reinsured by an insurer meeting standards of solvency equal to those set forth in Article 3.1 (§ 38.2-1316.1 et seq.) of Chapter 13 shall be deducted in determining the limitation of risk prescribed in this section.

B. For the purpose of this section, the surplus to policyholders shall be determined from (i) the insurer's last sworn statement filed with the Commission or (ii) the Commission's last report of examination, whichever is more recent at the time the risk is assumed.

C. For the purpose of this section, any one risk or hazard (i) in the case of municipal bond insurance shall mean average annual debt service of insured obligations backed by a single revenue source, provided that the insurance policy does not require any accelerated payment of principal by the insurer upon the event of default and (ii) in the case of all other kinds of financial guaranty insurance shall mean the insured unpaid principal with respect to obligations for any one entity, except that any risk or hazard shall be defined by revenue source, if the insured risk or hazard is payable from a specified revenue source or adequately secured by loan obligations or other assets.

D. As used in subsection C above:

"Municipal bond insurance" means a kind of financial guaranty insurance providing insurance against loss by reason of nonpayment of principal, interest or other payment obligations pursuant to the terms of municipal bonds.

"Municipal bond" means any security, or other instrument under which a payment obligation is created, issued by or on behalf of, or payable or guaranteed by, the United States, Canada, a state, a province of Canada, a municipality or political subdivision of any of the foregoing, or any public

agency or instrumentality thereof, or by any other entity provided that such security is eligible for issuance by one of the foregoing.

"Average annual debt service" means the amount of insured unpaid principal and interest on an obligation multiplied by the number of such insured obligations, assuming that each obligation represents a $1,000 par value, divided by the amount equal to the aggregate life of all such obligations.

"Financial guaranty insurance" means insurance against loss by reason of the failure of any obligor on any debt instrument or other monetary obligation, including common or preferred stock or capital leases, to pay when due principal, interest, premium, dividend, or purchase price of or on such instrument or obligation, or a fee in connection therewith, when such failure is the result of a financial default or insolvency, regardless of whether such obligation is incurred directly or as a guarantor by or on behalf of another obligor that has also defaulted.

For the purposes of subsection C of this section, the amount of insured unpaid principal shall be reduced by the amount of deposit of (i) cash, or (ii) the market value of obligations rated in the four highest major rating categories by a securities rating agency recognized by the Commission, or (iii) the stated amount of an unconditional, irrevocable letter of credit issued or confirmed by a bank or trust company that (a) is a member of the federal reserve system or chartered by any state or (b) is organized and existing under the laws of a foreign country, has been licensed as a branch or agency by any state or the federal government and is rated in the two highest major rating categories by a securities ratings agency recognized by the Commission or (c) is otherwise acceptable to the Commission or (iv) a conveyance or mortgage of real property, or (v) the scheduled cash flow from obligations rated in the four highest major rating categories by a securities rating agency recognized by the Commission if scheduled to be received on or prior to the date of scheduled debt service on the insured obligations. Such deposit shall be held by the insurer or held in trust for the benefit of the insurer or held in trust for the benefit of holders of the insured obligation whether in the form of debt service, sinking funds or other reserves pursuant to the bond indenture by a trustee acceptable to the Commission.

For the purpose of subsection C of this section, an insurer's surplus to policyholders shall include the amount of any contingency or similar reserve established and maintained by the insurer pursuant to applicable law for the protection of insureds covered by financial guaranty insurance policies against the effect of excessive losses usually occurring during adverse economic cycles.

E. The limitation of risk prescribed in this section for any alien insurer shall apply only to the exposure to risk and the trusteed surplus of the alien insurer's policyholders.

F. This section shall not apply to (i) life insurance, (ii) annuities, (iii) accident and sickness insurance, (iv) insurance of marine risks or marine protection and indemnity risks, (v) workers' compensation or employers' liability risks, or (vi) risks covered by title insurance.

Code 1950, §§ 38-167, 38-168; 1952, c. 317, § 38.1-32; 1986, c. 562; 1987, c. 353; 1988, c. 554.

§ 38.2-209. Award of insured's attorney fees in certain cases.

A. Notwithstanding any provision of law to the contrary, in any civil case in which an insured individual sues his insurer to determine what coverage, if any, exists under his present policy or fidelity bond or the extent to which his insurer is liable for compensating a covered loss, the individual insured shall be entitled to recover from the insurer costs and such reasonable attorney fees as the court may award. However, these costs and attorney's fees shall not be awarded unless the court determines that the insurer, not acting in good faith, has either denied coverage or failed or refused to make payment to the insured under the policy. "Individual," as used in this section, shall mean and include any person, group, business, company, organization, receiver, trustee, security, corporation, partnership, association, or governmental body, and this definition is declaratory of existing policy.

B. Nothing in this section shall be deemed to grant a right to bring an action against an insurer by an insured who would otherwise lack standing to bring an action.

C. As used in this section, "insurer" shall include "self-insurer."

1982, c. 576, § 38.1-32.1; 1986, c. 562; 2006, c. 279.

§ 38.2-210. Loans to officers, directors, etc., prohibited.

A. Except as provided in § 38.2-212, no insurer, legal services plan, health services plan, dental or optometric services plan, health maintenance organization, or home protection company, transacting business in this Commonwealth shall make a loan, either directly or indirectly, to any of its officers or directors. No such company shall make a loan to any other corporation or business unit in which any of its officers or directors has a substantial interest. No such officer or director shall accept or receive any such loan directly or indirectly.

B. For the purposes of this section and of § 38.2-211, "a substantial interest" in any corporation or business unit means an interest equivalent to ownership or control of at least ten percent of its stock or its equivalent by an officer or director, or the aggregate ownership or control by all officers and directors of the same company.

Code 1950, § 38-4.1; 1952, c. 317, § 38.1-33; 1978, c. 701; 1986, c. 562.

§ 38.2-211. Other interests and payments to officers, directors, etc., prohibited.

Except as provided in § 38.2-212, no officer or director of any company listed in § 38.2-210 and transacting business in this Commonwealth shall receive, directly, indirectly or through any substantial interest in any other corporation, any compensation for negotiating, procuring, recommending, or aiding in the purchase or sale of property by such company, or in obtaining any loan from the company. No such officer or director shall be pecuniarily interested, either as principal, agent, or beneficiary, in any such purchase, sale or loan. No financial obligation of any such officer or director shall be guaranteed by the company.

Code 1950, § 38-4.2; 1952, c. 317, § 38.1-34; 1978, c. 701; 1986, c. 562.

§ 38.2-212. Certain compensation not prohibited.

A. Nothing contained in §§ 38.2-210 and 38.2-211 shall prohibit any officer or director of any company listed in § 38.2-210 from receiving usual compensation for services rendered in the ordinary course of his duties as an officer or director, if the compensation is authorized by vote of the board of directors or other governing body of the company. Nor shall the provisions of §§ 38.2-210 and 38.2-211 prohibit the payment to an officer or director of any such company who is a licensed attorney-at-law of a fee in connection with loans made by the company if and when those fees are paid by the borrower and do not constitute a charge against the company.

B. Nothing contained in this chapter shall prohibit a life insurer from making a loan upon a policy of insurance issued by it and held by the borrower. This loan shall not exceed the net cash value of the policy. Nothing contained in this chapter shall prohibit any company from (i) making a loan on real property owned by the officer and improved with a dwelling that is to serve as his residence if the loan qualifies under subdivision 1 of § 38.2-1434 and under § 38.2-1437 or (ii) acquiring the residence of the officer in conformance with subsection D of § 38.2-1441 if the transaction is in connection with the relocation of the place of employment of an officer who is neither a director nor a trustee of the company.

C. Nothing contained in § 38.2-211 shall prohibit a director of any such company from receiving compensation that is usual and customary in the director's business with respect to transactions in the ordinary course of business of the company and of the director. Prior to payment of the compensation, written request for the Commission's approval shall be made. This written request shall set forth under oath complete details concerning the transactions that the company intends to conduct with a director. Any approval given by the Commission shall be in writing. No approval granted under this subsection shall imply that the Commission approves any investment of any company.

Code 1950, § 38-4.3; 1952, c. 317, § 38.1-35; 1977, c. 261; 1978, c. 701; 1981, c. 272; 1983, c. 457; 1986, c. 562; 1992, c. 588.

§ 38.2-213. Violation of § 38.2-210 or § 38.2-211.

Any company, officer or director violating any provision of § 38.2-210 or § 38.2-211 shall be guilty upon conviction of a Class 1 misdemeanor. Any funds of any company invested or used in violation of either of § 38.2-210 or § 38.2-211 may not be reported as an admitted asset in accordance with guidance set forth in the National Association of Insurance Commissioners accounting practices and procedures manuals.

Code 1950, § 38-4.4; 1952, c. 317, § 38.1-36; 1986, c. 562; 2000, c. 46.

§ 38.2-214. Restrictions upon purchase and sale of equity securities of domestic stock insurers.

A. Each person who is directly or indirectly the beneficial owner of more than ten percent of a class of any equity security of a domestic insurer, or who is a director or an officer of a domestic stock insurer, shall file a statement with the Commission within ten days after becoming a beneficial owner, director or officer. This statement shall be in a form prescribed by the Commission and shall show the amount of all the domestic insurer's equity securities of which he is the beneficial owner. Within ten days after

the close of each calendar month, if there has been a change in his ownership during such month, the person shall file with the Commission a statement prescribed by the Commission indicating his ownership at the close of the calendar month and such changes in his ownership as have occurred during such calendar month.

B. To prevent the unfair use of information obtained by any beneficial owner, director or officer, any profit realized by such person within six months from the purchase and sale, or any sale and purchase, of any of the insurer's equity securities shall inure to and be recoverable by the insurer. This provision shall apply regardless of any intention of the beneficial owner, director or officer to hold the equity security purchased or not to repurchase any sold equity security for a period exceeding six months. However, this provision shall not apply if the security was acquired in good faith in connection with a debt previously contracted. The insurer may sue at law or in equity to recover the profit in any court of competent jurisdiction. The owner of any equity security of the insurer may sue in the name and in behalf of the insurer if the insurer fails or refuses to bring suit within sixty days after request or if the insurer fails to diligently prosecute after bringing suit. No suit under this subsection shall be brought more than two years after the date the profit was realized. This subsection shall not be construed to cover any transaction where the person was not the beneficial owner at the time of either the purchase or sale of the equity security involved. The Commission may by rules and regulations exempt from the provisions of this subsection any transaction that is not comprehended within the purpose of this subsection.

C. No beneficial owner, director or officer shall directly or indirectly sell any equity security of the insurer if the person selling the security or his principal (i) does not own the security sold, or (ii) owns the equity security but does not deliver it within twenty days after the sale or does not mail it within five days after the sale. No person shall be deemed to have violated this subsection if he proves that, notwithstanding the exercise of good faith, he was unable to deliver or mail the security within the required time, or that to do so would cause undue inconvenience or expense. Any person violating this subsection shall be guilty upon conviction of a Class 1 misdemeanor.

D. Subsections B and C of this section shall not apply to the transactions of a dealer in an investment account that are conducted in the ordinary course of a dealer's business and incident to the establishment or maintenance of an equity security's primary or secondary market, other than on an exchange defined in the Securities Exchange Act of 1934. The Commission may, by rules and regulations, define and prescribe terms and conditions with respect to equity securities held in an investment account and transactions made in the ordinary course of business and incident to the establishment or maintenance of a primary or secondary market.

E. Subsections A, B, and C of this section shall not apply to foreign or domestic arbitrage transactions unless made in contravention of rules and regulations adopted by the Commission to carry out the purposes of this section.

F. The term "equity security" when used in this section means (i) any stock or similar security, (ii) any security that is convertible, with or without consideration, into another security, (iii) any security that carries any warrant or right to subscribe to or purchase a security, or (iv) any warrant, right or other security that the Commission, by rules and regulations, deems to be similar in nature to an equity security and considers the classification necessary or appropriate for protecting the public or an investor's interest.

G. Subsections A, B, and C of this section shall not apply to equity securities of a domestic stock insurer if (i) those equity securities are registered or are required to be registered pursuant to § 12 of the Securities Exchange Act of 1934, as amended; or (ii) the domestic stock insurer does not have any class of its equity securities held of record by 100 or more persons on the last business day of the year immediately preceding the year in which equity securities of the insurer would be subject to subsections A, B, and C of this section.

H. The Commission may adopt rules and regulations pursuant to § 38.2-223 for the execution of the functions vested in it by subsections A through G of this section. The Commission may classify for that purpose any domestic stock insurers, equity securities, and other persons or matters within its jurisdiction. The Commission may exempt from the provisions of this section any officer, director or beneficial owner of equity securities of any domestic stock insurer under the terms and conditions, and for the period of time the Commission considers necessary or appropriate if the Commission finds that the action is consistent with the public interest or the protection of investors. Any such exemption may be accomplished by (i) rules and regulations issued pursuant to § 38.2-223 or (ii) by order, upon application of any interested person, after due notice and an opportunity for hearing has been given. No provision of subsections A, B, and C of this section imposing any liability shall apply to any act done or omitted in good faith in conformity with any rule or regulation of the Commission. Notwithstanding the provisions of this subsection, such rule or regulation may be amended, rescinded or determined by judicial or other authority to be invalid for any reason after the act or omission has occurred.

1966, c. 265, § 38.1-36.1; 1986, c. 562.

§ 38.2-215. Liability of president, chief executive officer or directors if insurance issued when insurer insolvent.

If any insurer is insolvent, and the president, chief executive officer or directors with knowledge of insolvency make or agree to further insurance, they shall be personally liable for any loss under that insurance.

Code 1950, § 38-176; 1952, c. 317, § 38.1-37; 1986, c. 562.

§ 38.2-216. Restrictions on removal or transfer of property and on reinsurance; penalty.

A. No domestic insurer shall remove from this Commonwealth either all or substantially all of its property or business without the written approval of the Commission.

B. No domestic insurer shall transfer or attempt to transfer substantially its entire property, or enter into any transaction the effect of which is to merge substantially its entire property or business into the property or business of any other company, without prior written approval of the Commission.

C. No domestic insurer shall reinsure with any other insurer all or substantially all of its risks without prior written approval of the Commission of the reinsurance and of the contract under which reinsurance is effected.

D. No domestic insurer shall enter into or modify a reinsurance treaty or risk-sharing arrangement without prior written approval of the Commission if for any twelve-month period the reinsurance premium or anticipated change in the ceding insurer's liabilities equals or exceeds fifty percent of the insurer's surplus to policyholders as of the immediately preceding December 31.

E. Any director or officer of the insurer consenting to and participating in any violation of this section shall be guilty of a Class 1 misdemeanor.

Code 1950, § 38-6; 1952, c. 317, § 38.1-38; 1986, c. 562; 2000, c. 51.

§ 38.2-217. When assets may not be distributed among stockholders.

No domestic insurer shall distribute its assets among its stockholders until all risks have expired or have been cancelled, or have been replaced by the policies of another solvent insurer licensed to transact the business of insurance in this Commonwealth, and until all claims against the insurer have been settled. No insurer shall contract to reinsure its risks for the purpose of distributing its assets without first obtaining the written approval of the Commission. However, nothing in this section shall be construed to prohibit the lawful payment of dividends.

Code 1950, §§ 38-170, 38-171; 1952, c. 317, § 38.1-39; 1986, c. 562.

§ 38.2-218. Penalties and restitution payments.

A. Any person who knowingly or willfully violates any provision of this title or any regulation issued pursuant to this title shall be punished for each violation by a penalty of not more than $5,000.

B. Any person who violates without knowledge or intent any provision of this title or any rule, regulation, or order issued pursuant to this title may be punished for each violation by a penalty of not more than $1,000. For the purpose of this subsection, a series of similar violations resulting from the same act shall be limited to a penalty in the aggregate of not more than $10,000.

C. Any violation resulting solely from a malfunction of mechanical or electronic equipment shall not be subject to a penalty.

D. 1. The Commission may require a person to make restitution in the amount of the direct actual financial loss:

a. For charging a rate in excess of that provided by statute or by the rates filed with the Commission by the insurer;

b. For charging a premium that is determined by the Commission to be unfairly discriminatory, such restitution being limited to a period of one year from the date of determination;

c. For failing to pay amounts explicitly required by the terms of the insurance contract where no aspect of the claim is disputed by the insurer; and

d. For improperly withholding, misappropriating, or converting any money or property received in the course of doing business.

2. The Commission shall have no jurisdiction to adjudicate controversies growing out of this subsection regarding restitution among insurers, insureds, agents, claimants and beneficiaries.

E. The provisions provided under this section may be imposed in addition to or without imposing any other penalties or actions provided by law.

Code 1950, § 38-24; 1952, c. 317, § 38.1-40; 1986, c. 562; 2010, c. 226.

§ 38.2-219. Violations; procedure; cease and desist orders.

A. Whenever the Commission has reason to believe that any person has committed a violation of this title or of any rule, regulation, or order issued by the Commission under this title, it shall issue and serve an order upon that person by certified or registered mail or in any other manner permitted by law. The order shall include a statement of the charges and a notice of a hearing on the charges to be held at a fixed time and place which shall be at least ten days after the date of service of the notice. The order shall require that person to show cause why an order should not be made by the Commission directing the alleged offender to cease and desist from the violation or to show cause why the Commission should not issue any other appropriate order as the nature of the case and the interests of the policyholders, creditors, shareholders, or the public may require. At the hearing, that person shall have an opportunity to be heard in accordance with the Commission's order. In all matters in connection with the charges or hearing, the Commission shall have the jurisdiction, power and authority granted or conferred upon it by Title 12.1 and, except as otherwise provided in this title, the procedure shall conform to and the right of appeal shall be the same as that provided in Title 12.1.

B. If the Commission finds in the hearing that there is about to be or has been a violation of this title, it may issue and serve upon any person committing the violation by certified or registered mail or in any other manner permitted by law (i) an order reciting its findings and directing the person to cease and desist from the violation or (ii) such other appropriate order as the nature of the case and the interests of the policyholders, creditors, shareholders, or the public requires.

C. Any person who violates any order issued under subsection B of this section may upon conviction be subject to one or both of the following:

1. Punishment as provided in § 38.2-218; or

2. The suspension or revocation of any license issued by the Commission.

1952, c. 317, §§ 38.1-54, 38.1-55, 38.1-60 through 38.1-62; 1971, Ex. Sess., c. 1; 1973, c. 505, § 38.1-178.7; 1977, c. 414, § 38.1-178.17; 1977, c. 529; 1980, c. 404; 1982, c. 223, § 38.1-482.14:1; 1986, c. 562.

§ 38.2-220. Injunctions.

The Commission shall have the jurisdiction and powers of a court of equity to issue temporary and permanent injunctions restraining acts which violate or attempt to violate provisions of this title and to enforce the injunctions by civil penalty or imprisonment.

Code 1950, § 32-195.17; 1956, c. 268, § 38.1-830; 1978, c. 658, § 38.1-806; 1979, c. 721; 1980, c. 682, § 38.1-911; c. 720, § 38.1-884; 1981, c. 530, § 38.1-946; 1986, c. 562.

§ 38.2-221. Enforcement of penalties.

The Commission may impose, enter judgment for, and enforce any civil penalty or other penalty pronounced against any person for violating any of the provisions of this title, subject to the hearing provisions of § 12.1-28. The power and authority conferred upon the Commission by this section shall be in addition to and not in substitution for the power and authority conferred upon the courts by general law to impose civil penalties for violations of the laws of this Commonwealth.

Code 1950, § 38-26; 1952, c. 317, § 38.1-41; 1986, c. 562.

§ 38.2-221.1. Confidentiality of information.

Whenever, during the course of a market conduct examination pursuant to Article 4 (§ 38.2-1317 et seq.) of Chapter 13 or inspection request or inquiry pursuant to § 38.2-200, the Commission requests an insurer to furnish information which the insurer considers confidential proprietary information, such confidential proprietary information shall be submitted to the Commission but shall be excluded from, and the Commission shall not be subject to, subpoena or public inspection with respect to such information if the insurer (i) invokes such exclusion, in writing, upon submission of the data or other materials for which protection from disclosure is sought; (ii) identifies the data or other materials for which protection is sought; and (iii) states the reason why protection is necessary. Nothing contained herein shall prohibit the Commission from (i) using such confidential proprietary information in furtherance of any regulatory or legal action; (ii) publishing any decisions, orders, findings, opinions, or judgments; or (iii) publishing any final market conduct report or any other report containing aggregated findings, provided that such report, decisions, orders, findings, opinions, or judgments shall not disclose such confidential proprietary information unless the Commission has found, after the insurer has been provided notice and opportunity to be heard, that such information is not confidential proprietary information. No waiver of an existing privilege or claim of confidentiality shall occur as a result of disclosure to the Commission under this section.

2000, c. 527.

§ 38.2-221.2. Treatment of confidential information pursuant to federal law.

A. Any information denominated in writing as confidential by a federal regulator and received by the Commission pursuant to the Gramm-Leach-Bliley Act of 1999 (Public Law §§ 106-102) (hereafter, the

federal act) shall be excluded from, and the Commission shall not be subject to, subpoena or public inspection with respect to such information.

B. Pursuant to the federal act, and notwithstanding any other provision of law, the Commission may provide to a federal regulator any examination or other report, record or information to which the Commission has access with respect to any person who is engaged in the business of insurance in this Commonwealth and is an affiliate or agent of a depository institution or financial holding company, as those terms are defined in the federal act, provided that the federal regulator has the legal authority, and shall agree in writing, as a condition precedent to its receipt of such information, to maintain such information in confidence as provided in the federal act and to take all reasonable steps to oppose any effort to secure disclosure of such information.

C. The provision by the Commission pursuant to this section, or the provision by a federal regulator pursuant to the federal act, of such information shall not constitute, operate as a waiver of, or otherwise affect any existing privilege or any claim of confidentiality to which the information is otherwise subject.

D. Nothing contained herein shall prohibit the Commission from (i) using such confidential information in furtherance of any regulatory or legal action; (ii) publishing any decisions, orders, findings, opinions or judgments; or (iii) publishing any final report or any other report containing aggregated findings, provided that such reports, decisions, orders, findings, opinions or judgments shall not disclose any such confidential information.

E. For purposes of this section, "federal regulator" means the Board of Governors of the Federal Reserve System, the Office of the Comptroller of the Currency, the Office of Thrift Supervision, or the Federal Deposit Insurance Corporation.

2001, c. 519.

§ 38.2-221.3. Confidentiality of applications and investigations.

A. For purposes of this section, "business entity" means a partnership, limited partnership, limited liability company, corporation, or other legal entity that is entitled to hold property in its own name and that is not a sole proprietorship.

B. This section applies to the Commission's authority to license, register, or authorize business entities pursuant to this title. This section shall not apply to any license issued under Chapter 18 (§ 38.2-1800 et seq.).

C. All applications, documents, materials, or other information produced by, obtained by, or disclosed to the Commission or any other person in the course of an investigation, or a review of an application, shall be given confidential treatment, is not subject to subpoena, and may not be made public by the Commission or any other person. The Commission may grant access to (i) a regulatory official of any state or country; (ii) the National Association of Insurance Commissioners, its affiliate, or its subsidiary; or (iii) a law-enforcement authority of any state or country, provided that those officials are required

under their law to maintain its confidentiality. Any such disclosure by the Commission shall not constitute a waiver of confidentiality of such applications, documents, materials, or other information, or copies thereof. Any parties receiving such information shall agree in writing prior to receiving the information to provide to it the same confidential treatment as required by this section, unless the prior written consent of the business entity to which it pertains has been obtained.

D. Nothing in this section shall prohibit the Commission from (i) using such confidential information in furtherance of any regulatory or legal action; (ii) publishing any decisions, orders, findings, opinions, or judgments; or (iii) publishing any final report or any other report containing aggregated findings, provided that such reports, decisions, orders, findings, opinions, or judgments shall not disclose any such confidential information.

2009, c. 352; 2016, c. 250.

§ 38.2-222. Appeals generally.

Except as otherwise specifically provided in this title, § 12.1-39 shall apply to the appeal of any final (i) finding, (ii) decision settling the substantive law, (iii) order, or (iv) judgment of the Commission issued pursuant to this title.

1986, c. 562.

§ 38.2-223. Rules and regulations; orders.

The Commission, after notice and opportunity for all interested parties to be heard, may issue any rules and regulations necessary or appropriate for the administration and enforcement of this title.

1986, c. 562.

§ 38.2-224. Procedures.

Except as otherwise specifically provided in this title, Chapter 5 (§ 12.1-25 et seq.) of Title 12.1 shall apply to proceedings under this title.

1986, c. 562.

§ 38.2-225. Disposition of fines and penalties.

A. All fines recovered for criminal violations of this title or for criminal violations of rules, regulations, or orders issued pursuant to this title shall be paid into the state treasury to the credit of the Literary Fund.

B. All penalties and compromise settlements recovered for civil violations of this title or civil violations of rules, regulations, or orders issued pursuant to this title shall be paid into the state treasury. Pursuant to §§ 38.2-1620 and 38.2-1718 these funds shall be credited to the Literary Fund or if the Commission determines a need, to either (i) the Virginia Property and Casualty Insurance Guaranty Association established pursuant to Chapter 16 of this title or (ii) the Virginia Life, Accident and Sickness Insurance Guaranty Association established pursuant to Chapter 17 of this title.

Code 1950, § 38-25; 1952, c. 317, § 38.1-42; 1986, c. 562.

§ 38.2-226. Provisions of title not to apply to certain mutual aid associations.

This title shall not apply to beneficial, relief, or mutual aid societies, or partnerships, plans, associations, or corporations, established prior to 1935 and formed by churches for the purpose of aiding members who sustain property losses by fire, lightning, hail, storm, flood, explosion, power failure, theft, burglary, vandalism, civil commotion, airplane and vehicular damage, and in which the privileges and memberships in these societies, partnerships, plans, associations, or corporations are confined to members of the churches.

1981, c. 171, § 38.1-42.1; 1985, c. 361; 1986, c. 562.

§ 38.2-226.1. Expired.

Expired.

§ 38.2-226.2. Provisions of title not applicable to certain long-term care health plans.

A. This title shall not apply to pre-PACE long-term care health plans (i) authorized by the United States Health Care Financing Administration pursuant to § 1903 (m) (2) (B) of Title XIX of the United States Social Security Act (42 U.S.C. § 1396b et seq.) and the state plan for medical assistance services as established pursuant to Chapter 10 (§ 32.1-323 et seq.) of Title 32.1 and (ii) which have signed agreements with the Department of Medical Assistance Services as long-term care health plans.

B. This title shall not apply to PACE long-term care health plans (i) authorized as programs of all-inclusive care for the elderly by Subtitle I (§ 4801 et seq.) of Chapter 6 of Title IV of the Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 528 et seq., §§ 4801-4804, 1997, pursuant to Title XVIII and Title XIX of the United States Social Security Act (42 U.S.C. § 1395eee et seq.) and the state plan for medical assistance services as established pursuant to Chapter 10 (§ 32.1-323 et seq.) of Title 32.1 and (ii) which have signed agreements with the Department of Medical Assistance Services as long-term care health plans.

C. Enrollment in a pre-PACE or PACE plan shall be restricted to those individuals who participate in programs authorized pursuant to Title XIX or Title XVIII of the United States Social Security Act, respectively.

1998, c. 318.

§ 38.2-226.3. Expired.

Expired.

§ 38.2-227. Public policy regarding punitive damages.

It is not against the public policy of the Commonwealth for any person to purchase insurance providing coverage for punitive damages arising out of the death or injury of any person as the result of negligence, including willful and wanton negligence, but excluding intentional acts. This section declares existing policy.

1983, c. 353, § 38.1-42.2; 1986, c. 562.

§ 38.2-228. Proof of future financial responsibility.

At the request of a named insured, a licensed property and casualty insurer shall provide without unreasonable delay to the Commissioner of the Department of Motor Vehicles proof of future financial responsibility as required by the provisions of Title 46.2.

1986, c. 562.

§ 38.2-229. Immunity from liability.

A. There shall be no liability on the part of and no cause of action against any person for furnishing in good faith to the Commission information relating to the investigation of any insurance or reinsurance transaction when such information is furnished under the requirements of law or at the request or direction of the Commission.

B. There shall be no liability on the part of and no cause of action against the Commission, the Commissioner of Insurance, or any of the Commission's employees or agents, acting in good faith, for investigating any insurance or reinsurance transaction or for the dissemination of any official report related to an official investigation of any insurance or reinsurance transaction.

1986, c. 562.

§ 38.2-230. Distributions by nonstock corporation.

No dividend or distribution of income, as used in § 13.1-814, shall be made to a member corporation of a corporation licensed under the provisions of this title unless the corporation has received approval by the Commission prior to the distribution. In approving the distribution, the Commission shall give consideration to the subscribers' or policyholders' best interest.

1985, c. 380, § 38.1-39.1; 1986, c. 562.

§ 38.2-231. Notice of cancellation, refusal to renew, reduction in coverage or increase in premium of certain liability insurance policies.

A. 1. No cancellation or refusal to renew by an insurer of (i) a policy of insurance as defined in § 38.2-117 or 38.2-118 insuring a business entity; (ii) a policy of insurance that includes as a part thereof insurance as defined in § 38.2-117 or 38.2-118 insuring a business entity; (iii) a policy of motor vehicle insurance against legal liability of the insured as defined in § 38.2-124 insuring a business entity; or (iv) a policy of miscellaneous casualty insurance as defined in subsection B of § 38.2-111 insuring a business entity shall be effective unless the insurer delivers or mails to the first named insured at the address shown on the policy a written notice of cancellation or refusal to renew, or delivers such notice electronically to the address provided by the first named insured. Such notice shall:

a. Be in a type size authorized under § 38.2-311;

b. State the date, which shall not be less than 45 days after the delivery or mailing of the notice of cancellation or refusal to renew, on which such cancellation or refusal to renew shall become effective, except that such effective date may not be less than 15 days from the date of mailing or delivery when the policy is being cancelled or not renewed for failure of the insured to discharge when due any of its obligations in connection with the payment of premium for the policy;

c. State the specific reason or reasons of the insurer for cancellation or refusal to renew;

d. Advise the first named insured of its right to request in writing, within 15 days of the receipt of the notice, that the Commissioner of Insurance review the action of the insurer; and

e. In the case of a policy of motor vehicle insurance, inform the first named insured of the possible availability of other insurance which may be obtained through its agent, through another insurer, or through the Virginia Automobile Insurance Plan.

2. Nothing in this subsection shall apply to any policy of insurance if the named insured or his duly constituted attorney-in-fact has notified orally, or in writing, if the insurer requires such notification to be in writing, the insurer or its agent that he wishes the policy to be canceled or that he does not wish the policy to be renewed, or if, prior to the date of expiration, he fails to accept the offer of the insurer to renew the policy.

3. Nothing in this subsection shall apply if an affiliated insurer has manifested its willingness to provide coverage at a lower premium than would have been charged for the same exposures on the expiring policy. The affiliated insurer shall manifest its willingness to provide coverage by issuing a policy with the types and limits of coverage at least equal to those contained in the expiring policy unless the named insured has requested a change in coverage or limits. When such offer is made by an affiliated insurer, an offer of renewal shall not be required of the insurer of the expiring policy, and the policy issued by the affiliated insurer shall be deemed to be a renewal policy.

B. No insurer shall cancel or refuse to renew a policy of motor vehicle insurance against legal liability of the insured as defined in § 38.2-124 insuring a business entity solely because of lack of supporting business or lack of the potential for acquiring such business.

C. No reduction in coverage for personal injury or property damage liability initiated by an insurer and no insurer-initiated increase in the premium greater than 25 percent of (i) a policy of insurance defined in § 38.2-117 or 38.2-118 insuring a business entity; (ii) a policy of insurance that includes as a part thereof insurance defined in § 38.2-117 or 38.2-118 insuring a business entity; (iii) a policy of motor vehicle insurance against legal liability of the insured as defined in § 38.2-124 insuring a business entity; or (iv) a policy of miscellaneous casualty insurance as defined in subsection B of § 38.2-111 insuring a business entity, and which in the case of a reduction in coverage is subject to § 38.2-1912, shall be effective unless the insurer delivers or mails to the first named insured at the address shown on the policy, or delivers electronically to the address provided by the first named insured, a written notice of such reduction in coverage or premium increase not later than 45 days prior to the effective date of same. The increase in premium shall be the difference between the renewal premium and the premium charged by the insurer at the effective date of the expiring policy. Such notice shall:

1. Be in a type size authorized under § 38.2-311;

2. State the date, which shall not be less than 45 days after the delivery or mailing of the notice of reduction in coverage or increase in premium, on which such reduction in coverage or increase in premium shall become effective;

3. Advise the first named insured of the specific reason for the increase and the amount of the increase, or, if in the case of a reduction in coverage, the specific reason for the reduction and the manner in which coverage will be reduced, or that such information may be obtained from the agent or the insurer;

4. Advise the first named insured of its right to request in writing, within 15 days of receipt of the notice, that the Commissioner of Insurance review the action of the insurer.

D. If an insurer does not provide notice in the manner required in subsection C, coverage shall remain in effect until 45 days after written notice of reduction in coverage or increase in premium is mailed or delivered to the first named insured at the address shown on the policy, or delivered electronically to the address provided by the first named insured, unless the named insured obtains replacement coverage or elects to cancel sooner in either of which cases coverage under the prior policy shall cease on the effective date of the replacement coverage or the elected date of cancellation as the case may be. If the named insured fails to accept or rejects the changed policy, coverage for any period that extends beyond the expiration date will be under the prior policy's rates, terms and conditions as applied against the renewal policy's limits, rating exposures, and additional coverages. If the named insured accepts the changed policy, the reduction in coverage or increase in premium shall take effect upon the expiration of the prior policy.

E. Notice of reduction in coverage or increase in premium shall not be required if:

1. The insurer, after written demand, has not received, within 45 days after such demand has been mailed or delivered to the first named insured at the address shown on the policy, or delivered electronically to the address provided by the first named insured, sufficient information from the named insured to provide the required notice;

2. Such notice is waived in writing by the named insured;

3. The insurer delivers or mails to the first named insured a renewal policy or a renewal offer not less than 45 days prior to the effective date of the policy or, in the case of a medical malpractice insurance policy, not less than 90 days prior to the effective date of the policy;

4. The policy is issued to a large commercial risk as defined in subsection C of § 38.2-1903.1 but excluding policies of medical malpractice insurance; or

5. The policy is retrospectively rated, where the premium is adjusted at the end of the policy period to reflect the risk's actual loss experience.

F. No written notice of cancellation, refusal to renew, reduction in coverage, or increase in premium that is mailed or delivered electronically by an insurer to a first named insured in accordance with this

section shall be effective unless the insurer complies with the applicable provisions of subdivisions 1 through 4:

1. If the notice is mailed, proof of mailing a notice of cancellation, refusal to renew, reduction in coverage, or increase in premium shall be obtained using one of the following methods that demonstrates the date that the notice was sent to the first named insured at the address stated in the policy or to such insured's last known address:

a. The notice is sent by:

(1) Registered mail;

(2) Certified mail; or

(3) Any other similar first-class mail tracking method used or approved by the United States Postal Service, including Intelligent Mail barcode Tracing (IMb Tracing); or

b. The notice is sent by another method of mailing for which a certificate of mailing is obtained from the United States Postal Service at the time the notice is accepted for mailing. A certificate of mailing from the United States Postal Service does not include a certificate of bulk mailing.

2. If the notice is delivered electronically, the insurer retains evidence of electronic transmittal or receipt of the notification for at least one year from the date of the transmittal.

3. If the notice is mailed, the insurer retains a copy of the notice of cancellation, refusal to renew, reduction in coverage, or increase in premium for at least one year from the date such action was effective. If the notice is mailed, proof of mailing from the United States Postal Service consistent with the mailing method utilized by the insurer shall be maintained for one year from the date the cancellation, refusal to renew, reduction in coverage, or increase in premium is effective.

4. a. If the terms of a policy of motor vehicle insurance insuring a business entity require the notice of cancellation, refusal to renew, reduction in coverage, or increase in premium to be given to any lienholder, then the insurer shall mail such notice and retain a copy of the notice in the manner required by this subsection. If the notices sent to the first named insured and the lienholder are part of the same form, the insurer may retain a single copy of the notice. Proof of mailing from the United States Postal Service consistent with the mailing method utilized by the insurer shall be maintained for one year from the date the cancellation, refusal to renew, reduction in coverage, or increase in premium is effective.

b. Notwithstanding the provisions of subdivision 4 a, if the terms of the policy require the notice of cancellation, refusal to renew, reduction in coverage, or increase in premium to be given to any lienholder, the insurer and lienholder may agree by separate agreement that such notices may be transmitted electronically, provided that the insurer and lienholder agree upon the specifics for transmittal and acknowledgment of notification. Evidence of transmittal or receipt of the notification required by this subsection shall be retained by the insurer for at least one year from the date of termination.

"Copy," as used in this subsection, includes photographs, microphotographs, photostats, microfilm, microcard, printouts, or other reproductions of electronically stored data or copies from optical disks, electronically transmitted facsimiles, or any other reproduction of an original from a process that forms a durable medium for its recording, storing, and reproducing.

G. Nothing in this section shall prohibit any insurer or agent from including in a notice of cancellation, refusal to renew, reduction in coverage, or premium increase any additional disclosure statements required by state or federal laws.

H. For the purpose of this section, the terms (i) "business entity" shall mean an entity as defined by subsection A of § 13.1-543, § 13.1-603 or 13.1-803 and shall include an individual, a partnership, an unincorporated association, the Commonwealth, a county, city, town, or an authority, board, commission, sanitation, soil and water, planning or other district, public service corporation owned, operated or controlled by the Commonwealth, a locality or other local governmental authority; (ii) "policy of motor vehicle insurance" shall mean a policy or contract for bodily injury or property damage liability insuring a business entity issued or delivered in this Commonwealth covering liability arising from the ownership, maintenance, or use of any motor vehicle, but does not include (a) any policy issued through the Virginia Automobile Insurance Plan, (b) any policy providing insurance only on an excess basis, or (c) any other contract providing insurance to the named insured even though the contract may incidentally provide insurance on motor vehicles; and (iii) "reduction in coverage" shall mean, but not be limited to, any diminution in scope of coverage, decrease in limits of liability, addition of exclusions, increase in deductibles, or reduction in the policy term or duration except a reduction in coverage filed with and approved by the Commission and applicable to an entire line, classification or subclassification of insurance.

I. Within 15 days of receipt of the notice of cancellation, refusal to renew, reduction in coverage, or increase in premium, the named insured shall be entitled to request in writing to the Commissioner that he review the action of the insurer. Upon receipt of the request, the Commissioner shall promptly begin a review to determine whether the insurer's notice of cancellation, refusal to renew, reduction in coverage, or premium increase complies with the requirements of this section. Where the Commissioner finds from the review that the notice of cancellation, refusal to renew, reduction in coverage, or premium increase does not comply with the requirements of this section, he shall immediately notify the insurer, the named insured and any other person to whom such notice was required to be given by the terms of the policy that such notice is not effective. Nothing in this section authorizes the Commissioner to substitute his judgment as to underwriting for that of the insurer. Pending review by the Commission, this section shall not operate to relieve an insured from the obligation to pay any premium when due; however, if the Commission finds that the notice required by this section was not proper, the Commission may order the insurer to pay to the insured any overpayment of premium made by the insured.

J. Every insurer shall maintain for at least one year records of cancellation, refusals to renew, reductions in coverage, and premium increases to which this section applies and copies of every notice or statement required by subsections A, C, F, and L that it sends to any of its insureds.

K. There shall be no liability on the part of and no cause of action of any nature shall arise against (i) the Commissioner of Insurance or his subordinates; (ii) any insurer, its authorized representative, its agents, or its employees; or (iii) any firm, person, or corporation furnishing to the insurer information as to reasons for cancellation, refusal to renew, reduction in coverage, or premium increase, for any statement made by any of them in complying with this section or for providing information pertaining thereto.

L. Notwithstanding anything in this section to the contrary, if an insurer cancels or refuses to renew a policy of medical malpractice insurance as defined in § 38.2-2800, or if, as a result of an insurer-initiated increase in premium, the premium increases for a medical malpractice insurance policy by more than 25 percent of the previous policy's premium, the insurer shall provide no fewer than 90 days' notice prior to the renewal effective date, or, if such policy is being cancelled or non-renewed for failure of the insured to discharge when due any of its obligations in connection with the payment of premium for the policy, the effective date of cancellation or refusal to renew shall not be less than 15 days from the date of mailing or delivery of the notice. The increase in the premium shall be the difference between the renewal premium and the premium charged by the insurer at the effective date of the expiring policy.

M. As used in this section, an "insurer-initiated increase in premium" means an increase in premium other than one resulting from changes in (i) coverage requested by the insured, (ii) policy limits requested by the insured, (iii) the insured's operation or location that result in a change in the classification of the risk, or (iv) the rating exposures including, but not limited to, increases in payroll, receipts, square footage, number of automobiles insured, or number of employees.

1986, c. 376, § 38.1-43.01; 1987, c. 697; 1988, c. 189; 1989, c. 728; 1992, c. 160; 1996, c. 237; 1998, c. 142; 2000, c. 529; 2003, cc. 387, 678; 2005, cc. 290, 635; 2006, c. 554; 2008, cc. 58, 221; 2009, c. 215; 2013, cc. 13, 257; 2015, cc. 9, 443; 2016, cc. 4, 71.

§ 38.2-232. Notice of lapse or pending lapse of certain life and accident and sickness insurance policies.

A. Every insurer, health services plan, or health care plan that issues a policy, contract, or plan of insurance or annuity as defined in §§ 38.2-102 through 38.2-109 shall provide the policy owner, contract owner, or plan owner with a written notice prior to the date that the policy, contract, or plan will lapse for failure to pay premiums due.

B. The provisions of subsection A shall not apply (i) to group policies, contracts, or plans of insurance or (ii) to individual policies, contracts, or plans of insurance if the insurer, health services plan, or health care plan (a) as a general business practice provides its policy owners, contract owners, or plan owners with written notices of premiums due or (b) has furnished its policy owner, contract owner,

or plan owner with written notice separate from that contained in the policy that the failure to pay premiums in a timely manner will result in a lapse of such policy, contract, or plan.

1991, c. 369; 2013, c. 93.

§ 38.2-233. Credit involuntary unemployment insurance; credit property insurance; disclosure and readability.

A. If a creditor makes available to the debtors more than one plan of credit involuntary unemployment insurance as defined in § 38.2-122.1, or more than one plan of credit property insurance as defined in § 38.2-122.2, all debtors must be informed of all such plans for which they are eligible.

B. When elective credit property insurance or elective credit involuntary unemployment insurance is offered, the borrower shall be given written disclosure that purchase of such insurance is not required and is not a factor in granting credit. The disclosure shall also include notice that the borrower has the right to use alternative coverage or to buy insurance elsewhere.

C. If the debtor is given a contract which includes a single premium payment to be charged for elective credit property insurance or elective credit involuntary unemployment insurance, the debtor shall be given:

1. A contract which does not include the elective insurance premiums; or

2. A disclosure form which shall clearly disclose the difference in premiums charged for a contract with the elective insurance and one without the elective insurance. This disclosure shall include the difference between the amount financed, the monthly payment and the charge for insurance. The form shall be signed and dated by the debtor and the agent, if any, soliciting the application or the creditor's representative, if any, soliciting the enrollment request. A copy of this disclosure shall be given to the debtor and a copy shall be made a part of the creditor's loan file.

Nothing contained in this subsection shall be construed to prohibit the creditor from combining such disclosure, in order to avoid redundancy, with other forms of disclosure required under state or federal law.

D. If a creditor offers credit property insurance and requires evidence of insurance coverage on personal household property used as security for an indebtedness or credit involuntary unemployment insurance is required as security for any indebtedness, the debtor shall have the option of (i) furnishing the required amount of insurance through existing policies of insurance owned or controlled by him or (ii) procuring and furnishing the required coverage through any insurer authorized to transact insurance in this Commonwealth. The creditor shall inform the debtor of this option in writing and shall obtain the debtor's signature acknowledging that he understands this option. Nothing contained in this subsection shall be construed to prohibit the creditor from combining such disclosure, in order to avoid redundancy, with other forms of disclosure required under state or federal law.

E. No contract of insurance upon a debtor paid by a single premium shall be made or effectuated unless, at the time of the contract, the debtor is provided with a notice prominently disclosing the right

to a refund of premium in the event the insurance is terminated prior to its scheduled maturity date or the insured indebtedness is terminated or paid off early, and of the obligation of the debtor to provide notification to the insurer under subsection G. This notice shall be signed and dated by the debtor and the agent, if any, soliciting the application or the creditor's representative, if any, soliciting the enrollment request. A copy of the signed notice shall be given to the debtor and a copy shall be made part of the insurer's file.

F. The disclosure requirements set forth in subsections A, B, C, D, and E shall be disclosed separately from the loan or credit transaction papers in a form or forms approved by the Commission. When credit property insurance or credit involuntary unemployment insurance is offered with credit life insurance or credit accident and sickness insurance, the disclosure requirements set forth in subsections A, B, C, D, and E of § 38.2-233 and the disclosure requirements set forth in subsections A, B, C, D, and E of § 38.2-3735 may be disclosed together in a form which shall be approved by the Commission.

G. The Commission shall not approve any form providing credit property insurance or credit involuntary unemployment insurance unless the policy or certificate is written in nontechnical, readily understandable language, using words of common everyday usage. A form shall be deemed acceptable under this section if the insurer certifies that the form achieves a Flesch Readability Score of forty or more, using the Flesch Readability Formula as set forth in Rudolf Flesch, The Art of Readable Writing (1949, as revised 1974), and certifies compliance with the guidelines set forth in this section.

The Commission shall not approve any form providing credit property or credit involuntary unemployment insurance paid by single premium unless the form includes a provision, separately and prominently captioned, stating in substance the following:

"REFUND OF PREMIUM IN THE EVENT OF EARLY TERMINATION"

"In the event this insurance policy or certificate is terminated prior to its originally scheduled maturity date, or the insured indebtedness is terminated or paid off earlier than scheduled, the insurer shall, within 30 days of receipt of notification from the debtor of such termination or early payoff, refund or credit any amount paid by the debtor for the insurance beyond the actual date of termination or payoff. Early termination of debt includes termination by renewal or refinancing. The debtor's notification to the insurer shall include proof of termination or early payoff of the insured indebtedness."

The Commission shall not approve any form providing credit property or credit involuntary unemployment insurance unless the insurance policy or certificate states that the unearned premium refund will be calculated on a pro rata basis. No refund of five dollars or less need be made.

The Commission shall not approve any form providing credit property or credit involuntary unemployment insurance unless the form has printed on it a notice stating in substance that if, during a period of at least ten days from the date the policy or certificate is delivered to the policy owner or certificate holder the policy or certificate is surrendered to the insurer or its agent with a written request for

cancellation, the policy or certificate shall be void from the beginning and the insurer shall refund any premium paid for the policy or certificate.

H. Premium calculations for credit property insurance involving closed end credit transactions shall not be based on amounts paid for finance charges, service fees, delivery charges, taxes, interest, or any other item not covered under the credit property insurance form. If the premium calculations for credit property insurance involving open end monthly outstanding balance credit transactions are based on amounts paid for finance charges, service fees, delivery charges, taxes, interest, meals, entertainment, or any other item not covered under the credit property insurance form, then at least twice per year the premium notice for such insurance shall be accompanied by a disclosure in no smaller than eight-point boldface type substantially similar to the following:

Your credit property insurance premium is based on the entire outstanding balance of this account. However, your insurance coverage applies only to certain tangible personal property. Finance charges, service fees, delivery charges, taxes, interest, meals, and entertainment are not covered under your policy. Therefore, you may be paying premiums on items not covered under your policy.

The disclosure described in this subsection, with the same type-size requirements, shall also be included in any written materials provided at the time of invitation to contract and in policies or certificates provided to insureds.

I. A credit property insurance or credit involuntary unemployment insurance policy or certificate which provides truncated or critical period coverage, or any other type of similar coverage that does not provide benefits or coverage for the entire term or amount of the indebtedness, shall be subject to the following requirements:

1. The policy or certificate shall include a statement printed on the face of the policy or first page of the certificate which clearly describes the limited nature of the insurance. The statement shall be printed in capital letters and in bold twelve-point or larger type; and

2. The policy or certificate shall not include any benefits or coverage other than truncated or critical period coverage or any other type of similar coverage that does not provide benefits or coverage for the entire term or amount of the indebtedness.

J. A portion of the premium charged for credit property insurance or credit involuntary unemployment insurance may be allowed by the insurer to the creditor for providing and furnishing such insurance, and no such allowance shall be deemed a rebate of premium or as interest charges or consideration or an amount in excess of permitted charges in connection with the loan or other credit transaction.

K. All of the acts necessary to provide and service credit property insurance and credit involuntary unemployment insurance may be performed within the same place of business in which is transacted the business giving rise to the loan or other credit transaction.

L. Subsections A, B, C, D, F, and M shall not apply to credit property insurance or credit involuntary unemployment insurance that will insure open end monthly outstanding balance credit transactions if the following criteria are met:

1. The insurance is offered to the debtor after the loan or credit transaction it will insure has been approved by the creditor and has been effective at least seven days;

2. The solicitation for the insurance is by mail or telephone. The person making the solicitation shall not condition the future use or continuation of the open end credit upon the purchase of credit property insurance or credit involuntary unemployment insurance;

3. The creditor makes available only one plan of credit property insurance and only one plan of credit involuntary unemployment insurance to the debtor;

4. The debtor is provided written confirmation of the insurance coverage within thirty days of the effective date of such coverage. The effective date of such coverage shall begin on the date the solicitation is accepted; and

5. The individual policy or certificate has printed on it a notice stating that if, during a period of at least thirty days from the date the policy or certificate is delivered to the policy owner or certificate holder, the policy or certificate is surrendered to the insurer or its agent with a written request for cancellation, the policy or certificate shall be void from the beginning and the insurer shall refund any premium paid for the policy or certificate. This statement shall be prominently located on the face page of the policy or certificate, and shall be printed in capital letters and in bold face twelve-point or larger type.

M. Subsections A, B, C, D, F, and L shall not apply to open end credit transactions by mail, telephone, or brochure solicitations that are not excluded from the requirements of subsections A, B, C, D, and F by subsection L where the insurer is offering only one plan of credit property insurance and only one plan of credit involuntary unemployment insurance and the following criteria are met:

1. The following disclosures shall be included in solicitations, whether as part of the application or enrollment request or separately:

a. The name and address of the insurer(s) and creditor; and

b. A description of the coverage offered, including the amount of coverage, the premium rate for the insurance coverage offered, and a description of any exceptions, limitations or restrictions applicable to such coverage.

2. The application or enrollment requests shall comply as follows:

a. Notwithstanding requirements set forth elsewhere, the application and enrollment request shall be printed in a type size of not less than eight-point type, one-point leaded;

b. The application or enrollment request shall contain a prominent statement that the insurance offered is optional, voluntary or not required;

c. The application or enrollment request shall contain no questions relating to insurability other than the debtor's age or date of birth and, if applicable, active employment status; and

d. If the disclosures required by subdivision 1 of this subsection are not included in the application or enrollment request, the application and enrollment request shall make reference to such disclosures with sufficient information to assist the reader in locating such disclosures within separate solicitation material.

3. Each insurer proposing to utilize an application or enrollment request in such transactions shall file such form for approval by the Commission. If the insurer anticipates utilizing such application or enrollment form in more than one solicitation, the insurer shall submit, as part of its filing of such form, a certification signed by an officer of the insurer, stating that any such subsequent use of the application or enrollment form will utilize the same form number and will not vary in substance from the wording and format in which the form is submitted for approval. Upon approval of such application or enrollment form by the Commission, the insurer shall be permitted to utilize such form in various solicitation materials provided that the application or enrollment form, when incorporated into such solicitation materials, has the same form number and wording substantially identical to that contained on the approved application or enrollment form. When credit property insurance or credit involuntary unemployment insurance is offered with credit life insurance or credit accident and sickness insurance, insurers may file one common form which shall be subject to prior approval by the Commission and shall incorporate the requirements of subsection M of this section and subsection F of § 38.2-3737, according to the requirements stated in this paragraph and in subdivision F 3 of § 38.2-3737.

1993, c. 774; 1994, c. 306; 1995, c. 167; 1999, c. 586; 2000, c. 526; 2009, c. 643.

§ 38.2-234. Release of information.

Notwithstanding the provisions of subdivision 5 of § 2.2-3802, the Commission may share information with databases developed by the National Association of Insurance Commissioners (NAIC) for use by regulators.

1996, c. 32.

§ 38.2-235. Liability insurance; carbon monoxide exclusions.

No policy of insurance furnishing personal injury liability or property damage liability coverage as defined in §§ 38.2-117 and 38.2-118, including any endorsements thereto, shall be deemed to exclude coverage for the discharge, dispersal, seepage, migration, release, emission, leakage or escape of carbon monoxide from a residential or commercial heating system unless excluded in such policy by explicit reference thereto.

1997, c. 157.

§ 38.2-236. Notice of settlement payment.

A. Upon payment by any insurer of at least $5,000 in a single check to an attorney licensed in the Commonwealth, or other representative, in settlement or satisfaction by an insured or a third party of any claim arising out of an insurance policy issued or delivered in the Commonwealth, the insurer

shall send to the claimant or judgment creditor on the underlying insurance or liability claim a notice of such payment as required by subsection B within five business days after the date payment is made or sent to the attorney or other representative of the claimant or judgment creditor. A copy of the notice shall be sent simultaneously to the attorney or representative of the claimant or judgment creditor.

B. The notice required pursuant to subsection A shall be sent to the physical address, or email or other electronic address, furnished by the claimant or judgment creditor to the insurance company, unless the claimant or judgment creditor has notified the insurance company in writing that he waives notice of payment. In the absence of any address or waiver furnished by the claimant or judgment creditor, the notice shall be sent to the last known physical address, or email or other electronic address, of the claimant or judgment creditor.

The notice shall be sent by the insurance company only after a settlement has been agreed to by the attorney or other representative of the claimant or judgment creditor, and shall contain only the following language:

"Pursuant to § 38.2-236 of the Code of Virginia, you are hereby notified that a payment was sent on (insert date on which payment was sent) by (insert name of insurer) to your attorney or other representative (insert name, address, and telephone number of attorney or other representative known to insurer), in satisfaction of your claim or judgment against (insert name of insurer, or insured, whichever is appropriate).

If you have any questions, please contact your attorney or other representative."

C. Nothing in subsection A or B shall (i) create any cause of action for monetary damages for any person against an insurer based upon a failure to provide notice as required by this section or the provision of a defective notice, (ii) establish a defense for any person to any cause of action based on a failure to provide notice as required by this section or the provision of a defective notice, or (iii) invalidate or in any way affect the settlement or satisfaction for which the payment was made by the insurer.

D. Except as provided and authorized by this section, no insurer shall otherwise communicate with a claimant or judgment creditor known to be represented by an attorney licensed in the Commonwealth, or other representative, regarding settlement of a claim or satisfaction of a judgment without the written consent of such attorney or other representative.

2013, c. 146.

§ 38.2-237. Provider complaints.

Any person may submit a complaint of one or more issues of noncompliance by an insurer with any insurance law, insurance regulation, or order of the Commission on behalf of a health care provider. The complainant shall provide detailed information supporting the allegation of noncompliance. The Commission shall investigate complaints alleging violations of insurance laws, regulations, and orders of the Commission and notify the complainants of the outcomes. The Commission shall have

no jurisdiction to adjudicate (i) individual controversies or (ii) as between two contracting parties, matters of contractual dispute unrelated to insurance laws, regulations, or Commission orders.

2022, c. 164.

Chapter 3 - PROVISIONS RELATING TO INSURANCE POLICIES AND CONTRACTS

§ 38.2-300. Scope of chapter.

This chapter shall apply to all classes of insurance except:

1. Ocean marine insurance other than private pleasure vessels;

2. Life insurance policies and accident and sickness insurance policies not delivered or issued for delivery in this Commonwealth;

3. Contracts of reinsurance; or

4. Annuities, except as provided for in §§ 38.2-305, 38.2-316 and 38.2-321.

1952, c. 317, § 38.1-328; 1986, c. 562; 1988, cc. 333, 523.

§ 38.2-301. Insurable interest required; life, accident and sickness insurance.

A. Any individual of lawful age may take out an insurance contract upon himself for the benefit of any person. No person shall knowingly procure or cause to be procured any insurance contract upon another individual unless the benefits under the contract are payable to (i) the insured or his personal representative or (ii) a person having an insurable interest in the insured at the time when the contract was made.

B. As used in this section and § 38.2-302, "insurable interest" means:

1. In the case of individuals related closely by blood or by law, a substantial interest engendered by love and affection;

2. In the case of other persons, a lawful and substantial economic interest in the life, health, and bodily safety of the insured. "Insurable interest" shall not include an interest which arises only or is enhanced by the death, disability or injury of the insured;

3. In the case of employees of corporations, with respect to whom the corporate employer, a trust established by the corporate employer, or an employee benefit trust is the beneficiary under an insurance contract, the lawful and substantial economic interest required in subdivision 2 of this subsection shall be deemed to exist in (i) key employees and (ii) other employees who have been employed by the corporation for 12 consecutive months, provided that the amount of insurance coverage on such other employees shall be limited to an amount which is commensurate with employer-provided benefits to non-key employees as a group;

4. In the case of a party to a contract or option for the purchase or sale, including a redemption, of an interest in a business proprietorship, partnership or firm or of shares of stock of a corporation or of an

interest in such shares, the lawful and substantial economic interest required in subdivision 2 shall be deemed to exist in each individual party to such contract or option and for the purpose of such contract or option only, in addition to any insurable interest that may otherwise exist as to the life of such individual;

5. In the case of a trustee, other than the trustee of a domestic business trust or foreign business trust, as defined in § 13.1-1201, the lawful and substantial economic interest required in subdivision 2 shall be deemed to exist, whether the life insurance policy is owned by a trustee before, on or after July 1, 2005, in (i) the individual insured who established the trust, (ii) each individual in whose life the owner of the trust for federal income tax purposes has an insurable interest, and (iii) each individual in whose life a beneficiary of the trust has an insurable interest; and

6. In the case of an organization described in § 501(c) of the Internal Revenue Code, the lawful and substantial economic interest required in subdivision 2 of this subsection shall be deemed to exist where (i) the insured or proposed insured has either assigned all or part of his ownership rights in a policy or contract to such an organization or has executed a written consent to the issuance of a policy or contract to such organization and (ii) such organization is named in the policy or contract as owner or as beneficiary.

1952, c. 317, § 38.1-329; 1986, c. 562; 1988, c. 831; 1992, cc. 8, 50; 1993, c. 105; 2005, cc. 656, 698; 2007, c. 186.

§ 38.2-302. Life, accident, and sickness insurance; application required.

A. No contract of insurance upon a person shall be made or effectuated unless at the time of the making of the contract the individual insured, being of lawful age and competent to contract for the insurance contract, (i) applies for insurance or (ii) consents in writing to the insurance contract. However:

1. Either spouse may effect an insurance contract upon each other;

2. Any person having an insurable interest in the life of a minor, or any person upon whom a minor is dependent for support and maintenance, may effect an insurance contract upon the life of or pertaining to the minor; or

3. A corporate employer or an employee benefit trust having the insurable interest described in subdivision B 3 of § 38.2-301 may effect an insurance contract upon the lives of such employees, provided that the employer or trust provides the employee with notice in writing that such insurance has been purchased, the amount of such coverage, and to whom benefits are payable in the event of the employee's death.

B. Nothing in this section shall prohibit a minor from obtaining insurance on his own life as authorized in § 38.2-3105.

1952, c. 317, § 38.1-330; 1986, c. 562; 1988, c. 831; 1993, c. 105; 2020, c. 900.

§ 38.2-303. Insurable interest required; property insurance.

A. No insurance contract on property or on any interest therein or arising therefrom shall be enforceable except for the benefit of persons having an insurable interest in the property insured.

B. As used in this section, "insurable interest" means any lawful and substantial economic interest in the safety or preservation of the subject of insurance free from loss, destruction or pecuniary damage.

1952, c. 317, § 38.1-331; 1986, c. 562.

§ 38.2-304. Contracts of temporary insurance; duration; what deemed to include.

A. Oral or written binders or other temporary insurance contracts may be made and used for a period not exceeding sixty days pending the issuance of the policy. Unless otherwise provided, oral or written binders or other temporary insurance contracts shall be deemed to include the usual provisions, stipulations and agreements which are commonly used in this Commonwealth in effecting the class of insurance being written.

B. This section shall not apply to:

1. Binders or other contracts referred to in §§ 38.2-2112 and 38.2-4605;

2. Conditional receipts issued by life insurers; or

3. Group insurance policies.

Code 1950, § 38-181; 1952, c. 317, § 38.2-332; 1986, c. 562.

§ 38.2-305. Contents of policies.

A. Each insurance policy or contract shall specify:

1. The names of the parties to the contract;

2. The subject of the insurance;

3. The risks insured against;

4. The time the insurance takes effect and, except in the case of group insurance, title insurance, and insurance written under perpetual policies, the period during which the insurance is to continue;

5. A statement of the premium, except in the case of group insurance and title insurance; and

6. The conditions pertaining to the insurance.

In addition, each policy of property and casualty insurance shall contain a list of all policy forms and endorsements applicable to that policy, which shall display the respective form numbers and, if those form numbers are not unique identifiers of such forms, the applicable edition dates.

B. Each new or renewal insurance policy, contract, certificate, or evidence of coverage issued to a policyholder, covered person, or enrollee shall be accompanied by a notice stating substantially:

"IMPORTANT INFORMATION REGARDING YOUR INSURANCE"

"In the event you need to contact someone about this insurance for any reason, please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions, you

may contact the insurance company issuing this insurance at the following address and telephone number: [Insert the appropriate address and telephone number, toll free number if available, for the company's home or regional office]."

"If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at: [Insert the appropriate address, toll free phone number, and phone number for out-of-state calls for the Bureau of Insurance]."

"Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available."

Health maintenance organizations shall add the following: "We recommend that you familiarize yourself with our grievance procedure and make use of it before taking any other action."

C. In any life insurance or annuity contract containing a beneficiary designation in which the designated beneficiary is the spouse of the policy owner, the following notice shall be included with the policy when issued, either attached to or incorporated into the front or first page of such contract:

"BENEFICIARY DESIGNATION MAY NOT APPLY IN THE EVENT OF ANNULMENT OR DIVORCE"

"Under Virginia law (Virginia Code § 20-111.1), a revocable beneficiary designation in a policy owned by one spouse that names the other spouse as beneficiary becomes void upon the entry of a decree of annulment or divorce, and the death benefit prevented from passing to a former spouse will be paid as if the former spouse had predeceased the decedent. In the event of annulment or divorce proceedings, and if it is the intent of the parties that the beneficiary designation of the former spouse is to continue, you are advised to make certain that one of the following courses of action is taken prior to the entry of a decree of annulment or divorce: (i) change the beneficiary designation to make it irrevocable; (ii) change the ownership of the policy or contract; (iii) execute a separate written agreement stating the intention of both parties that the beneficiary designation is to remain in effect beyond the date of entry of the decree of annulment or divorce; or (iv) make certain that the decree of annulment or divorce contains a provision stating that the beneficiary designation is not to be revoked pursuant to § 20-111.1."

D. If, under the contract, the exact amount of premiums is determinable only at the termination of the contract, a statement of the basis and rates upon which the final premium is to be determined and paid shall be furnished to any policy-examining bureau having jurisdiction or to the insured upon request.

E. This section shall not apply to surety insurance contracts.

1952, c. 317, § 38.1-333; 1986, c. 562; 1987, c. 519; 1988, c. 333; 1997, c. 688; 2000, c. 193; 2012, c. 264; 2013, c. 27.

§ 38.2-306. Additional contents.

A policy or contract may contain additional provisions that are not substantially in conflict with this title and that:

1. Are required to be inserted by the laws of the insurer's state or country of domicile or of the state or country in which the policy is to be delivered or issued for delivery; or

2. Are necessary to state the rights and obligations of the parties to the contract because of the manner in which the insurer is constituted or operated.

Code 1950, § 38-513; 1952, c. 317, § 38.1-334; 1986, c. 562.

§ 38.2-307. Charter and bylaw provisions in policies.

No policy shall contain any provision purporting to make any portion of the charter, bylaws or other organic law of the insurer, however designated, a part of the contract unless that portion is set out in full in the policy. Any policy provision in violation of this section shall be invalid.

1952, c. 317, § 38.1-335; 1986, c. 562.

§ 38.2-308. Contingent liability provisions in policies issued by certain mutual insurers.

Except in the case of nonassessable policies, the contingent liability of each member of a mutual insurer, other than a life insurer, shall be clearly stated in the mutual insurer's policies. The contingent liability may be limited, but such limitation shall not be less than one additional annual premium on each policy held by the member.

Code 1950, § 38-508; 1952, c. 317, § 38.1-335.1; 1986, c. 562.

§ 38.2-309. When answers or statements of applicant do not bar recovery on policy.

All statements, declarations and descriptions in any application for an insurance policy or for the reinstatement of an insurance policy shall be deemed representations and not warranties. No statement in an application or in any affidavit made before or after loss under the policy shall bar a recovery upon a policy of insurance unless it is clearly proved that such answer or statement was material to the risk when assumed and was untrue.

Code 1950, § 38-7; 1952, c. 317, § 38.1-336; 1986, c. 562.

§ 38.2-310. All fees, charges, etc., to be stated in policy.

A. All fees, charges, premiums or other consideration charged for the insurance or for the procurement of insurance shall be stated in the policy except in the case of fidelity, surety, title, and group insurance, and except for consulting services as provided in Article 4 (§ 38.2-1837 et seq.) of Chapter 18 of this title. Except as provided in this subsection, no person shall charge or receive any fee, compensation, or consideration for insurance or for the procurement of insurance that is not included in the premium or stated in the policy.

B. Service charges for installment payments of insurance premiums do not need to be stated in the policy if the charges are provided to the insured in writing.

Code 1950, § 38-508; 1952, c. 317, § 38.1-337; 1986, c. 562; 1990, c. 281.

§ 38.2-311. Type size in which conditions and restrictions to be printed.

Except as otherwise provided in this title, no restriction, condition or provision in or endorsed on any insurance policy shall be valid unless the condition or provision is printed in type as large as eight point type, or is written in ink or typewritten in or on the policy. This section shall not apply to a copy of an application or parts thereof, attached to or made part of an insurance policy.

Code 1950, § 38-9; 1952, c. 317, § 38.1-338; 1986, c. 562.

§ 38.2-312. Provisions limiting jurisdiction, or requiring construction of contracts by law of other states, prohibited.

No insurance contract delivered or issued for delivery in this Commonwealth and covering subjects which are located or residing in this Commonwealth, or which are performed in this Commonwealth shall contain any condition, stipulation or agreement:

1. Requiring the contract to be construed according to the laws of any other state or country, except as may be necessary to meet the requirements of the motor vehicle financial responsibility laws of the other state or country; or

2. Depriving the courts of this Commonwealth of jurisdiction in actions against the insurer.

Any such condition, stipulation or agreement shall be void, but such voiding shall not affect the validity of the remainder of the contract.

1952, c. 317, § 38.1-339; 1986, c. 562.

§ 38.2-313. Where certain contracts deemed made.

All insurance contracts on or with respect to the ownership, maintenance or use of property in this Commonwealth shall be deemed to have been made in and shall be construed in accordance with the laws of this Commonwealth.

Code 1950, § 38-162; 1952, c. 317, § 38.1-340; 1986, c. 562.

§ 38.2-314. Limitation of action and proof of loss.

No provision in any insurance policy shall be valid if it limits the time within which an action may be brought to less than one year after the loss occurs or the cause of action accrues.

If an insurance policy requires a proof of loss, damage or liability to be filed within a specified time, all time consumed in an effort to adjust the claim shall not be considered part of such time.

Code 1950, § 38-9; 1952, c. 317, § 38.1-341; 1986, c. 562.

§ 38.2-315. Intervening breach.

If any breach of warranty or condition in any insurance contract covering property located in this Commonwealth occurs prior to a loss under the contract, the breach shall not void the contract nor permit the insurer to avoid liability unless the breach existed at the time of the loss.

Code 1950, § 38-8; 1952, c. 317, § 38.1-342; 1986, c. 562.

§ 38.2-316. Policy forms to be filed with Commission; notice of approval or disapproval; exceptions.

A. No policy of life insurance, industrial life insurance, variable life insurance, modified guaranteed life insurance, group life insurance, family leave insurance, accident and sickness insurance, or group accident and sickness insurance; no annuity, modified guaranteed annuity, pure endowment, variable annuity, group annuity, group modified guaranteed annuity, or group variable annuity contract; no health services plan, legal services plan, dental or optometric services plan, or health maintenance organization contract; no dental plan organization dental benefit contract; and no fraternal benefit certificate nor any certificate or evidence of coverage issued in connection with such policy, contract, or plan issued or issued for delivery in Virginia shall be delivered or issued for delivery in the Commonwealth unless a copy of the form has been filed with the Commission. In addition to the above requirement, no policy of accident and sickness insurance or family leave insurance shall be delivered or issued for delivery in the Commonwealth unless the rate manual showing rates, rules, and classification of risks applicable thereto has been filed with the Commission.

B. Except as provided in this section, no application form shall be used with the policy or contract and no rider or endorsement shall be attached to or printed or stamped upon the policy or contract unless the form of such application, rider or endorsement has been filed with the Commission. No individual certificate and no enrollment form shall be used in connection with any group life insurance policy, group accident and sickness insurance policy, group annuity contract, group variable annuity contract, or group family leave insurance policy unless the form for the certificate and enrollment form have been filed with the Commission.

C. 1. None of the policies, contracts, and certificates specified in subsection A shall be delivered or issued for delivery in the Commonwealth and no applications, enrollment forms, riders, and endorsements shall be used in connection with the policies, contracts, and certificates unless the forms thereof have been approved in writing by the Commission as conforming to the requirements of this title and not inconsistent with law.

2. In addition to the above requirement, no premium rate change applicable to individual accident and sickness insurance policies, subscriber contracts of health services plans, dental or optometric services plans, or fraternal benefit contracts providing individual accident and sickness coverage as authorized in § 38.2-4116 shall be used unless the premium rate change has been approved in writing by the Commission. No premium rate change applicable to individual or group Medicare supplement policies shall be used unless the premium rate change has been approved in writing by the Commission.

D. The Commission may disapprove or withdraw approval of the form of any policy, contract or certificate specified in subsection A, or of any application, enrollment form, rider or endorsement, if the form:

1. Does not comply with the laws of the Commonwealth;

2. Has any title, heading, backing or other indication of the contents of any or all of its provisions that is likely to mislead the policyholder, contract holder or certificate holder; or

3. Contains any provisions that encourage misrepresentation or are misleading, deceptive or contrary to the public policy of the Commonwealth.

E. Within 30 days after the filing of any form requiring approval, the Commission shall notify the organization filing the form of its approval or disapproval of the form which has been filed, and, in the event of disapproval, its reason therefor. The Commission, at its discretion, may extend for up to an additional 30 days the period within which it shall approve or disapprove the form. Any form received but neither approved nor disapproved by the Commission shall be deemed approved at the expiration of the 30 days if the period is not extended, or at the expiration of the extended period, if any; however, no organization shall use a form deemed approved under the provisions of this section until the organization has filed with the Commission a written notice of its intent to use the form together with a copy of the form and the original transmittal letter thereof. The notice shall be filed in the offices of the Commission at least 10 days prior to the organization's use of the form.

F. If the Commission proposes to withdraw approval previously given or deemed given to the form of any policy, contract or certificate, or of any application, rider or endorsement, it shall notify the insurer in writing at least 15 days prior to the proposed effective date of withdrawal giving its reasons for withdrawal.

G. Any insurer or fraternal benefit society aggrieved by the disapproval or withdrawal of approval of any form may proceed as indicated in § 38.2-1926.

H. This section shall not apply to any special rider or endorsement on any policy, except an accident and sickness insurance policy that relates only to the manner of distribution of benefits or to the reservation of rights and benefits under such policy, and that is used at the request of the individual policyholder, contract holder or certificate holder.

I. The Commission may exempt any categories of such policies, contracts, and certificates and any applicable rate manuals from (i) the filing requirements, (ii) the approval requirements of this section, or (iii) both such requirements. The Commission may modify such requirements, subject to such limitations and conditions which the Commission finds appropriate. In promulgating an exemption, the Commission may consider the nature of the coverage, the person or persons to be insured or covered, the competence of the buyer or other parties to the contract, and other criteria the Commission considers relevant.

J. In lieu of complying with the requirements of subsections A, B, and C, any legal services organization operating, conducting, or administering a legal services plan may provide the Commission with an informational filing regarding a subscription contract, enrollment form, rider, or endorsement used by the legal services organization in connection with a legal services plan offered in the Commonwealth together with written notice of its intent to use the form. Upon providing such informational filing and notice, the legal services organization may use the subscription contract, enrollment form, rider, or endorsement without its prior approval by the Commission. This subsection shall not limit the authority of the Commission to review a legal services plan and any subscription contract, enrollment

form, rider, or endorsement used in connection therewith and to disapprove the use of such form for any of the grounds set forth in subsection D.

K. Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such rules and regulations as it may deem necessary to set standards for policy and other form submissions required by this section or § 38.2-3501.

1952, c. 317, § 38.1-342.1; 1972, c. 836; 1973, c. 504; 1977, c. 325; 1986, c. 562; 1990, c. 332; 1994, c. 316; 1996, c. 12; 1998, c. 17; 2004, c. 668; 2020, c. 408; 2022, cc. 131, 132.

§ 38.2-316.1. Premium rates.

A. As used in this section:

"Anticipated loss ratio" means the ratio of the present value of the future benefits to the present value of the future premiums of a policy form over the entire period for which rates are computed to provide coverage.

"Student health insurance coverage" means a type of individual health insurance coverage offered in the individual market that is provided pursuant to a written agreement between an institution of higher education, as defined by the Higher Education Act of 1965, P.L. 89-329, and a health carrier to students enrolled in that institution of higher education and their dependents; that does not make health insurance coverage available other than in connection with enrollment as a student or as a dependent of a student in the institution of higher education; and that does not condition eligibility for health insurance coverage on any health status-related factor related to a student or a dependent of the student.

B. The Commission shall review and approve accident and sickness insurance premium rates applicable to (i) health benefit plans issued in the Commonwealth in the individual and small group markets, as those terms are defined in § 38.2-3431, and (ii) health benefit plans providing health insurance coverage, as defined in § 38.2-3431, in the individual market to residents of the Commonwealth through a group trust, association, purchasing cooperative, or other group that is not an employer plan. In connection therewith, the Commission is authorized to establish minimum loss ratios to assure that the benefits provided by accident and sickness insurance policies are or are likely to be reasonable in relation to the premiums charged. The Commission shall promulgate regulations to establish standards applicable to such review and approval.

C. Premium rate filings for a health benefit plan issued in the Commonwealth in the individual and small group markets shall include a description of agent commissions and any limitations or exceptions as they relate to the payment of such commissions.

D. Every policy, rider, or endorsement form affecting benefits that is submitted for approval shall be accompanied by a rate filing, as required by § 38.2-316. Any subsequent addition to or change in rates applicable to such policy, rider, or endorsement form shall also be filed. Each rate submission shall comply with the requirements of 14VAC5-130.

E. Benefits shall be deemed reasonable in relation to premiums, provided that the anticipated loss ratio of the policy form, including riders and endorsements, is at least as great as provided in 14VAC5-130. The reasonableness of benefits with respect to filings of rate revisions for a previously approved form shall be determined as provided in 14VAC5-130.

F. A health insurance issuer shall consider the claims experience of all enrollees in all health benefit plans, other than grandfathered plans and student health insurance coverage, in the individual market to be members of a single risk pool. A health insurance issuer shall consider the claims experience of all enrollees in all health plans, other than grandfathered plans, in the small group market to be members of a single risk pool. Each plan year or policy year, as applicable, a health insurance issuer shall establish an index rate based on the total combined claims costs for providing essential health benefits within the single risk pool of the individual or small group market as provided in 14VAC5-130. A health insurance issuer may vary premium rates for a particular plan from its index rate for a relevant state market only on the basis of an actuarially justified plan-specific factor permitted under 14VAC5-130.

G. If the Commission finds that the premium rate filed in accordance with this section is not meeting or will not meet the originally filed and approved loss ratio, the Commission may require appropriate rate adjustments, premium refunds, or premium credits (i) as deemed necessary for the coverage to conform with the minimum loss ratio standards established pursuant to subsection B and (ii) that are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current rates by the health insurance issuer for the coverage. The Commission may take into consideration any previous or expected premium refunds or credits. The Commission may require the submission of detailed supporting documents as necessary to justify the adjustment.

H. The Commission may request information subsequent to approval of a policy form or rate revision so that it may determine whether premium rates are reasonable in relation to the benefits provided as specified in 14VAC5-130.

I. Except as otherwise provided, nothing contained in this section shall be construed to relieve a health insurance issuer from complying with other statutory requirements set forth in this title.

J. The Commission may prescribe procedures for the effective monitoring of actual experience under any form subject to 14VAC5-130.

2013, cc. 670, 679; 2018, c. 708; 2019, c. 607.

§ 38.2-317. Delivery and use of certain policies and endorsements.

A. No insurance policy or endorsement of the kind to which Chapter 19 (§ 38.2-1900 et seq.) applies shall be delivered or issued for delivery in the Commonwealth unless the policy form or endorsement is filed with the Commission prior to its effective date. The provisions of this section shall not apply to statutory fire insurance policies, standard automobile policy forms and endorsements, workers' compensation and employers' liability insurance as defined in § 38.2-119, surety insurance as defined in § 38.2-121, or insurance of large commercial risks as defined in § 38.2-1903.1.

B. The Commission may disapprove or withdraw approval of the policy form or endorsement to which the section applies if the policy form or endorsement:

1. Is in violation of any provision of this title;

2. Contains provisions that are contrary to the public policy of this Commonwealth;

3. Contains or incorporates by reference, even where such incorporation is otherwise permissible, any inconsistent, ambiguous, or misleading clauses or exceptions and conditions that deceptively affect the risk purported to be assumed in the general coverage of the policy;

4. Has any title, heading, or other indication of its provisions that is misleading;

5. Contains provisions that are so unclear or deceptively worded that they encourage misrepresentation; or

6. Provides coverage of such a limited nature that it is contrary to the public interest of the Commonwealth.

C. No policy form or endorsement specified in subsection A shall be delivered, issued for delivery, or used in the Commonwealth unless the policy form or endorsement has been approved in writing by the Commission as conforming to the requirements of this title and not inconsistent with law. Within 30 days after the filing of any policy form or endorsement requiring approval pursuant to this section, the Commission shall notify the insurer or rate service organization filing the policy form or endorsement of its approval or disapproval, and in the event of disapproval, its reason therefor. The Commission, at its discretion, may extend for up to an additional 30 days the period within which it shall approve or disapprove the policy form or endorsement. Any policy form or endorsement received but neither approved nor disapproved by the Commission shall be deemed approved at the expiration of the 30 days if the period is not extended, or at the expiration of the extended period, if any; however, no policy form or endorsement shall be deemed approved under the provisions of this section unless written notice of the intent to use the policy form or endorsement has been filed with the Commission.

D. If the Commission proposes to withdraw approval previously given or deemed given to the policy form or endorsement to which this section applies, it shall notify the insurer in writing at least ninety days prior to the proposed effective date of withdrawal giving its reasons for withdrawal.

E. The policy and endorsement forms referred to in subsection A of this section in use on October 1, 1976, may continue to be used, subject to disapproval by the Commission.

F. The Commission may by rule exempt any person, class of persons, or market segment from any or all of the provisions of this section. In promulgating an exemption, the Commission may consider the nature of the coverage, the person or persons to be insured or covered, the competence of the buyer or other parties to the contract, and other criteria the Commission considers relevant.

G. The policy and endorsement forms referred to in subsection A of this section shall be open to public inspection. Copies may be obtained by any person on request and upon payment of a reasonable charge for the copies.

H. Any insurer whose rate service organization files on behalf of such insurer shall notify the Commission prior to the effective date of any filing if the insurer is not going to accept the filing made on its behalf.

I. Notwithstanding anything to the contrary in subsection A, the provisions of this section shall apply to policies and endorsements of credit involuntary unemployment insurance, as defined in § 38.2-122.1, and to policies and endorsements of credit property insurance, as defined in § 38.2-122.2, delivered or issued for delivery in this Commonwealth, and to certificates of credit involuntary unemployment insurance and credit property insurance delivered or issued for delivery in this Commonwealth where the group policy is delivered in another state.

1976, c. 278, § 38.1-279.48:1; 1986, c. 562; 1988, c. 523; 1993, c. 985; 1997, c. 26; 2000, cc. 526, 548; 2021, Sp. Sess. I, c. 138.

§ 38.2-318. Validity of noncomplying forms.

A. Any insurance policy or form containing any condition or provision that is not in compliance with this title shall be valid, but shall be construed and applied in accordance with the conditions and provisions required by this title.

B. As used in this section, "form" means any contract, rider, endorsement, amendment, certificate, or application or other instrument providing, modifying, or eliminating insurance coverage.

1952, c. 317, § 38.1-343; 1986, c. 562.

§ 38.2-319. Validity of contracts in violation of law.

Any insurance contract made in violation of the laws of this Commonwealth may be enforced against the insurer.

Code 1950, §§ 38-32, 38-223; 1952, c. 317, § 38.1-344; 1986, c. 562.

§ 38.2-320. Insurer to furnish forms for proof of loss.

Whenever notice of any loss or damage has been given to the insurer or its agent, the insurer shall, upon written request, deliver to the insured or to the person to whom the benefits are payable the forms for such preliminary proof of loss or damage as may be required under the policy. Such forms shall be delivered within fifteen days after written request has been made or mailed to the insurer by the insured or person to whom benefits are payable. The failure or refusal of an insurer or its agent to deliver such forms within fifteen days of written request shall be deemed a waiver of any condition, stipulation or provision in the policy requiring preliminary proof.

Code 1950, § 38-11; 1952, c. 317, § 38.1-345; 1986, c. 562.

§ 38.2-321. Payment discharges insurer.

A. An insurer shall be fully discharged from all claims under a life insurance policy, accident and sickness insurance policy, or annuity contract:

1. When the proceeds of or payments under a policy or contract become payable in accordance with (i) the terms of the policy or contract or (ii) the exercise of any right or privilege under the contract; and

2. If the insurer makes payments in accordance with the terms of the policy or contract or any written assignment to the person designated in the policy or contract or by assignment as being entitled to the proceeds or payments.

B. An insurer may not be fully discharged from all claims under a life insurance policy, accident and sickness insurance policy, or annuity contract before payment is made and if the insurer has received, at its home office, written notice that some other person claims to be entitled to payment or some interest in the policy or contract.

1952, c. 317, § 38.1-346.1; 1986, c. 562.

§ 38.2-322. Standardized claims forms.

A. No accident and sickness insurer, health maintenance organization, health services plan, or optometric services plan licensed in the Commonwealth shall refuse to accept, as a standard claims form for physician services or for services provided by chiropractors, optometrists, opticians, professional counselors, psychologists, clinical social workers, podiatrists, physical therapists, clinical nurse specialists who render mental health services, audiologists, and speech pathologists, the standardized HCFA-1500 health insurance claims form, or its successor as it may be amended from time to time. However, nothing in this section shall prohibit an insurer, health maintenance organization, health services plan, or optometric services plan from accepting any other claims form.

B. No accident and sickness insurer, health maintenance organization, or health services plan licensed in the Commonwealth shall refuse to accept as a standard claims form for hospital services the standardized UB-82 claims form, or its successor as it may be amended from time to time. However, nothing in this section shall prohibit an accident and sickness insurer, health maintenance organization, or health services plan from accepting any other claims form.

C. No accident and sickness insurer, health maintenance organization, health services plan, or dental services plan licensed in the Commonwealth shall refuse to accept as a standard claims form for dental services the standardized ADA form prepared by the American Dental Association, or its successor as it may be amended from time to time. However, nothing in this section shall prohibit an accident and sickness insurer, health maintenance organization, health services plan, or dental services plan from accepting any other claims form.

D. The forms specified in this section may be modified as necessary to accommodate the transmission and administration of claims by electronic means.

E. After July 1, 1998, no health maintenance organization authorized to transact business in this Commonwealth and no health insurer, health services plan or preferred provider organization authorized to

offer health benefits in this Commonwealth that requires the use of the Physicians' Current Procedural Terminology (CPT) identifying codes published by the American Medical Association for reporting claims for medical services and procedures, including any standardized form, shall refuse to accept and utilize these identifying codes and any appropriate modifiers listed therein when the same are appropriately used for processing such claims for provider services and procedures.

1993, c. 307; 1997, c. 531.

§ 38.2-323. Repealed.

Repealed by Acts 2010, c. 337, cl. 1.

§ 38.2-324. Disclosure of property damage information.

Nothing in this title shall prohibit an insurer or its agent from disclosing information obtained from policyholders or other persons regarding claims or reports of property damage resulting from a natural disaster, as defined in clause (ii) of the definition of "disaster" in § 44-146.16, to the Director of the Department of Emergency Management or his designees or other state officials, to federal officials, or to local government officials of the locality where the damage occurred; provided that the disclosures (i) do not identify persons whose property is damaged or the address thereof and (ii) include only aggregated data that relates to the assessment of damage from a natural disaster, including, but not limited to, the number of claims, estimates of the dollar amount of damage, and types of damage, for a specified geographic area, such as a census tract or zip code area.

2005, c. 192; 2008, cc. 121, 157.

§ 38.2-325. Electronic delivery.

A. If parties have agreed to conduct business by electronic means, and the agent of record, if applicable, has been so notified by the insurer, any information that is required to be delivered in writing may be delivered by (i) placing such information within the body of the electronic message; (ii) placing such information as an attachment to the electronic message that may be opened through the use of software that is readily available; (iii) displaying the information, or a clear and conspicuous link to the information, as an essential step to completing the transaction to which the information relates; or (iv) placing such information on the insurer's secured server and an electronic message is provided advising that insurance information or, when appropriate, time-sensitive insurance information has been placed on the insurer's secured server and is available for retrieval. This section should be construed to be consistent with the Electronic Signatures in Global and National Commerce Act (15 U.S.C. § 7001 et seq.).

B. If parties have agreed to conduct business by electronic means, and notice is provided by the insurer to the named insured pursuant to § 38.2-231, 38.2-2113, 38.2-2114, 38.2-2208, or 38.2-2212, an electronic notification shall also be provided to the agent of record of the named insured, if the named insured has an agent of record. Such electronic notification shall be transmitted to the agent of record as soon as practicable, but in no case more than 72 hours after electronic notice is transmitted to the named insured.

C. The insurer shall retain evidence of electronic notification to the agent of record for at least one year from the date of transmittal. Failure to provide such notice to the agent of record shall not be deemed to invalidate any electronic notice otherwise properly provided to the named insured. For purposes of this section, an electronic notification to the agent of record shall mean a copy of the actual notice, as set forth herein, or in the alternative, shall include the named insured's name, policy number, and termination date. Electronic notice need not be given to the agent of record if the agent (i) is an employee of the insurer, (ii) is a non-employee exclusive agent of the insurer, or (iii) has waived the receipt of such notices in writing.

D. Notwithstanding any other provision of law, any property and casualty insurance forms and endorsements that do not contain personally identifiable information may be posted to the insurer's publicly available website in lieu of any other method of delivery, provided that:

1. Such forms and endorsements are readily accessible on the insurer's website and that once such forms or endorsements are no longer used in the Commonwealth they are stored in a readily accessible archive portion of the insurer's website;

2. Such forms and endorsements are posted in such a manner that they may be readily printed and downloaded without charge and without the use of any special program or application that is not readily available to the public without charge;

3. The insurer provides written notice at time of the issuance of the initial policy forms and any renewal forms of a method by which policyholders may obtain, upon request and without charge, a paper or electronic copy of their policy or contract; and

4. The insurer gives notice, in the manner it customarily communicates with a policyholder, of any changes to the forms or endorsements, and of the policyholder's right to obtain, upon request and without charge, a paper or electronic copy of such forms or endorsements.

E. The notification to an insurer of any change of the electronic address for the named insured shall be the sole responsibility of the named insured. The giving to the agent of record by any person of notice of such change of the named insured's electronic address shall not be deemed to be notice to the insurer unless it is specifically identified as a change and receipt has been accepted by the agent of record.

F. Notwithstanding any other provision of law, any evidence of coverage or other forms that do not contain personally identifiable information that a health carrier is required to provide to a policyholder, subscriber, or enrollee may be delivered electronically to the policyholder, subscriber, or enrollee or posted to the health carrier's publicly available website in lieu of any other method of delivery, provided that:

1. Such evidence of coverage and endorsements, riders, or amendments to it are readily accessible on the health carrier's website and that once such evidence of coverage and endorsements, riders, or

amendments to it are no longer used in the Commonwealth they will be made available electronically upon request;

2. Such evidence of coverage and endorsements, riders, or amendments to it are posted in such a manner that they may be readily printed and downloaded without charge and without the use of any special program or application that is not readily available to the public without charge;

3. The health carrier provides written notice at the time of the issuance of the initial evidence of coverage and any renewals of a method by which the policyholder, subscriber, or enrollee may obtain, upon request and without charge, a paper or electronic copy of such person's evidence of coverage or endorsements, riders, or amendments to it; and

4. The health carrier gives notice, in the manner in which it customarily communicates with a policyholder, subscriber, or enrollee, of any changes to the evidence of coverage or endorsements, riders, or amendments to it and of the right of such policyholder, subscriber, or enrollee to obtain a paper or electronic copy of such evidence of coverage or endorsements, riders, or amendments to it.

2009, c. 215; 2012, c. 293; 2013, c. 257; 2016, c. 475.

§ 38.2-326. Plan management functions.

A. As used in this section:

"Exchange" means either the (i) federal health benefit exchange established by the Secretary of the U.S. Department of Health and Human Services pursuant to § 1321 of the Patient Protection and Affordable Care Act codified as 42 U.S.C. § 18041(c) in the Commonwealth or (ii) state-based exchange established pursuant to Chapter 65 (§ 38.2-6500 et seq.) and § 1311(b) of the Patient Protection and Affordable Care Act codified as 42 U.S.C. § 18031.

"Plan management functions" means analyses and reviews necessary to support the certification, decertification, and recertification of qualified health plans and stand-alone dental plans for the participation in an exchange and the collection of data necessary to perform the above functions.

B. The Commission's Bureau of Insurance, with the assistance of the Virginia Department of Health, shall perform plan management functions required to certify health benefit plans and stand-alone dental plans for participation in the exchange, provided that: (i) full funding is available; (ii) the technology infrastructure, including integration with federal, state, and other necessary entities, is made available to the Commission in order for it to carry out the plan management functions authorized in this section; and (iii) there are no other impediments that effectively prevent the Commission from performing any required plan management functions.

C. The Commission's Bureau of Insurance may contract and enter into memoranda of understanding to carry out its plan management functions.

D. The Commission shall not use any special fund revenues dedicated to its other functions and duties unrelated to exchange operations, including revenues from utility consumer taxes or fees from

licensees or registrants regulated by the Commission or fees paid to the Clerk's Office, to fund the plan management functions.

E. Technology resources provided by the Commission in carrying out the plan management functions shall be limited to existing Commission technology support functions such as desktop support, network administration support, web services support, or other similar support functions.

F. The Commission shall make available to the public on its website a written report on the implementation and performance of its plan management functions during the preceding fiscal year, including, at a minimum, the manner in which all funds utilized for its plan management functions were expended.

2013, cc. 670, 679; 2020, cc. 916, 917.

Chapter 4 - Assessment for Administration of Insurance Laws and Declarations of Estimated Assessments by Insurers

§ 38.2-400. Expense of administration of insurance laws borne by licensees; minimum contribution.

A. The expense of maintaining the Bureau of the Commission responsible for administering the insurance laws of this Commonwealth, including a reasonable margin in the nature of a reserve fund, shall be assessed annually by the Commission against all companies and surplus lines brokers subject to this title except premium finance companies and providers of continuing care registered pursuant to Chapter 49 (§ 38.2-4900 et seq.) of this title. The assessment shall be in proportion to the direct gross premium income on business done in this Commonwealth. The assessment shall not exceed one-tenth of one percent of the direct gross premium income and shall be levied pursuant to § 38.2-403. For any year a company is subject to an assessment, the assessment shall not be less than $300.

B. All fees assessed under any provision of this title and paid into the state treasury shall be deposited to a special fund designated "Bureau of Insurance Special Fund -- State Corporation Commission," and out of such special fund and the unexpended balance thereof shall be appropriated the sums necessary for the regulation, supervision and examination of all entities subject to regulation under this title. Any references in the Code of Virginia to funds being paid directly into the state treasury and credited to the fund for the maintenance of the Bureau of Insurance shall hereinafter mean the "Bureau of Insurance Special Fund -- State Corporation Commission."

Code 1950, § 38-17; 1952, c. 317, § 38.1-44; 1954, c. 231; 1960, c. 294; 1977, cc. 317, 613; 1978, c. 4; 1981, c. 605; 1986, c. 562; 1987, cc. 558, 565, 655; 1994, c. 316.

§ 38.2-401. Fire Programs Fund.

A. 1. There is hereby established in the state treasury a special nonreverting fund to be known as the Fire Programs Fund, hereinafter referred to as "the Fund." The Fund shall be administered by the Department of Fire Programs under policies and definitions established by the Virginia Fire Services Board. All moneys collected pursuant to the assessment made by the Commission pursuant to subdivision 2 of this subsection shall be paid into the state treasury and credited to the Fund. The Fund

shall also consist of any moneys appropriated thereto by the General Assembly and any grants or other moneys received by the Virginia Fire Services Board or Department of Fire Programs for the purposes set forth in this section. Any moneys deposited to or remaining in such Fund during or at the end of each fiscal year or biennium, including interest thereon, shall not revert to the general fund but shall remain in the Fund. Interest earned on all moneys in the Fund and interest earned on moneys held by the Commission pursuant to subdivision 2 of this subsection prior to the deposit of such moneys into the Fund, including interest earned on such moneys during any period when the Commission is reconciling payments from insurers, shall remain in or be deposited into the Fund, as the case may be, and be credited to it. Such interest shall be set aside for fire service purposes in accordance with policies developed by the Virginia Fire Services Board. Notwithstanding any other provision of law to the contrary, policies established by the Virginia Fire Services Board for the administration of the Fund, and any grants provided from the Fund, that are not inconsistent with the purposes set out in this section shall be binding upon any locality that accepts such funds or related grants. The Commission shall be reimbursed from the Fund for all expenses necessary for the administration of this section. The balance of moneys in the Fund shall be allocated periodically as provided in this section. Expenditures and disbursements from the Fund shall be made by the State Treasurer on warrants issued by the Comptroller upon written request signed by the Executive Director of the Department of Fire Programs (Director) or his designee.

2. The Commission shall annually assess against all licensed insurance companies doing business in the Commonwealth by writing any type of insurance as defined in §§ 38.2-110, 38.2-111, 38.2-126, 38.2-130 and 38.2-131 and those combination policies as defined in § 38.2-1921 that contain insurance as defined in §§ 38.2-110, 38.2-111 and 38.2-126, an assessment in the amount of one percent of the total direct gross premium income for such insurance. Such assessment shall be apportioned, assessed and paid as prescribed by § 38.2-403. In any year in which a company has no direct gross premium income or in which its direct gross premium income is insufficient to produce at the rate of assessment prescribed by law an amount equal to or in excess of $100, there shall be so apportioned and assessed against such company a contribution of $100.

B. After reserving funds for the Fire Services Grant Program and Dry Fire Hydrant Grant Program pursuant to subsection D, 75 percent of the remaining moneys available for allocation from the Fund shall be allocated to the several counties, cities, and towns of the Commonwealth providing fire service operations to be used for the improvement of volunteer and career fire services in each of the receiving localities. Funds allocated to the counties, cities, and towns pursuant to this subsection shall not be used directly or indirectly to supplant or replace any other funds appropriated by the counties, cities, and towns for fire service operations. Such funds shall be used solely for the purposes of (i) training volunteer or career firefighting personnel in each of the receiving localities; (ii) funding fire prevention and public safety education programs; (iii) constructing, improving, and expanding regional or local fire service training facilities; (iv) purchasing emergency medical care and equipment for fire personnel; (v) payment of personnel costs related to fire and medical training for fire personnel; (vi)

purchasing personal protective equipment, vehicles, equipment, and supplies for use in the receiving locality specifically for fire service purposes; or (vii) providing training and education and purchasing products, including personal protective equipment, diesel exhaust removal systems, decontamination equipment, and commercial extractors, that are designed to reduce the incidence of cancer among firefighters. Notwithstanding any other provision of the Code, when localities use such funds to construct, improve, or expand fire service training facilities, fire-related training provided at such training facilities shall be by instructors certified or approved according to policies developed by the Virginia Fire Services Board. Distribution of this 75 percent of the Fund shall be made on the basis of population as provided for in §§ 4.1-116 and 4.1-117; however, no county or city eligible for such funds shall receive less than $10,000, nor eligible town less than $4,000. The Virginia Fire Services Board shall be authorized to exceed allocations of $10,000 for eligible counties and cities and $4,000 for eligible towns, respectively. Allocations to counties, cities, and towns receiving such allocations shall be fair and equitable as set forth in Board policy. Any increases or decreases in such allocations shall be uniform for all localities. In order to remain eligible for such funds, each receiving locality shall report annually to the Department on the use of the funds allocated to it for the previous year and shall provide a completed Fire Programs Fund Disbursement Agreement form. Each receiving locality shall be responsible for certifying the proper use of the funds. If, at the end of any annual reporting period, a satisfactory report and a completed agreement form have not been submitted by a receiving locality, any funds due to that locality for the next year shall not be retained. Such funds shall be added to the 75 percent of the Fund allocated to the counties, cities, and towns of the Commonwealth for improvement of fire services in localities.

C. The remainder of the moneys available for allocation from the Fund shall be used for (i) the purposes of carrying out the powers and duties assigned to the Department of Fire Programs under Chapter 2 (§ 9.1-200) of Title 9.1, which shall include providing funded training and administrative support services for nonfunded training to localities and (ii) the payment of the compensation and costs of expenses of the members of the Fire Services Board in performing their official duties; however, the Fund shall not be used for salaries or operating expenses associated with the Office of the State Fire Marshal.

D. The Fire Services Grant Program is hereby established and will be used as grants to provide regional fire services training facilities, to finance the Virginia Fire Incident Reporting System and to build or repair live fire training structures as determined by the Virginia Fire Services Board. Beginning January 1, 1996, $1 million from the assessments made pursuant to this section shall be distributed each year for the Fire Services Grant Program to be used as herein provided, and $100,000 shall be distributed annually for continuing the statewide Dry Fire Hydrant Grant Program. Moneys allocated pursuant to this subsection shall be used for the purposes stated in this subsection, and for no other purpose. All grants provided from these programs shall be administered by the Department according to the policies established by the Virginia Fire Services Board.

E. Moneys in the Fund shall not be diverted or expended for any purpose not authorized by this section.

F. The Director shall establish written standards for determining the extent to which clients outside the Commonwealth shall be financially responsible for the cost of fire and emergency services training provided by the Department of Fire Programs. Revenues generated by such training shall be retained in the Fire Programs Fund and may be used solely for providing additional funded direct training to members of Virginia's fire and emergency services.

1985, c. 545, § 38.1-44.1; 1986, cc. 60, 562; 1988, c. 336; 1995, cc. 615, 637; 1997, c. 791; 1998, cc. 166, 877; 2000, c. 820; 2001, cc. 397, 413; 2002, c. 389; 2004, c. 164; 2006, cc. 58, 322; 2007, cc. 647, 741; 2018, c. 649; 2019, c. 509.

§ 38.2-401.1. Dam Safety, Flood Prevention and Protection Assistance Fund assessment.

The Commission shall annually assess against all licensed insurance companies doing business in this Commonwealth by writing any type of flood insurance an assessment in the amount of one percent of the total direct gross premium income for such insurance. Such assessment shall be apportioned, assessed, and paid as prescribed by § 38.2-403. In any year in which a company has no direct gross premium income from flood insurance or in which its direct gross premium income from flood insurance is insufficient to produce at the rate of assessment prescribed by law an amount equal to or in excess of $100, there shall be so apportioned and assessed against such company a contribution of $100. One hundred percent of the total amount collected annually pursuant to this section shall be paid into the Dam Safety, Flood Prevention and Protection Assistance Fund established per § 10.1-603.17. The assessment established by this section shall not apply to premium income for policies written pursuant to the National Flood Insurance Act of 1968 or for policies providing comprehensive motor vehicle insurance coverage.

1990, c. 916; 2006, cc. 648, 765.

§ 38.2-402. Definitions.

As used in this chapter:

"Assessable year" means the calendar year upon which the direct gross premium income is computed under this chapter. In the case of direct gross premium income for a fraction of a calendar year, the term includes the period in which that direct gross premium income is received or derived from business in this Commonwealth.

"Direct gross premium income" means direct gross premium as defined in § 58.1-2500.

"License year" means the 12-month period beginning on July 1 next succeeding the assessable year and ending on June 30 of the subsequent year. This shall also be the year in which annual reports of direct gross premium income are required to be filed under § 38.2-406 and the annual assessment paid under the provisions of this chapter.

1977, c. 317, §§ 38.1-48.1, 38.1-48.2; 1978, c. 4; 1986, c. 562; 1996, c. 22; 2012, c. 584.

§ 38.2-403. Assessment for expenses.

The Commission shall assess each company annually for its just share of expenses. The assessment shall be in proportion to direct gross premium income for the year immediately preceding that for which the assessment is made. The Commission shall give the companies notice of the assessment which shall be paid to the Commission on or before March 1 of each year for deposit into the state treasury as provided in subsection B of § 38.2-400. Any company that fails to pay the assessment on or before the date herein prescribed shall be subject to a penalty imposed by the Commission. The penalty shall be ten percent of the assessment and interest shall be charged at a rate pursuant to § 58.1-1812 for the period between the due date and the date of full payment. If a payment is made in an amount later found to be in error, the Commission shall, (i) if an additional amount is due, notify the company of the additional amount and the company shall pay the additional amount within fourteen days of the date of the notice or, (ii) if an overpayment is made, process a refund.

Code 1950, § 38-18; 1952, c. 317, § 38.1-45; 1977, c. 317; 1978, c. 4; 1986, c. 562; 1994, c. 316; 2012, c. 584; 2017, c. 39.

§ 38.2-403.1. Omitted assessments.

If the Commission ascertains that any assessment that could have been assessed during any current assessable year has not been assessed for any assessable year of the three years last past, or that the same has been assessed at less than the law required for any one or more of such years, or that the assessment, for any cause, has not been realized, the Commission shall list and assess the same at the rate prescribed for that year, adding thereto a penalty of 10 percent and interest at the rate established pursuant to § 58.1-1812 which shall be computed upon the assessment from the due date of the assessment until the assessment is paid.

2016, c. 193.

§ 38.2-404. Recovery of such assessments; revocation or suspension of license.

If an assessment made under § 38.2-403 is not paid to the Commission by the prescribed date, the amount of the assessment, penalty, and interest may be recovered from the defaulting company on motion of the Commission made in the name and for the use of the Commonwealth in the appropriate circuit court after ten days' notice to the company. The license or certificate of authority of any defaulting company to transact business in this Commonwealth may be revoked or suspended by the Commission until it has paid such assessment.

Code 1950, § 38-19; 1952, c. 317, § 38.1-46; 1978, c. 4; 1986, c. 562.

§ 38.2-405. Application for correction of assessment.

Any corporation aggrieved by the assessment assessed or imposed by or under authority of this chapter and collected from any corporation, domestic or foreign, may, within one year from the date of the payment of such assessment, apply to the Commission for a refund, in whole or in part, of the amount so assessed or imposed and paid. No payment shall be recovered after a formal adjudication in a proceeding in which the right of appeal existed and was not taken. Such application shall be by

written petition, in duplicate and verified by affidavit. Such application shall be filed with the Commission and shall set forth the names and addresses of every party in interest.

Code 1950, § 38-20; 1952, c. 317, § 38.1-47; 1978, c. 4; 1986, c. 562; 2016, c. 193.

§ 38.2-406. Report of gross premium income.

Each company subject to assessment under this chapter shall, on or before March 1 of each year, report under oath to the Commission, upon forms to be furnished or approved by, and in such detail as may be prescribed by, the Commission, the direct gross premium income derived from its business in this Commonwealth during the preceding year ending December 31. Every company failing to file the assessment report on or before March 1 shall be subject to a penalty of $50 for each day after the report is due. If such failure is due to providential or other good cause shown to the satisfaction of the Commission, such report may be accepted exclusive of penalties.

Code 1950, § 38-21; 1952, c. 317, § 38.1-48; 1977, c. 317; 1978, c. 4; 1986, c. 562; 2003, c. 371; 2012, c. 584.

§§ 38.2-407 through 38.2-411. Repealed.

Repealed by Acts 2012, c. 584, cl. 2.

§ 38.2-412. Companies going out of business.

If a company goes out of business or ceases to be a company in this Commonwealth in any assessable or license year, the company shall remain liable for the payment of the assessment measured by direct gross premium income for the period in which it operated as a company and received or derived direct gross premium income from business in this Commonwealth.

1977, c. 317, § 38.1-48.7; 1986, c. 562.

§ 38.2-413. Double assessment respecting same direct gross premium income negated.

This chapter shall not be construed to require including any direct gross premium income used previously in calculating the assessment imposed by this chapter for any license year or fraction thereof, and the assessment paid thereon.

1977, c. 317, § 38.1-48.9; 1986, c. 562.

§ 38.2-414. Assessments to fund program to reduce losses from motor vehicle thefts.

A. To provide funds to establish and operate a statewide program to receive and reward information leading to the arrest of persons who commit motor vehicle theft-related crimes in Virginia, each insurer licensed to write insurance coverage as defined in § 38.2-124 shall, prior to March 1 of each year, pay an assessment equal to one-quarter of one percent of the total direct gross premium income for automobile physical damage insurance other than collision written in the Commonwealth during the preceding calendar year.

B. Assessments received pursuant to subsection A of this section, and all other moneys received by the Commission for the same purpose, shall be segregated and placed in a fund to be known as the Help Eliminate Automobile Theft Fund, hereinafter referred to as the HEAT Fund.

C. Any insurer that fails to pay the assessment on or before the date prescribed in subsection A shall be subject to a penalty imposed by the Commission. The penalty shall be ten percent of the assessment and interest shall be charged at a rate pursuant to § 58.1-1812 for the period between the date due and the date of full payment. If a payment is made in an amount later found to be in error, the Commission shall, (i) if an additional amount is due, notify the insurer of the additional amount, which the insurer shall pay within fourteen days of the date of the notice or, (ii) if an overpayment is made, order a refund of the amount of the overpayment, which shall be paid out of the HEAT Fund. The Commission shall be reimbursed from the Fund for all expenses necessary for the administration of this section.

D. The HEAT Fund shall be controlled and administered by the Superintendent of the Department of State Police. The Superintendent shall appoint an advisory committee of seven members to assist in developing and annually reviewing the plan of operation for the HEAT Fund program.

E. Money in the HEAT Fund shall be expended as follows:

1. To pay the costs of establishing and operating a program to receive and reward information leading to the arrest of persons who commit motor vehicle theft-related crimes in Virginia.

2. Any uncommitted funds remaining in the HEAT Fund on the last day of February of each year may be transferred to the Department of State Police, Department of Motor Vehicles, or Department of Criminal Justice Services for the following purposes: (i) providing financial support to state or local law-enforcement agencies for motor vehicle theft enforcement efforts, (ii) providing financial support to local prosecutors or judicial agencies for programs designed to reduce the incidence of motor vehicle theft, and (iii) conducting educational programs to inform vehicle owners of methods of preventing motor vehicle theft.

1991, c. 318; 1993, c. 196.

§ 38.2-415. Assessment to fund program to reduce losses from insurance fraud.

A. Each licensed insurer doing business in the Commonwealth by writing any type of insurance as defined in §§ 38.2-110 through 38.2-122.2 and 38.2-124 through 38.2-132 shall pay, in addition to any other assessments provided in this title, an assessment in an amount equal to 0.05 of one percent of the direct gross premium income during the preceding calendar year. The assessment shall be apportioned and assessed and paid as prescribed by § 38.2-403. The Commission shall be reimbursed from the fund for all necessary expenses for the administration of this section.

B. The assessments made by the Commission under subsection A and paid into the state treasury shall be deposited to a special fund designated "Virginia State Police, Insurance Fraud," and out of such special fund and the unexpended balance thereof shall be appropriated the sums necessary for accomplishing the powers and duties assigned to the Virginia State Police under Chapter 9 (§ 52-36 et seq.) of Title 52. All interest earned from the deposit of moneys accumulated in the Fund shall be deposited in the Fund for the same use.

C. The moneys deposited in the Fund shall not be considered general revenue of the Commonwealth but shall be used only to (i) effectuate the purposes enumerated in Chapter 9 (§ 52-36 et seq.) of Title 52 and (ii) reimburse the Commission for its necessary expenses for the administration of this section. The Fund shall be subject to audit by the Auditor of Public Accounts.

D. In the event that the Insurance Fraud Investigation Unit is dissolved by operation of law or otherwise, any balance remaining in the Fund, after deducting administrative costs associated with the dissolution, shall be returned to insurers in proportion to their financial contributions to the Fund in the preceding calendar year.

1998, c. 590; 1999, c. 483; 2000, c. 526.

Chapter 5 - UNFAIR TRADE PRACTICES

§ 38.2-500. Declaration of purpose.

The purpose of this chapter is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the McCarran-Ferguson Act, 15 U.S.C. §§ 1011 through 1015, by defining and prohibiting all practices in this Commonwealth that constitute unfair methods of competition or unfair or deceptive acts or practices.

1952, c. 317, § 38.1-49; 1986, c. 562.

§ 38.2-501. Definitions.

As used in this chapter:

"Insurance policy" or "insurance contract" includes annuities and any group or individual contract, certificate, or evidence of coverage, including, but not limited to, those issued by a health services plan, health maintenance organization, legal services organization, legal services plan, or dental or optometric services plan as provided for in Chapters 42 (§ 38.2-4200 et seq.), 43 (§ 38.2-4300 et seq.), 44 (§ 38.2-4400 et seq.) and 45 (§ 38.2-4500 et seq.) of this title issued, proposed for issuance, or intended for issuance, by any person.

"Lending institution" means any corporation, company or organization that accepts deposits from the public and lends money in this Commonwealth, including banks and savings institutions.

"Person," in addition to the definition in Chapter 1 (§ 38.2-100 et seq.) of this title, extends to any other legal entity transacting the business of insurance, including agents, brokers and adjusters. "Person" also means health, legal, dental, and optometric service plans and health maintenance organizations, as provided for in Chapters 42, 43, 44 and 45 of this title. For the purposes of this chapter, such service plans shall be deemed to be transacting the business of insurance. "Person" also means premium finance companies.

1952, c. 317, § 38.1-50; 1977, c. 529; 1980, c. 404; 1986, c. 562; 1989, c. 653; 1992, c. 7; 2001, c. 707.

§ 38.2-502. Misrepresentations and false advertising of insurance policies.

No person shall make, issue, circulate, cause or knowingly allow to be made, issued or circulated, any estimate, illustration, circular, statement, sales presentation, omission, or comparison that:

1. Misrepresents the benefits, advantages, conditions or terms of any insurance policy;

2. Misrepresents the dividends or share of the surplus to be received on any insurance policy;

3. Makes any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy;

4. Misrepresents or is misleading as to the financial condition of any person or the legal reserve system upon which any life insurer operates;

5. Uses any name or title of any insurance policy or class of insurance policies that misrepresents the true nature of the policy or policies;

6. Misrepresents any material fact for the purpose of inducing or tending to induce the lapse, forfeiture, exchange, conversion, replacement, or surrender of any insurance policy;

7. Misrepresents any material fact for the purpose of effecting a pledge, assignment, or loan on any insurance policy; or

8. Misrepresents any insurance policy as being a share of stock.

Code 1950, § 38.1-52; 1952, c. 317, § 38.1-52.1; 1977, c. 529; 1978, c. 441; 1979, c. 324; 1980, c. 404; 1986, c. 562; 1990, c. 265.

§ 38.2-503. False information and advertising generally.

No person shall knowingly make, publish, disseminate, circulate, or place before the public, or cause or knowingly allow, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, representation or statement relating to (i) the business of insurance or (ii) any person in the conduct of his insurance business, which is untrue, deceptive or misleading.

Code 1950, § 38.1-52; 1952, c. 317, § 38.1-52.2; 1977, c. 529; 1978, c. 441; 1979, c. 324; 1980, c. 404; 1986, c. 562.

§ 38.2-504. Defamation.

No person shall make, publish, disseminate, or circulate, directly or indirectly, or aid, abet or encourage the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature that is false, and maliciously critical of, or derogatory to, any person with respect to the business of insurance or with respect to any person in the conduct of his insurance business and that is calculated to injure that person.

Code 1950, § 38.1-52; 1952, c. 317, § 38.1-52.3; 1977, c. 529; 1978, c. 441; 1979, c. 324; 1980, c. 404; 1986, c. 562.

§ 38.2-505. Boycott, coercion and intimidation.

No person shall enter into any agreement to commit, or by any concerted action commit, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.

Code 1950, § 38.1-52; 1952, c. 317, § 38.1-52.4; 1977, c. 529; 1978, c. 441; 1979, c. 324; 1980, c. 404; 1986, c. 562.

§ 38.2-506. False statements and entries.

No person shall:

1. Knowingly file with any supervisory or other public official, or knowingly make, publish, disseminate, circulate, or deliver to any person, or place before the public, or knowingly cause, directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false material statement of fact as to the financial condition of a person; or

2. Knowingly make any false entry of a material fact in any book, report or statement of any person or knowingly fail to make a true entry of any material fact pertaining to the business of any person in any book, report or statement of that person.

Code 1950, § 38.1-52; 1952, c. 317, § 38.1-52.5; 1977, c. 529; 1978, c. 441; 1979, c. 324; 1980, c. 404; 1986, c. 562.

§ 38.2-507. Stock operations and advisory board contracts.

No person shall issue or deliver or permit agents, officers, or employees to issue or deliver capital stock, benefit certificates or shares in any corporation, securities, any special or advisory board contracts or any contract promising returns and profits as an inducement to insurance.

Code 1950, § 38.1-52; 1952, c. 317, § 38.1-52.6; 1977, c. 529; 1978, c. 441; 1979, c. 324; 1980, c. 404; 1986, c. 562.

§ 38.2-508. Unfair discrimination.

No person shall:

1. Unfairly discriminate or permit any unfair discrimination between individuals of the same class and equal expectation of life (i) in the rates charged for any life insurance or annuity contract, or (ii) in the dividends or other benefits payable on the contract, or (iii) in any other of the terms and conditions of the contract;

2. Unfairly discriminate or permit any unfair discrimination between individuals of the same class and of essentially the same hazard (i) in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance, (ii) in the benefits payable under such policy or contract, (iii) in any of the terms or conditions of such policy or contract, or (iv) in any other manner;

3. Refuse to insure, refuse to continue to insure, or limit the amount, extent or kind of insurance coverage available to an individual, or charge an individual a different rate for the same coverage solely because of blindness, or partial blindness, or mental or physical impairments, unless the refusal,

limitation or rate differential is based on sound actuarial principles. This paragraph shall not be interpreted to modify any other provision of law relating to the termination, modification, issuance or renewal of any insurance policy or contract;

4. Unfairly discriminate or permit any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, cancelling or limiting the amount of insurance coverage solely because of the geographic location of the individual or risk, unless:

a. The refusal, cancellation or limitation is for a business purpose that is not a mere pretext for unfair discrimination; or

b. The refusal, cancellation or limitation is required by law or regulatory mandate;

5. Make or permit any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, cancelling or limiting the amount of insurance coverage on a residential property risk, or the personal property contained in a residential property risk, solely because of the age of the residential property, unless:

a. The refusal, cancellation or limitation is for a business purpose that is not a mere pretext for unfair discrimination; or

b. The refusal, cancellation or limitation is required by law or regulatory mandate;

6. Refuse to issue or renew any individual accident and sickness insurance policy or contract for coverage over and above any lifetime benefit of a group accident and sickness policy or contract solely because an individual is insured under a group accident and sickness insurance policy or contract, provided that medical expenses covered by both individual and group coverage shall be paid first by the group policy or contract to the extent of the group coverage;

7. Consider the status of a victim of domestic violence as a criterion in any decision with regard to insurance underwriting, pricing, renewal, scope of coverage, or payment of claims on any and all insurance defined in § 38.2-100 and further classified in Article 2 (§ 38.2-101 et seq.) of Chapter 1 of this title, other than (i) legal services plans as provided for in Chapter 44 (§ 38.2-4400 et seq.) of this title and (ii) the insurance classified in §§ 38.2-110 through 38.2-133. The term "domestic violence" means the occurrence of one or more of the following acts by a current or former family member, household member as defined in § 16.1-228, person against whom the victim obtained a protective order or caretaker:

a. Attempting to cause or causing or threatening another person physical harm, severe emotional distress, psychological trauma, rape or sexual assault;

b. Engaging in a course of conduct or repeatedly committing acts toward another person, including following the person without proper authority, under circumstances that place the person in reasonable fear of bodily injury or physical harm;

c. Subjecting another person to false imprisonment; or

d. Attempting to cause or causing damage to property so as to intimidate or attempt to control the behavior of another person.

Nothing in this subsection shall prohibit an insurer or insurance professional from asking about a medical condition or from using medical information to underwrite or to carry out its duties under an insurance policy even if the medical information is related to a medical condition that the insurer or insurance professional knows or has reason to know resulted from domestic violence, to the extent otherwise permitted under this section and other applicable law; or

8. Refuse to insure, refuse to continue to insure, or limit the amount or extent of life insurance, disability insurance, or long-term care insurance coverage available to an individual or charge an individual a different rate for the same coverage based solely and without any additional actuarial risks upon the status of such individual as a living organ donor. For the purposes of this subdivision, "living organ donor" means a living individual who donates one or more of such individual's human organs, including bone marrow, to be medically transplanted into the body of another individual.

Code 1950, § 38.1-52; 1952, c. 317, § 38.1-52.7; 1977, c. 529; 1978, c. 441; 1979, c. 324; 1980, c. 404; 1986, c. 562; 1993, c. 130; 2001, c. 34; 2013, cc. 136, 210; 2022, c. 649.

§ 38.2-508.1. Unfair discrimination; members of the armed forces.

A. No person shall refuse to issue or refuse to continue a life insurance policy on the life of any member of the United States Armed Forces, the Reserves of the United States Armed Forces or the National Guard due to (i) their status as a member of any such military organization or (ii) their duty assignment while a member of any such military organization.

B. In circumstances where an individual's or family member's coverage under a group life or group health insurance policy or contract was terminated due to such individual's status as a member of the United States Armed Forces, the Reserves of the United States Armed Forces or the National Guard, no person shall refuse to reinstate such coverage, regardless of continuation, renewal, reissue or replacement of the group insurance policy, upon the occurrence of the individual's return to eligibility status under the policy or contract. Such reinstated coverage shall not contain any new preexisting condition or other exclusions or limitations except that the remainder of a preexisting condition requirement that was not satisfied prior to termination of the individual's coverage resulting from such military status may be applied once the individual returns and coverage under the group policy is reinstated.

C. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

1991, cc. 663, 678; 2013, c. 751.

§ 38.2-508.2. Discrimination prohibited.

No person shall refuse to issue or refuse to continue a life insurance policy on the life of any individual solely because of that individual's race, color, sexual orientation, gender identity, religion, national origin, or sex.

1993, c. 152; 2020, c. 1137.

§ 38.2-508.3. Consideration of Medicaid eligibility prohibited.

A. No person shall, in determining the eligibility of an individual for coverage under an individual or group accident and sickness policy, health services plan or health maintenance organization contract, consider the eligibility of such individual for medical assistance ("Medicaid") from this Commonwealth or from any other state.

B. No person shall, in determining benefits payable to, or on behalf of an individual covered under an individual or group accident and sickness policy, health services plan or health maintenance organization contract, take into account the eligibility of such individual for medical assistance ("Medicaid") from this Commonwealth or from any other state.

1994, c. 213.

§ 38.2-508.4. Genetic information privacy.

A. As used in this section:

"Genetic characteristic" means any scientifically or medically identifiable gene or chromosome, or alteration thereof, which is known to be a cause of a disease or disorder, or determined to be associated with a statistically increased risk of development of a disease or disorder, and which is asymptomatic of any disease or disorder.

"Genetic information" means information about genes, gene products, or inherited characteristics that may derive from an individual or a family member.

"Genetic test" means a test for determining the presence or absence of genetic characteristics in an individual in order to diagnose a genetic characteristic.

B. No person proposing to issue, re-issue, or renew any policy, contract, or plan of accident and sickness insurance defined in § 38.2-109, but excluding disability income insurance, issued by any (i) insurer providing hospital, medical and surgical or major medical coverage on an expense incurred basis, (ii) corporation providing a health services plan, or (iii) health maintenance organization providing a health care plan for health care services shall, on the basis of any genetic information obtained concerning an individual or on the individual's request for genetic services, with respect to such policy, contract, or plan:

1. Terminate, restrict, limit, or otherwise apply conditions to coverage of an individual or restrict the sale to an individual;

2. Cancel or refuse to renew the coverage of an individual;

3. Exclude an individual from coverage;

4. Impose a waiting period prior to commencement of coverage of an individual;

5. Require inclusion of a rider that excludes coverage for certain benefits and services; or

6. Establish differentials in premium rates for coverage.

In addition, no discrimination shall be made in the fees or commissions of an agent or agency for an enrollment, a subscription, or the renewal of an enrollment or subscription of any person on the basis of a person's genetic characteristics which may, under some circumstances, be associated with disability in that person or that person's offspring.

C. Notwithstanding any other provisions of law, all information obtained from genetic screening or testing conducted prior to the repeal of this section shall be confidential and shall not be made public nor used in any way, in whole or in part, to cancel, refuse to issue or renew, or limit benefits under any policy, contract or plan subject to the provisions of this section.

1996, c. 704.

§ 38.2-508.5. Re-underwriting individual under existing group or individual accident and sickness insurance policy prohibited; exceptions.

A. No premium increase, including a reduced premium increase in the form of a discount, may be implemented for an insured individual under existing individual health insurance coverage as defined in subsection B of § 38.2-3431 subsequent to the initial effective date of coverage under such policy or certificate to the extent that such premium increase is determined based upon: (i) a change in a health-status-related factor of the individual insured as defined in subsection B of § 38.2-3431 or (ii) the past or prospective claim experience of the individual insured.

B. No reduction in benefits may be implemented for an insured individual under existing individual health insurance coverage as defined in subsection B of § 38.2-3431 subsequent to the initial effective date of coverage under such policy or certificate to the extent that such reduction in benefits is determined based upon: (i) a change in a health-status-related factor of the individual insured as defined in subsection B of § 38.2-3431 or (ii) the past or prospective claim experience of the individual insured.

C. No modifications to contractual terms and conditions may be implemented for an insured individual under existing individual health insurance coverage as defined in subsection B of § 38.2-3431 subsequent to the initial effective date of coverage under such policy or certificate to the extent that such modifications to contractual terms and conditions are determined based upon: (i) a change in a health-status-related factor of the individual insured as defined in subsection B of § 38.2-3431 or (ii) the past or prospective claim experience of the individual insured.

D. This section shall not prohibit adjustments to premium, rescission of, or amendments to the insurance contract in the following circumstances:

1. When an insurer learns of information subsequent to issuing the policy or certificate that was not disclosed in the underwriting process and that, had it been known, would have resulted in a higher premium level or denial of coverage. Any adjustment to premium or rescission of coverage made for this reason may be made only to extent that it would have been made had the information been disclosed in the application process, and shall not be imposed beyond any period of incontestability, or beyond any time period proscribing an insurer from asserting defenses based upon misstatements in

applications, as otherwise may be provided by applicable law. Any such rescission shall be consistent with § 38.2-3430.3 regarding guaranteed availability.

2. When an insurer provides a lifestyle-based good health discount based upon an individual's adherence to a healthy lifestyle and this discount is not based upon a specific health condition or diagnosis.

3. When an insurer removes waivers or riders attached to the policy at issue that limit coverage for specific named pre-existing medical conditions.

E. For purposes of this section, re-underwriting means the reevaluation of any health-status-related factor of an individual for purposes of adjusting premiums, benefits or contractual terms as provided in subsections A, B, and C.

F. The provisions of this section shall not apply to individual health insurance coverage issued to members of a bona fide association, as defined in subsection B of § 38.2-3431, where coverage is available to all members of the association and eligible dependents of such members without regard to any health-status-related factor.

G. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

2003, c. 699; 2011, c. 882.

§ 38.2-509. Rebates.

A. Except as otherwise expressly provided by law, no person shall:

1. Knowingly permit, offer, or make any insurance or annuity contract or agreement which is not plainly expressed in the contract issued;

2. Pay, allow or give, or offer to pay, allow or give, directly or indirectly, as inducement to any insurance or annuity contract, any rebate of premium payable on the contract, any special favor or advantage in the dividends or other benefits on the contract, any valuable consideration or inducement not specified in the contract, except in accordance with an applicable rating plan authorized for use in this Commonwealth;

3. Give, sell, purchase, or offer to give, sell or purchase as inducement to insurance, or annuity contracts, or in connection with such contracts, any stocks, bonds, or other securities of any company, any dividends or profits accrued on any stocks, bonds or other securities of any company, or anything of value not specified in the contract; or

4. Receive or accept as inducement to insurance, or annuity contracts, any rebate of premium payable on the contract, any special favor or advantage in the dividends or other benefit to accrue on the contract, or any valuable consideration or inducement not specified in the contract.

B. Nothing in § 38.2-508 or in this section shall be construed to include within the definition of discrimination or rebates any of the following practices:

1. In the case of any life insurance or annuity contract, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance if the bonuses or abatement of premiums are fair and equitable to policyholders and in the best interests of the insurer and its policyholders;

2. In the case of life or accident and sickness insurance policies issued on the industrial debit plan, making allowance to policyholders who, for a specified period, have continuously made premium payments directly to an office of the insurer in an amount that fairly represents the savings in collection expense;

3. Readjustment of the rate of premium for a group insurance policy based on the loss or expense experience under the policy, at the end of the first or any subsequent policy year of insurance;

4. In the case of insurers, allowing their bona fide employees to receive a reduction on the premiums paid by them on policies or contracts on their own lives and property, and on the lives and property of their spouses and dependent children;

5. Issuing life or accident and sickness policies or annuity contracts on a salary savings or payroll deduction plan at a reduced rate consistent with the savings made by the use of such plan;

6. Paying commissions or other compensation to duly licensed agents or brokers; or

7. Allowing or returning to participating policyholders, members or subscribers, dividends, savings or unabsorbed premium payments.

Code 1950, § 38.1-52; 1952, c. 317, § 38.1-52.8; 1977, c. 529; 1978, c. 441; 1979, c. 324; 1980, c. 404; 1986, c. 562.

§ 38.2-510. Unfair claim settlement practices.

A. No person shall commit or perform with such frequency as to indicate a general business practice any of the following:

1. Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

2. Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

3. Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

4. Refusing arbitrarily and unreasonably to pay claims;

5. Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

6. Not attempting in good faith to make prompt, fair and equitable settlements of claims in which liability has become reasonably clear;

7. Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;

8. Attempting to settle claims for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application;

9. Attempting to settle claims on the basis of an application that was altered without notice to, or knowledge or consent of, the insured;

10. Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made;

11. Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

12. Delaying the investigation or payment of claims by requiring an insured, a claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, when both contain substantially the same information;

13. Failing to promptly settle claims where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage;

14. Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement;

15. Failing to comply with § 38.2-3407.15, or to perform any provider contract provision required by that section;

16. Payment to an insurer or its representative by a repair facility, or acceptance by an insurer or its representative from a repair facility, directly or indirectly, of any kickback, rebate, commission, thing of value, or other consideration in connection with such person's appraisal service; or

17. Making appraisals of the cost of repairing a motor vehicle that has been damaged as a result of a covered loss unless such appraisal is based upon a personal inspection by a representative of the repair facility or a representative of the insurer who is making the appraisal. Notwithstanding the requirement that an appraisal be based upon a personal inspection, the repair facility or the insurer making the appraisal may prepare an initial, which may be the final, repair appraisal on a motor vehicle that has been damaged as a result of a covered loss either from the representative's personal inspection of the motor vehicle or from photographs, videos, or electronically transmitted digital imagery of the motor vehicle; however, no insurer may require an owner of a motor vehicle to submit photographs, videos, or electronically transmitted digital imagery as a condition of an appraisal. Supplemental repair estimates that become necessary after the repair work has been initiated due to discovery of additional damage to the motor vehicle may also be made from photographs, videos, or

electronically transmitted digital imagery of the motor vehicle, provided that in the case of disputed repairs a personal inspection is required.

B. No violation of this section shall of itself be deemed to create any cause of action in favor of any person other than the Commission; but nothing in this subsection shall impair the right of any person to seek redress at law or equity for any conduct for which action may be brought.

C. 1. No insurer shall prepare or use an estimate of the cost of automobile repairs based on the use of an after market part, as defined herein, unless:

The insurer discloses to the claimant in writing either on the estimate or in a separate document attached to the estimate the following information:

"THIS ESTIMATE HAS BEEN PREPARED BASED ON THE USE OF AUTOMOBILE PARTS NOT MADE BY THE ORIGINAL MANUFACTURER. PARTS USED IN THE REPAIR OF YOUR VEHICLE BY OTHER THAN THE ORIGINAL MANUFACTURER ARE REQUIRED TO BE AT LEAST EQUAL IN LIKE KIND AND QUALITY IN TERMS OF FIT, QUALITY AND PERFORMANCE TO THE ORIGINAL MANUFACTURER PARTS THEY ARE REPLACING."

2. "After market part" as used in this section shall mean an automobile part which is not made by the original equipment manufacturer and which is a sheet metal or plastic part generally constituting the exterior of a motor vehicle, including inner and outer panels.

Code 1950, § 38.1-52; 1952, c. 317, § 38.1-52.9; 1977, c. 529; 1978, c. 441; 1979, c. 324; 1980, c. 404; 1986, c. 562; 1988, c. 29; 1999, cc. 709, 739; 2000, c. 187; 2001, c. 335; 2016, cc. 183, 286.

§ 38.2-511. Failure to maintain record of complaints.

No person other than agents or brokers, shall fail to maintain a complete record of all the complaints that it has received since the date of its last examination under § 38.2-1317, provided that the records of complaints of a health carrier subject to Chapter 58 (§ 38.2-5800 et seq.) of this title shall be retained for no less than five years. The record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints, and the time it took to process each complaint.

As used in this section, "complaint" shall mean any written communication from a policyholder, subscriber or claimant primarily expressing a grievance.

Code 1950, § 38.1-52; 1952, c. 317, § 38.1-52.10; 1977, c. 529; 1978, c. 441; 1979, c. 324; 1980, c. 404; 1986, c. 562; 1998, c. 891.

§ 38.2-512. Misrepresentation in insurance documents or communications.

A. No person shall make or cause or allow to be made false or fraudulent statements or representations on or relative to an application or any document or communication relating to the business of insurance for the purpose of obtaining a fee, commission, money, or other benefit from any insurer, agent, broker, premium finance company, or individual.

B. No person shall, with respect to any document pertaining to the business of insurance, including payments made to an insurer or by an insurer, affix or cause or allow to be affixed the signature of any other person to such document without the written authorization of the person whose signature appears on such document.

C. No person shall, with respect to any document pertaining to the business of insurance, obtain or cause or allow to be obtained by false pretense the signature of another person or utilize such signature for the purpose of altering, changing or effecting the benefits, advantages, terms or conditions of any insurance contract or document related thereto, including payments made to an insurer or by an insurer.

Code 1950, § 38.1-52; 1952, c. 317, § 38.1-52.11; 1977, c. 529; 1978, c. 441; 1979, c. 324; 1980, c. 404; 1986, c. 562; 1998, c. 12.

§ 38.2-513. Repealed.

Repealed by Acts 2001, c. 371.

§ 38.2-513.1. Insurance sales by depository institutions and other lending institutions.

A. No depository institution, in the sale or solicitation of insurance, shall:

1. Reject an insurance policy required in connection with a loan or extension of credit solely because the policy has been issued or underwritten by a person who is not associated with such depository institution or its affiliate;

2. Require a debtor, insurer, agent, or surplus lines broker to pay a separate charge in connection with the handling of insurance required in connection with a loan or extension of credit or other banking product, unless such charge would be required when the depository institution or its affiliate is the licensed agent or surplus lines broker;

3. Use any advertisement that would cause a reasonable person to believe mistakenly that (i) the federal government or the Commonwealth is responsible for the insurance sales activities of, or stands behind the credit of, the depository institution or its affiliate; or (ii) the federal government or the Commonwealth guarantees any returns on insurance products or is a source of payment on any insurance obligation of or sold by the depository institution or its affiliate;

4. Act as an agent unless licensed in accordance with the provisions of Chapter 18 (§ 38.2-1800 et seq.) of this title;

5. Pay or receive commissions or other valuable consideration except in accordance with the provisions of Chapter 18 (§ 38.2-1800 et seq.) of this title; however, nothing herein shall prohibit the payment of compensation to a person not licensed under Chapter 18 (§ 38.2-1800 et seq.) of this title for the referral of a customer, provided that (i) such compensation is not based on the purchase of insurance by the customer, (ii) such compensation is a one-time, nominal fee of a fixed dollar amount for each referral, and (iii) the referral does not include a discussion of specific insurance policy terms and conditions;

6. Release insurance information of a customer to any person other than an officer, director, employee, agent, or affiliate of the depository institution, for the purpose of soliciting or selling insurance, without the express written consent of the customer. This provision shall not apply to (i) the release of information as otherwise authorized by state or federal law or (ii) the transfer of insurance information to an unaffiliated insurer in connection with transferring insurance in force on existing insureds of the depository institution or its affiliate, or in connection with a merger with or acquisition of an unaffiliated insurer. A depository institution or its affiliate shall be deemed to be in compliance with this paragraph if it complies with Chapter 6 (§ 38.2-600 et seq.) of this title;

7. Use, disclose, or release health information obtained from the insurance records of a customer for any purpose other than for its activities as a licensed agent or surplus lines broker, without the express written consent of the customer. A depository institution or its affiliate shall be deemed to be in compliance with this paragraph if it complies with Chapter 6 (§ 38.2-600 et seq.) of this title;

8. Extend credit or provide any product or service that is equivalent to an extension of credit, lease or sell property of any kind, furnish any services, or fix or vary the consideration for any of the foregoing on the condition or requirement that the customer obtain insurance from the depository institution or its affiliate, or a particular insurer, agent, or surplus lines broker; except that nothing shall prohibit the depository institution or its affiliate from:

a. Engaging in any activity that would not violate section 106 of the Bank Holding Company Act Amendments of 1970, as interpreted by the Board of Governors of the Federal Reserve System, or

b. Informing a customer that (i) insurance is required in order to obtain a loan or credit approval; (ii) the loan or credit approval is contingent upon the procurement by the customer of acceptable insurance; or (iii) insurance is available from the depository institution or its affiliate;

9. Offer, sell, or require insurance in connection with a loan or extension of credit, when an application for a loan or extension of credit from a depository institution is pending, unless a written disclosure is given to the customer indicating that the customer's choice of an insurer will not affect the credit decision or credit terms in any way; provided, however, that the depository institution may impose reasonable requirements concerning the creditworthiness of the insurer and the scope of coverage chosen. Any disapproval of an insurer shall be deemed unreasonable if it is not based on reasonable standards uniformly applied, relating to the extent of coverage required and the financial soundness and the services of an insurer. Such standards shall not discriminate against any particular type of insurer, nor shall such standards call for disapproval of an insurance policy because the policy contains coverage in addition to that required by the creditor. Use of the ratings of a nationally recognized rating service shall not be deemed unreasonable provided such ratings are based on reasonable standards uniformly applied. If an insurer, duly licensed in Virginia, does not possess the required rating of a nationally recognized rating service, no person who lends money or extends credit shall refuse to accept from the insurer a certificate of 100 percent reinsurance issued by another insurer pursuant to § 38.2-136, which does possess the required rating;

10. Sell an insurance policy unless:

a. A clear and conspicuous disclosure is given, in writing, where practicable, to the customer prior to the sale stating that such insurance policy (i) is not a deposit; (ii) is not insured by the Federal Deposit Insurance Corporation or any other federal government agency; (iii) is not guaranteed by the depository institution or, if appropriate, its affiliate or any person soliciting or selling insurance on its premises; and (iv) where appropriate, involves investment risk, including the potential loss of principal, and

b. Written acknowledgment of the disclosure is obtained from the customer at the time the customer receives the disclosure or at the time of the initial purchase of the insurance policy;

11. Solicit or sell insurance, other than credit insurance or flood insurance, unless such solicitation or sale is completed through documents separate from any credit transactions;

12. Include the expense of insurance premiums, other than credit insurance premiums, title insurance premiums, or flood insurance premiums, in the primary credit transaction without the express written consent of the customer; or

13. Solicit or sell insurance unless (i) its insurance sales activities are, to the extent practicable, physically segregated from areas where retail deposits are routinely accepted; (ii) it maintains separate and distinct books and records relating to such insurance transactions for the three previous calendar years; and (iii) it makes all such books and records available to the Commission for inspection upon reasonable notice.

B. As used in this section:

"Affiliate" means any company that controls, is controlled by, or is under common control with another company.

"Credit insurance" means the lines of insurance defined in §§ 38.2-103, 38.2-108, 38.2-122.1, and 38.2-122.2.

"Customer" means an individual who obtains, applies for, or is solicited to obtain insurance.

"Depository institution" means any bank or savings association.

"Insurance information" means information concerning the premiums, terms, and conditions of insurance coverage, including expiration dates and rates, and insurance claims of a customer contained in the records of a depository institution or its affiliate.

C. Notwithstanding anything to the contrary, the provisions of this section, except subdivision A. 10., shall also apply to any person who lends money or extends credit and who sells or solicits any insurance as classified and defined in Article 2 (§ 38.2-101 et seq.) of Chapter 1 of this title in connection therewith. However, this section shall not apply to premium finance companies licensed under Chapter 47 (§ 38.2-4700 et seq.) of this title or agents who extend credit as authorized in § 38.2-1806

to the extent that such premium finance companies or agents are not affiliated with a depository institution.

D. If the customer agrees, the written disclosures and acknowledgements required by subsection A of this section may be provided electronically. Such disclosures shall be provided in a format that the customer may retain and reproduce for later reference. When a purchase of insurance is made by telephone, the disclosures and acknowledgements required by subsection A of this section may be given orally, provided that (i) such disclosures are mailed or provided in electronic form within three working days after the sale, solicitation, or offer of the insurance policy; (ii) documentation is maintained showing that oral acknowledgement was given by the customer; and (iii) a reasonable effort is made to obtain written acknowledgement from the customer.

E. The Commission shall have the power to examine and investigate the affairs of any person to whom this section applies to determine whether that person has violated this section. If a violation of this section is found, the person in violation shall be subject to the same procedures and penalties as are applicable to other provisions of this chapter.

F. Except as provided for specifically in subsection A, this section shall not prevent or restrict a depository institution or its affiliate from engaging directly or indirectly, either by itself or in conjunction with an affiliate, or any other person, in any activity authorized or permitted under state or federal law.

2001, c. 371; 2002, c. 76.

§ 38.2-514. Failure to make disclosure.

A. No person shall sell, solicit, or negotiate the sale of an annuity, a life insurance policy or an accident and sickness insurance policy without furnishing the disclosure information required by any rules and regulations of the Commission.

B. No person shall provide to an insured, claimant, subscriber or enrollee under an accident and sickness insurance policy, subscription contract, or health maintenance organization contract, an explanation of benefits which does not clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services.

Code 1950, § 38.1-52; 1952, c. 317, § 38.1-52.13; 1977, c. 529; 1978, c. 441; 1979, c. 324; 1980, c. 404; 1986, c. 562; 1991, c. 620; 1992, c. 7; 1994, c. 320; 2001, cc. 371, 706.

§ 38.2-514.1. Disclosure required.

A. Any agent selling, soliciting, or negotiating a contract of insurance in conjunction with any automobile club service agreement or in conjunction with any accidental death and dismemberment policy shall provide to the applicant, at the time of application, a written disclosure which shall contain:

1. The name or type of each policy or contract of insurance and automobile club service agreement for which application has been made;

2. The premium quotation associated with each policy or contract of insurance and the cost of any dues, assessments or periodic payments of money associated with each automobile club service agreement for which application has been made; and

3. A statement that the applicant has elected to purchase such policies, contracts, or automobile club service agreements.

B. The disclosure required by this section shall be signed and dated by the agent and the applicant. A copy of the signed disclosure shall be given to the applicant at the time of application. If the application is made by telephonic or electronic request, a copy of the disclosure shall be signed and dated by the agent and shall be mailed to the applicant within ten calendar days of the application.

C. The provisions of this section shall apply only to the original issuance of policies or contracts of insurance and automobile club service agreements covering personal, family, or household needs rather than business or professional needs. As used in this section, an automobile club service agreement is an agreement issued by an automobile club as defined in subsection E.

D. Notwithstanding subsections A, B and C, this section shall not apply to the sale of group insurance.

E. As used in this section, "automobile club" means a legal entity that, in consideration of dues, assessments, or periodic payments of money, promises its members or subscribers to assist them in matters relating to motor travel or the operation, use, or maintenance of a motor vehicle by supplying services that may include, but are not limited to, towing service, emergency road service, indemnification service, guaranteed arrest bond certificate service, discount service, financial service, theft service, map service, or touring service.

1996, c. 473; 2001, c. 706; 2016, c. 250; 2017, c. 653.

§ 38.2-514.2. Disclosures required of motor vehicle rental contract insurance agents and enrollers.

No insurance may be sold, solicited, or negotiated by a motor vehicle rental contract insurance agent or enroller unless a conspicuous written disclosure is provided to the prospective renter that (i) summarizes clearly and correctly the material terms of coverage offered, including the identity of the insurer or insurers, (ii) advises that the coverage offered may duplicate coverage already provided by the renter's personal motor vehicle insurance policy, homeowner's insurance policy, personal liability insurance policy, or other source of coverage, and (iii) states that the purchase of the coverages offered is not required in order to rent a motor vehicle.

1998, c. 47; 1999, c. 493; 2001, c. 706.

§ 38.2-515. Power of Commission.

A. The Commission shall have power to examine and investigate the affairs of each person subject to this chapter to determine whether such person has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by this chapter.

B. The Commission is further empowered to gather information from any person subject to this chapter relative to trade practices and whether such practices adequately and fairly serve the public interest.

C. Any person who refuses or fails to provide information in a timely manner to the Commission as provided in this section shall be subject to the enforcement and penalty provisions set forth in Chapter 2 (§ 38.2-200 et seq.).

1952, c. 317, § 38.1-53; 1977, c. 529; 1980, c. 404; 1986, c. 562; 1991, c. 356; 2012, cc. 273, 277.

§ 38.2-515.1. Power of Commission; policies issued outside of the Commonwealth.

A. Notwithstanding any other provision of law to the contrary, the Commission shall have the power to assist consumers and to examine and investigate complaints and inquiries relating to trade practices and claim settlement practices of insurers involving policies issued outside of the Commonwealth but covering residents of the Commonwealth, provided that the policy was issued (i) as a policy of group accident and sickness insurance in accordance with § 38.2-3521.1 or (ii) to a group other than one described in § 38.2-3521.1 in compliance with the requirements of § 38.2-3522.1.

B. The Commission's investigatory powers with respect to residents of the Commonwealth are limited to assisting consumers and examining and investigating complaints and inquiries as provided in subsection A and shall not extend to applying or enforcing federal laws or the laws of another state or jurisdiction.

C. The Commission shall have no jurisdiction to adjudicate controversies arising out of this section.

2018, c. 256.

§ 38.2-516. Prohibited compensation for intra-company replacement.

No insurer shall pay a commission or other compensation to an appointed agent who has replaced an existing individual accident and sickness policy with a policy issued by the same insurer when such new policy provides benefits substantially similar to the benefits under the replaced policy, except that an insurer may pay to such agent a commission or other compensation to the extent that the commission or other compensation does not exceed the renewal commission that would have been paid to the agent had the replaced policy continued in force.

1990, c. 265.

§ 38.2-517. Unfair settlement practices; replacement and repair; penalty.

A. No person shall:

1. Require an insured or claimant to utilize designated replacement or repair facilities or services, or the products of designated manufacturers, as a prerequisite to settling or paying any claim arising under a policy or policies of insurance;

2. Engage in any act of coercion or intimidation causing or intended to cause an insured or claimant to utilize designated replacement or repair facilities or services, or the products of designated manufacturers, in connection with settling or paying any claim arising under a policy or policies of insurance;

3. Fail to disclose to the insured or claimant, prior to being referred to a third party representative in connection with a glass claim arising under a motor vehicle insurance policy, that the third party representative is not the insurer and is acting on behalf of the insurer;

4. Fail to disclose to the insured or claimant, at such time as the insurer or its third party representative recommends the use of a designated motor vehicle replacement or repair facility or service, or products of a designated manufacturer, in connection with settling or paying any claim arising under a policy or policies of insurance, that the insured or claimant is under no obligation to use the replacement or repair facility or service or products of the manufacturer recommended by the insurer or by a representative of the insurer;

5. Fail to disclose to the insured or claimant, at such time as it or its third party representative recommends the use of a designated motor vehicle replacement or repair facility in connection with settling or paying any claim arising under a policy or policies of insurance, that the insurer or its third party representative has a financial interest in such replacement or repair facility, if the insurer or its third party representative has such an interest; or

6. Engage in the practice of capping. As used in this subdivision, "capping" means the setting of arbitrary and unreasonable limits on what an insurer will allow as reimbursement for paint and materials.

B. This section shall not be construed to require an insurer to pay an amount for motor vehicle repair services or repair products necessary to properly and fairly repair the vehicle to its pre-loss condition that is greater than the prevailing competitive charges for equivalent services or products charged by similar contractors or repair shops within a reasonable geographic or trade area of the address of the repair facility. Offering an explanation of the extent of an insurer's obligation under this section to its policyholder or third party claimant shall not constitute a violation of this section.

C. Any person violating this section shall be subject to the injunctive, penalty, and enforcement provisions of Chapter 2 (§ 38.2-200 et seq.) of this title. The Commission shall investigate, with the written authorization of the insured or the claimant, any written complaints received pursuant to this section, regardless of whether such written complaints are submitted by an individual or a repair facility. For the purpose of this section, any insurance company utilizing a third party representative shall be held accountable for any violation of this section by such third party representative.

1992, cc. 870, 882; 1999, c. 129; 2003, c. 361; 2004, c. 767; 2008, cc. 111, 516.

§ 38.2-518. Certificates of insurance.

A. As used in this section, "certificate of insurance" means a document, regardless of how titled or described, that is provided to a third party and is prepared or issued by an insurer or insurance producer as a statement or summary of an insured's property or casualty insurance coverage. The term does not include any (i) policy of insurance, (ii) insurance binder, (iii) policy endorsement, (iv) automobile identification card, (v) certificate issued under a group or master policy, or (vi) evidence of coverage provided to a lender in a lending transaction involving a mortgage, lien, deed of trust, or other security interest in or on any real or personal property.

B. No person shall issue or deliver any certificate of insurance that attempts to confer any rights upon a third party beyond what the referenced policy of insurance expressly provides.

C. No certificate of insurance may represent an insurer's obligation to give notice of cancellation or nonrenewal to a third party unless the giving of such notice is required by the policy.

D. No person shall issue or deliver a certificate of insurance unless it contains a substantially similar statement to the following: "This certificate of insurance is issued as a matter of information only. It confers no rights upon the third party requesting the certificate beyond what the referenced policy of insurance expressly provides. This certificate of insurance does not extend, amend, or alter the coverage, terms, exclusions, or conditions afforded by the policy referenced in this certificate of insurance." If a certificate of insurance is required by a state or federal agency and accurately reflects the coverage provided by the underlying policies, no such statement is required.

E. No person shall knowingly demand or require the issuance of a certificate of insurance from an insurer, insurance producer, or policyholder that contains any false or misleading information concerning the policy of insurance to which the certificate makes reference.

F. No person shall knowingly prepare or issue a certificate of insurance that contains any false or misleading information or that purports to affirmatively or negatively alter, amend, or extend the coverage provided by the policy of insurance to which the certificate makes reference.

G. The provisions of this section shall apply to all certificate holders, policyholders, insurers, insurance producers, and certificate of insurance forms issued as a statement or summary of insurance coverages on property, operations, or risks located in the Commonwealth.

2012, cc. 273, 277.

Chapter 6 - Insurance Information and Privacy Protection

Article 1 - Collection, Use, and Dissemination of Information

§ 38.2-600. Purposes.

The purposes of this article are to:

1. Establish standards for the collection, use, and disclosure of information gathered in connection with insurance transactions by insurance institutions, agents or insurance-support organizations;

2. Maintain a balance between the need for information by those conducting the business of insurance and the public's need for fairness in insurance information practices, including the need to minimize intrusiveness;

3. Establish a regulatory mechanism to enable natural persons to ascertain what information is being or has been collected about them in connection with insurance transactions and to have access to such information for the purpose of verifying or disputing its accuracy;

4. Limit the disclosure of information collected in connection with insurance transactions; and

5. Enable insurance applicants and policyholders to obtain the reasons for any adverse underwriting decision.

1981, c. 389, § 38.1-57.3; 1986, c. 562; 2020, c. 264.

§ 38.2-601. Application of article.

A. The obligations imposed by this article shall apply to those insurance institutions, agents or insurance-support organizations that:

1. In the case of life or accident and sickness insurance:

a. Collect, receive or maintain information in connection with insurance transactions that pertains to natural persons who are residents of the Commonwealth; or

b. Engage in insurance transactions with applicants, individuals, or policyholders who are residents of the Commonwealth; and

2. In the case of property or casualty insurance:

a. Collect, receive or maintain information in connection with insurance transactions involving policies, contracts or certificates of insurance delivered, issued for delivery or renewed in the Commonwealth; or

b. Engage in insurance transactions involving policies, contracts or certificates of insurance delivered, issued for delivery or renewed in the Commonwealth.

B. The rights granted by this article shall extend to:

1. In the case of life or accident and sickness insurance, the following persons who are residents of the Commonwealth:

a. Natural persons who are the subject of information collected, received or maintained in connection with insurance transactions; and

b. Applicants, individuals or policyholders who engage in or seek to engage in insurance transactions; and

2. In the case of property or casualty insurance, the following persons:

a. Natural persons who are the subject of information collected, received or maintained in connection with insurance transactions involving policies, contracts or certificates of insurance delivered, issued for delivery or renewed in the Commonwealth; and

b. Applicants, individuals, or policyholders who engage in or seek to engage in insurance transactions involving policies, contracts or certificates of insurance delivered, issued for delivery or renewed in the Commonwealth.

C. For purposes of this section, a person shall be considered a resident of the Commonwealth if the person's last known mailing address, as shown in the records of the insurance institution, agent or insurance-support organization, is located in the Commonwealth.

D. Notwithstanding subsections A and B, this article shall not apply to information collected from the public records of a governmental authority and maintained by an insurance institution or its representatives for the purpose of insuring the title to real property located in the Commonwealth.

E. The provisions of this article shall apply only to insurance purchased primarily for personal, family or household purposes.

1981, c. 389, § 38.1-57.4; 1986, c. 562; 2001, c. 371; 2020, c. 264.

§ 38.2-602. Definitions.

As used in this article:

"Adverse underwriting decision" means:

1. Any of the following actions with respect to insurance transactions involving insurance coverage that is individually underwritten:

a. A declination of insurance coverage;

b. A termination of insurance coverage;

c. Failure of an agent to apply for insurance coverage with a specific insurance institution that an agent represents and that is requested by an applicant;

d. In the case of a property or casualty insurance coverage:

(1) Placement by an insurance institution or agent of a risk with a residual market mechanism or an unlicensed insurer; or

(2) The charging of a higher rate on the basis of information that differs from that which the applicant or policyholder furnished; or

e. In the case of a life or accident and sickness insurance coverage, an offer to insure at higher than standard rates, or with limitations, exceptions or benefits other than those applied for.

2. Notwithstanding subdivision 1 of this definition, the following actions shall not be considered adverse underwriting decisions, but the insurance institution or agent responsible for their occurrence shall provide the applicant or policyholder with the specific reason or reasons for their occurrence:

a. The termination of an individual policy form on a class or statewide basis;

b. A declination of insurance coverage solely because such coverage is not available on a class or statewide basis;

c. The rescission of a policy.

"Affiliate" or "affiliated" means a person that directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with another person.

"Agent" shall have the meaning as set forth in § 38.2-1800 and shall include surplus lines brokers.

"Applicant" means any person who seeks to contract for insurance coverage other than a person seeking group insurance that is not individually underwritten.

"Clear and conspicuous notice" means a notice that is reasonably understandable and designed to call attention to the nature and significance of the information in the notice.

"Consumer report" means any written, oral, or other communication of information bearing on a natural person's credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics or mode of living that is used or expected to be used in connection with an insurance transaction.

"Consumer reporting agency" means any person who:

1. Regularly engages, in whole or in part, in the practice of assembling or preparing consumer reports for a monetary fee;

2. Obtains information primarily from sources other than insurance institutions; and

3. Furnishes consumer reports to other persons.

"Control," including the terms "controlled by" or "under common control with," means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person.

"Declination of insurance coverage" means a denial, in whole or in part, by an insurance institution or agent of requested insurance coverage.

"Financial information" means personal information other than medical record information or records of payment for the provision of health care to an individual.

"Financial institution" means any institution the business of which is engaging in financial activities as described in Section 4(k) of the Bank Holding Company Act of 1956 (12 U.S.C. § 1843 (k)).

"Financial product or service" means any product or service that a financial holding company could offer by engaging in an activity that is financial in nature or incidental to such a financial activity under Section 4(k) of the Bank Holding Company Act of 1956 (12 U.S.C. § 1843 (k)).

"Individual" means any natural person who:

1. In the case of property or casualty insurance, is a past, present, or proposed named insured or certificate holder;

2. In the case of life or accident and sickness insurance, is a past, present, or proposed principal insured or certificate holder;

3. Is a past, present or proposed policyowner;

4. Is a past or present applicant;

5. Is a past or present claimant;

6. Derived, derives, or is proposed to derive insurance coverage under an insurance policy or certificate subject to this article;

7. For the purposes of §§ 38.2-612.1 and 38.2-613, is a beneficiary of a life insurance policy;

8. For the purposes of §§ 38.2-612.1 and 38.2-613, is a mortgagor of a mortgage covered under a mortgage guaranty insurance policy; or

9. For the purposes of §§ 38.2-612.1 and 38.2-613, is an owner of property used as security for an indebtedness for which single interest insurance is required by a lender.

Notwithstanding any provision of this definition to the contrary, for purposes of § 38.2-612.1, "individual" shall not include any natural person who is covered under an employee benefit plan, group or blanket insurance contract, or group annuity contract when the insurance institution or agent that provides such plan or contract: (i) furnishes the notice required under § 38.2-604.1 to the employee benefit plan sponsor, group or blanket insurance contract holder, or group annuity contract holder; and (ii) does not disclose the financial information of the person to a nonaffiliated third party other than as permitted under § 38.2-613.

"Institutional source" means any person or governmental entity that provides information about an individual to an agent, insurance institution or insurance-support organization, other than:

1. An agent;

2. The individual who is the subject of the information; or

3. A natural person acting in a personal capacity rather than in a business or professional capacity.

"Insurance institution" means any corporation, association, partnership, reciprocal exchange, interinsurer, Lloyd's type of organization, fraternal benefit society, or other person engaged in the business of insurance, including health maintenance organizations, and health, legal, dental, and optometric service plans. "Insurance institution" shall not include agents or insurance-support organizations.

"Insurance-support organization" means any person who regularly engages, in whole or in part, in the practice of assembling or collecting information about natural persons for the primary purpose of providing the information to an insurance institution or agent for insurance transactions, including (i) the furnishing of consumer reports or investigative consumer reports to an insurance institution or agent for use in connection with an insurance transaction or (ii) the collection of personal information from insurance institutions, agents or other insurance-support organizations for the purpose of detecting or preventing fraud, material misrepresentation or material nondisclosure in connection with insurance underwriting or insurance claim activity. However, the following persons shall not be considered "insurance-support organizations" for purposes of this article: agents, governmental institutions, insurance institutions, medical-care institutions and medical professionals.

"Insurance transaction" means any transaction involving insurance primarily for personal, family, or household needs rather than business or professional needs that entails:

1. The determination of an individual's eligibility for an insurance coverage, benefit or payment; or

2. The servicing of an insurance application, policy, contract, or certificate.

"Investigative consumer report" means a consumer report or a portion thereof in which information about a natural person's character, general reputation, personal characteristics, or mode of living is obtained through personal interviews with the person's neighbors, friends, associates, acquaintances, or others who may have knowledge concerning such items of information.

"Joint marketing agreement" means a formal written contract pursuant to which an insurance institution jointly offers, endorses, or sponsors a financial product or service with another financial institution.

"Life insurance" includes annuities.

"Medical-care institution" means any facility or institution that is licensed to provide health care services to natural persons, including but not limited to, hospitals, skilled nursing facilities, home-health agencies, medical clinics, rehabilitation agencies, and public-health agencies or health-maintenance organizations.

"Medical professional" means any person licensed or certified to provide health care services to natural persons, including but not limited to, a physician, dentist, nurse, chiropractor, optometrist, physical or occupational therapist, social worker, clinical dietitian, clinical psychologist, licensed professional counselor, licensed marriage and family therapist, pharmacist, or speech therapist.

"Medical-record information" means personal information that:

1. Relates to an individual's physical or mental condition, medical history, or medical treatment; and

2. Is obtained from a medical professional or medical-care institution, from the individual, or from the individual's spouse, parent, or legal guardian.

"Nonaffiliated third party" means any person who is not an affiliate of an insurance institution but does not mean (i) an agent who is selling or servicing a product on behalf of the insurance institution or (ii) a person who is employed jointly by the insurance institution and the company that is not an affiliate.

"Personal information" means any individually identifiable information gathered in connection with an insurance transaction from which judgments can be made about an individual's character, habits, avocations, finances, occupation, general reputation, credit, health, or any other personal characteristics. "Personal information" includes an individual's name and address and medical-record information, but does not include (i) privileged information or (ii) any information that is publicly available.

"Policyholder" means any person who:

1. In the case of individual property or casualty insurance, is a present named insured;

2. In the case of individual life or accident and sickness insurance, is a present policyowner; or

3. In the case of group insurance that is individually underwritten, is a present group certificate holder.

"Policyholder information" means personal information about a policyholder, whether in paper, electronic, or other form, that is maintained by or on behalf of an insurance institution, agent, or insurance-support organization.

"Pretext interview" means an interview whereby a person, in an attempt to obtain information about a natural person, performs one or more of the following acts:

1. Pretends to be someone he or she is not;

2. Pretends to represent a person he or she is not in fact representing;

3. Misrepresents the true purpose of the interview; or

4. Refuses to identify himself or herself upon request.

"Privileged information" means any individually identifiable information that (i) relates to a claim for insurance benefits or a civil or criminal proceeding involving an individual, and (ii) is collected in connection with or in reasonable anticipation of a claim for insurance benefits or civil or criminal proceeding involving an individual.

"Residual market mechanism" means an association, organization, or other entity defined, described, or provided for in the Virginia Automobile Insurance Plan as set forth in § 38.2-2015, or in the Virginia Property Insurance Association as set forth in Chapter 27 (§ 38.2-2700 et seq.) of this title.

"Termination of insurance coverage" or "termination of an insurance policy" means either a cancellation or nonrenewal of an insurance policy other than by the policyholder's request, in whole or in part, for any reason other than the failure to pay a premium as required by the policy.

"Unlicensed insurer" means an insurance institution that has not been granted a license by the Commission to transact the business of insurance in Virginia.

1981, c. 389, § 38.1-57.5; 1986, c. 562; 2001, c. 371; 2003, c. 729; 2006, c. 638; 2020, c. 264.

§ 38.2-603. Pretext interviews.

No insurance institution, agent, or insurance-support organization shall use or authorize the use of pretext interviews to obtain information in connection with an insurance transaction. However, a pretext interview may be undertaken to obtain information from a person or institution that does not have a generally or statutorily recognized privileged relationship with the person about whom the information relates for the purpose of investigating a claim where, based upon specific information available for review by the Commission, there is a reasonable basis for suspecting criminal activity, fraud, material misrepresentation, or material nondisclosure in connection with the claim.

1981, c. 389, § 38.1-57.6; 1986, c. 562.

§ 38.2-604. Notice of information collection and disclosure practices.

A. An insurance institution or agent shall provide a notice of insurance information practices to all applicants or policyholders in connection with insurance transactions as provided in this section:

1. In the case of an application for insurance a notice shall be provided no later than:

a. At the time of the delivery of the insurance policy or certificate when personal information is collected only from the applicant or from public records;

b. At the time the collection of personal information is initiated when personal information is collected from a source other than the applicant or public records; or

c. Notwithstanding the provisions of subdivision 1 b of subsection A, when an application for insurance is made by telephone and personal information is collected from a source other than the applicant or public records, the notice of insurance information practices may be given orally at the time of application, provided that, if a policy is issued, such notice is given in writing or, if the applicant agrees, in electronic format, no later than at the time of the delivery of the insurance policy or certificate.

2. In the case of a policy renewal, a notice shall be provided no later than the policy renewal date, except that no notice shall be required in connection with a policy renewal if:

a. Personal information is collected only from the policyholder or from public records; or

b. A notice meeting the requirements of this section has been given within the previous 24 months; or

3. In the case of a policy reinstatement or change in insurance benefits, a notice shall be provided no later than the time a request for a policy reinstatement or change in insurance benefits is received by the insurance institution, except that no notice shall be required if personal information is collected only from the policyholder or from public records.

B. The notice required by subsection A of this section shall be in writing or, if the applicant or policyholder agrees, in electronic format, and shall state:

1. Whether personal information may be collected from persons other than an individual proposed for coverage;

2. The types of personal information that may be collected and the types of sources and investigative techniques that may be used to collect such information;

3. The types of disclosures made under subdivisions 1, 2, 3, 4, 5, 8, 10, and 12 of subsection B and subdivision 2 of subsection C of § 38.2-613 and the circumstances under which such disclosures may be made without prior authorization, however only those circumstances need be described that occur with such frequency as to indicate a general business practice;

4. A description of the rights established under §§ 38.2-608 and 38.2-609 and the manner in which those rights may be exercised; and

5. That information obtained from a report prepared by an insurance-support organization may be retained by the insurance-support organization and disclosed to other persons.

C. Instead of the notice prescribed in subsection B of this section, the insurance institution or agent may provide an abbreviated notice in writing or, if the applicant or policyholder agrees, in electronic format, informing the applicant or policyholder that:

1. Personal information may be collected from persons other than an individual proposed for coverage;

2. The information, as well as other personal or privileged information subsequently collected by the insurance institution or agent, in certain circumstances, may be disclosed to third parties without authorization;

3. A right of access and correction exists with respect to all personal information collected; and

4. The notice prescribed in subsection B of this section will be furnished to the applicant or policyholder upon request.

D. The obligations imposed by this section upon an insurance institution or agent may be satisfied by another insurance institution or agent authorized to act on its behalf.

E. An insurance agent shall not be subject to the requirements of this section in any instance where the insurance institution on whose behalf the agent is acting otherwise complies with the requirements contained herein, and the agent does not disclose any personal information to any person other than the insurance institution or its affiliates, or as permitted by § 38.2-613.

F. [Repealed.]

G. An insurance agent seeking to place coverage on behalf of a current policyholder shall be deemed to be in compliance with the requirements of this section in any instance where the agent has provided the notice required by this section within the previous 12 months.

1981, c. 389, § 38.1-57.7; 1986, c. 562; 2001, c. 371; 2002, c. 76; 2003, c. 266.

§ 38.2-604.1. Notice of financial information collection and disclosure practices.

A. An insurance institution or agent shall provide clear and conspicuous notice of financial information collection and disclosure practices in connection with insurance transactions as required by subsection B of this section:

1. To an applicant before any financial information is disclosed about that applicant to any nonaffiliated third party, if the disclosure is made other than as permitted under § 38.2-613. For purposes of this subdivision, a notice provided to an employer benefit plan sponsor, group or blanket insurance contract holder, or group annuity contract holder shall satisfy the notice requirements of this subdivision for applicants of such plan, policy, or annuity, provided the insurance institution or agent does not disclose the financial information of those applicants to a nonaffiliated third party, other than as permitted under § 38.2-613;

2. To a policyholder no later than delivery or issuance of the policy or any other evidence of coverage, or at the later of these events. For purposes of this subdivision, a notice provided to an employee benefit plan sponsor, group or blanket insurance contract holder, or group annuity contract holder shall satisfy the notice requirements of this subdivision for persons covered under such plans, policies, or annuities, provided the insurance institution or agent does not disclose the financial information of those persons to a nonaffiliated third party, other than as permitted under § 38.2-613; and

3. To a policyholder, other than a policyholder of a title insurance policy, not less than once in each calendar year. A notice provided to the sponsor of an employee benefit plan or the owner of a group or blanket insurance policy or group annuity contract shall satisfy the notice requirements of this subdivision for persons covered under such plan, policy or contract. For purposes of this subdivision only, "policyholder" does not include a person who owns a policy that is lapsed, expired or otherwise inactive or dormant under the insurance institution's business practices, and with whom the insurance institution has not communicated about the relationship for a period of 12 consecutive months, other than annual privacy notices, material required by law or regulation, communication at the direction of a state or federal authority, or promotional materials. An insurance institution or agent that provides nonpublic personal information to nonaffiliated third parties only in accordance with § 38.2-613 and has not changed its policies and practices with regard to disclosing nonpublic financial information from the policies and practices that were disclosed in the most recent notice sent to the policyholder in accordance with this section shall not be required to provide an annual notice under this section until such time as the licensee does not comply with any criteria described in this subdivision.

B. Any notice required by subsection A of this section shall be in writing or, if the applicant or policyholder agrees, in electronic format, and shall state:

1. The types of financial information that may be collected;

2. The types of financial information that may be disclosed;

3. The categories of persons to whom financial information may be disclosed; however, when disclosures are made pursuant to subsection B of § 38.2-613, the notice is only required to state that disclosures may be made without prior authorization as permitted by law;

4. If financial information is disclosed pursuant to subdivision C 1 of § 38.2-613, the types of financial information that may be disclosed and the categories of nonaffiliated third parties to whom financial information may be disclosed by contractual agreement;

5. An explanation of the right to direct that financial information not be disclosed to nonaffiliated third parties as provided in § 38.2-612.1, provided that this explanation shall not be required to be given when information is disclosed pursuant to the provisions of § 38.2-613;

6. A description of the policies and practices for protecting the confidentiality and security of financial information;

7. The disclosure required, if any, under Section 603 (d)(2)(A)(iii) of the federal Fair Credit Reporting Act (15 U.S.C. § 1681 et seq.) pertaining to the notices regarding the ability to opt out of disclosure of information among affiliates; and

8. A description of the types of financial information about former policyholders that may be disclosed and a description of the types of affiliates and nonaffiliated third parties to whom financial information about former policyholders may be disclosed; however, when disclosures are made pursuant to subsection B of § 38.2-613, the notice is only required to state that disclosures may be made without prior authorization as permitted by law.

C. An insurance institution or agent that does not disclose, and does not wish to reserve the right to disclose, financial information about policyholders or former policyholders to affiliates or nonaffiliated third parties except as authorized in subsection B of § 38.2-613 may satisfy the requirements of this section by providing a notice, as set forth in subdivisions A 2 and A 3 of this section, that:

1. States the foregoing information regarding such insurance institution or agent;

2. Includes the information described in subdivisions B 1 and B 6 of this section; and

3. States that the insurance institution or agent makes disclosures to other affiliated or nonaffiliated third parties, as applicable, as permitted by law.

D. An insurance institution or agent may satisfy the notice requirements of subdivision A 1 of this section by providing a short form notice at the same time that the insurance institution or agent delivers an opt out notice as required by § 38.2-612.1. Such a short form notice shall: (i) be clear and conspicuous; (ii) state that the notice prescribed in subsection B of this section is available upon request; (iii) explain a reasonable means by which the applicant may obtain that notice; and (iv) be in writing or, if the applicant agrees, in electronic format. The insurance institution or agent is not required to deliver the notice prescribed in subsection B of this section with its short form notice, provided the insurance institution or agent provides the applicant with a reasonable means to obtain such notice.

E. The obligations imposed by this section upon an insurance institution or agent may be satisfied by another insurance institution or agent authorized to act on its behalf. An insurance institution may provide a joint notice from the insurance institution and one or more of its affiliates or other financial institutions, as identified in the notice, if the notice is accurate with respect to the insurance institution and the other institutions.

F. An insurance institution or agent, prior to disclosing financial information to a nonaffiliated third party other than as described in the notice prescribed in subsection B of this section, shall send a revised notice that accurately describes its information collection and disclosure practices. Such notice shall comply with the provisions of subsection B of this section.

G. An insurance institution or agent may satisfy the notice requirements of § 38.2-604 and this section through the use of separate notices or a combined notice.

H. An insurance agent shall not be subject to the requirements of this section in any instance where the insurance institution on whose behalf the agent is acting otherwise complies with the requirements contained herein, and the agent does not disclose any financial information to any person other than the insurance institution or its affiliates, or as permitted by § 38.2-613.

I. An insurance agent seeking to place coverage on behalf of a current policyholder shall be deemed to be in compliance with the requirements of this section in any instance where the agent has provided the notice required by this section within the previous 12 months.

2001, c. 371; 2002, c. 76; 2003, c. 266; 2017, c. 648.

§ 38.2-605. Marketing and research surveys.

An insurance institution or agent shall clearly specify those questions designed to obtain information solely for marketing or research purposes from an individual in connection with an insurance transaction.

1981, c. 389, § 38.1-57.8; 1986, c. 562.

§ 38.2-606. Content of disclosure authorization forms.

Notwithstanding any other provision of law of this Commonwealth, no insurance institution, agent, or insurance-support organization shall utilize as its disclosure authorization form in connection with insurance transactions involving insurance policies or contracts issued after January 1, 1982, a form or statement that authorizes the disclosure of personal or privileged information about an individual to the insurance institution, agent, or insurance-support organization unless the form or statement:

1. Is written in plain language;

2. Is dated;

3. Specifies the types of persons authorized to disclose information about the individual;

4. Specifies the nature of the information authorized to be disclosed;

5. Names the insurance institution or agent and identifies by generic reference representatives of the insurance institution to whom the individual is authorizing information to be disclosed;

6. Specifies the purposes for which the information is collected;

7. Specifies the length of time such authorization shall remain valid, which shall be no longer than:

a. In the case of authorizations signed for the purpose of collecting information in connection with an application for an insurance policy, a policy reinstatement, or a request for change in policy benefits:

(1) Thirty months from the date the authorization is signed if the application or request involves life, accident and sickness, or disability insurance; or

(2) Two years from the date the authorization is signed if the application or request involves property or casualty insurance;

b. In the case of authorizations signed for the purpose of collecting information in connection with a claim for benefits under an insurance policy:

(1) The term of coverage of the policy if the claim is for an accident and sickness insurance benefit; or

(2) The duration of the claim if the claim is not for an accident and sickness insurance benefit; and

8. Advises the individual or a person authorized to act on behalf of the individual that the individual or the individual's authorized representative is entitled to receive a copy of the authorization form.

1981, c. 389, § 38.1-57.9; 1986, c. 562; 2001, c. 371.

§ 38.2-607. Investigative consumer reports.

A. No insurance institution, agent, or insurance-support organization may prepare or request an investigative consumer report about an individual in connection with an insurance transaction involving an application for insurance, a policy renewal, a policy reinstatement or a change in insurance benefits unless the insurance institution or agent informs the individual:

1. That he may request to be interviewed in connection with the preparation of the investigative consumer report; and

2. That upon a request pursuant to § 38.2-608, he is entitled to receive a copy of the investigative consumer report.

B. If an investigative consumer report is to be prepared by an insurance institution or agent, the insurance institution or agent shall institute reasonable procedures to conduct a personal interview requested by an individual.

C. If an investigative consumer report is to be prepared by an insurance-support organization, the insurance institution or agent desiring the report shall inform the insurance-support organization whether a personal interview has been requested by the individual. The insurance-support organization shall institute reasonable procedures to conduct such interviews, if requested.

1981, c. 389, § 38.1-57.10; 1986, c. 562.

§ 38.2-608. Access to recorded personal information.

A. If any individual, after proper identification, submits a written request to an insurance institution, agent, or insurance-support organization for access to recorded personal information about the individual that is reasonably described by the individual and reasonably able to be located and retrieved by the insurance institution, agent, or insurance-support organization, the insurance institution, agent, or insurance-support organization shall within 30 business days from the date the request is received:

1. Inform the individual of the nature and substance of the recorded personal information in writing, by telephone, or by other oral communication, whichever the insurance institution, agent, or insurance-support organization prefers;

2. Permit the individual to see and copy, in person, the recorded personal information pertaining to him or to obtain a copy of the recorded personal information by mail, whichever the individual prefers,

unless the recorded personal information is in coded form, in which case an accurate translation in plain language shall be provided in writing;

3. Disclose to the individual the identity, if recorded, of those persons to whom the insurance institution, agent, or insurance-support organization has disclosed the personal information within two years prior to such request, and if the identity is not recorded, the names of those insurance institutions, agents, insurance-support organizations or other persons to whom such information is normally disclosed; and

4. Provide the individual with a summary of the procedures by which he may request correction, amendment, or deletion of recorded personal information.

B. Any personal information provided pursuant to subsection A of this section shall identify the source of the information if it is an institutional source.

C. Medical-record information supplied by a medical-care institution or medical professional and requested under subsection A of this section, together with the identity of the medical professional or medical care institution that provided the information, shall be supplied either directly to the individual or to a medical professional designated by the individual and licensed to provide medical care with respect to the condition to which the information relates, whichever the individual prefers. If the individual elects to have the information disclosed to a medical professional designated by him, the insurance institution, agent or insurance-support organization shall notify the individual, at the time of the disclosure, that it has provided the information to the medical professional.

However, disclosure directly to the individual may be denied if a treating physician, clinical psychologist, clinical social worker, or licensed professional counselor has determined, in the exercise of professional judgment, that the disclosure requested would be reasonably likely to endanger the life or physical safety of the individual or another person or that the information requested makes reference to a person other than a health care provider and disclosure of such information would be reasonably likely to cause substantial harm to the referenced person.

If disclosure to the individual is denied, upon the individual's request, the insurance institution, agent or insurance support organization shall either (i) designate a physician, clinical psychologist, clinical social worker, or licensed professional counselor acceptable to the insurance institution, agent or insurance support organization, who was not directly involved in the denial, and whose licensure, training, and experience relative to the individual's condition are at least equivalent to that of the physician, clinical psychologist, clinical social worker, or licensed professional counselor who made the original determination, who shall, at the expense of the insurance institution, agent or insurance support organization, make a judgment as to whether to make the information available to the individual; or (ii) if the individual so requests, make the information available, at the individual's expense to a physician, clinical psychologist, clinical social worker, or licensed professional counselor selected by the individual, whose licensure, training and experience relative to the individual's condition are at least equivalent to that of the physician, clinical psychologist, clinical social worker, or licensed

professional counselor who made the original determination, who shall make a judgment as to whether to make the information available to the individual. The insurance institution, agent, or insurance support organization shall comply with the judgment of the reviewing physician, clinical psychologist, clinical social worker, or licensed professional counselor made in accordance with the foregoing procedures.

D. Except for personal information provided under § 38.2-610, an insurance institution, agent, or insurance-support organization may charge a reasonable fee to cover the costs incurred in providing a copy of recorded personal information to individuals.

E. The obligations imposed by this section upon an insurance institution or agent may be satisfied by another insurance institution or agent authorized to act on its behalf. With respect to the copying and disclosure of recorded personal information pursuant to a request under subsection A of this section, an insurance institution, agent, or insurance-support organization may make arrangements with an insurance-support organization or a consumer reporting agency to copy and disclose recorded personal information on its behalf.

F. The rights granted to individuals in this section shall extend to all natural persons to the extent information about them is collected and maintained by an insurance institution, agent or insurance-support organization in connection with an insurance transaction. The rights granted to all natural persons by this subsection shall not extend to information about them that relates to and is collected in connection with or in reasonable anticipation of a claim or civil or criminal proceeding involving them.

G. For purposes of this section, the term "insurance-support organization" does not include "consumer reporting agency."

1981, c. 389, § 38.1-57.11; 1986, c. 562; 2004, cc. 65, 1014; 2020, c. 945; 2022, c. 509.

§ 38.2-609. Correction, amendment, or deletion of recorded personal information.

A. Within thirty business days from the date of receipt of a written request from an individual to correct, amend, or delete any recorded personal information about the individual within its possession, an insurance institution, agent, or insurance-support organization shall either:

1. Correct, amend, or delete the portion of the recorded personal information in dispute; or

2. Notify the individual of:

a. Its refusal to make the correction, amendment, or deletion;

b. The reasons for the refusal; and

c. The individual's right to file a statement as provided in subsection C of this section.

B. If the insurance institution, agent, or insurance-support organization corrects, amends, or deletes recorded personal information in accordance with subdivision 1 of subsection A of this section, the insurance institution, agent, or insurance-support organization shall so notify the individual in writing and furnish the correction, amendment, or fact of deletion to:

1. Any person specifically designated by the individual who, within the preceding two years, may have received the recorded personal information;

2. Any insurance-support organization whose primary source of personal information is insurance institutions if the insurance-support organization has systematically received the recorded personal information from the insurance institution within the preceding seven years. The correction, amendment, or fact of deletion need not be furnished if the insurance-support organization no longer maintains recorded personal information about the individual; and

3. Any insurance-support organization that furnished the personal information that has been corrected, amended, or deleted.

C. Whenever an individual disagrees with an insurance institution's, agent's, or insurance-support organization's refusal to correct, amend, or delete recorded personal information, the individual shall be permitted to file with the insurance institution, agent, or insurance-support organization:

1. A concise statement setting forth what the individual thinks is the correct, relevant, or fair information; and

2. A concise statement of the reasons why the individual disagrees with the insurance institution's, agent's, or insurance-support organization's refusal to correct, amend, or delete recorded personal information.

D. In the event an individual files either statement as described in subsection C of this section, the insurance institution, agent, or support organization shall:

1. File the statement with the disputed personal information and provide a means by which anyone reviewing the disputed personal information will be made aware of the individual's statement and have access to it; and

2. In any subsequent disclosure by the insurance institution, agent, or support organization of the recorded personal information that is the subject of disagreement, clearly identify the matter or matters in dispute and provide the individual's statement along with the recorded personal information being disclosed; and

3. Furnish the statement to the persons and in the manner specified in subsection B of this section.

E. The rights granted to individuals in this section shall extend to all natural persons to the extent information about them is collected and maintained by an insurance institution, agent, or insurance-support organization in connection with an insurance transaction. The rights granted to all natural persons by this subsection shall not extend to information about them that relates to and is collected in connection with or in reasonable anticipation of a claim or civil or criminal proceeding involving them.

F. For purposes of this section, the term "insurance-support organization" does not include "consumer reporting agency."

1981, c. 389, § 38.1-57.12; 1986, c. 562.

§ 38.2-610. Notice of adverse underwriting decision; furnishing reasons for decisions and sources of information.

A. In the event of an adverse underwriting decision, including those that involve policies referred to in subdivision 1 of subsection E of § 38.2-2114 and in subdivision 3 of subsection F of § 38.2-2212, the insurance institution or agent responsible for the decision shall give a written notice in a form approved by the Commission that:

1. Either provides the applicant, policyholder, or individual proposed for coverage with the specific reason or reasons for the adverse underwriting decision in writing or advises such person that upon written request he may receive the specific reason or reasons in writing; and

2. Provides the applicant, policyholder, or individual proposed for coverage with a summary of the rights established under subsection B of this section and §§ 38.2-608 and 38.2-609.

B. Upon receipt of a written request within ninety business days from the date of the mailing of notice or other communication of an adverse underwriting decision to an applicant, policyholder or individual proposed for coverage, the insurance institution or agent shall furnish to such person within twenty-one business days from the date of receipt of the written request:

1. The specific reason or reasons for the adverse underwriting decision, in writing, if that information was not initially furnished in writing pursuant to subdivision 1 of subsection A of this section;

2. The specific items of personal and privileged information that support those reasons, however:

a. The insurance institution or agent shall not be required to furnish specific items of privileged information if it has a reasonable suspicion, based upon specific information available for review by the Commission, that the applicant, policyholder, or individual proposed for coverage has engaged in criminal activity, fraud, material misrepresentation, or material nondisclosure; and

b. Specific items of medical-record information supplied by a medical-care institution or medical professional shall be disclosed either directly to the individual about whom the information relates or to a medical professional designated by the individual and licensed to provide medical care with respect to the condition to which the information relates, whichever the insurance institution or agent prefers; and

3. The names and addresses of the institutional sources that supplied the specific items of information given pursuant to subdivision 2 of subsection B of this section. However, the identity of any medical professional or medical-care institution shall be disclosed either directly to the individual or to the designated medical professional, whichever the insurance institution or agent prefers.

C. The obligations imposed by this section upon an insurance institution or agent may be satisfied by another insurance institution or agent authorized to act on its behalf. However, the insurance institution or agent making an adverse underwriting decision shall remain responsible for compliance with the obligations imposed by this section.

D. When an adverse underwriting decision results solely from an oral request or inquiry, the explanation of reasons and summary of rights required by subsection A of this section may be given orally.

1981, c. 389, § 38.1-57.13; 1986, c. 562.

§ 38.2-611. Information concerning previous adverse underwriting decisions.

No insurance institution, agent, or insurance-support organization may seek information in connection with an insurance transaction concerning: (i) any previous adverse underwriting decision experienced by an individual, or (ii) any previous insurance coverage obtained by an individual through a residual market mechanism, unless the inquiry also requests the reasons for any previous adverse underwriting decision or the reasons why insurance coverage was previously obtained through a residual market mechanism.

1981, c. 389, § 38.1-57.14; 1986, c. 562.

§ 38.2-612. Bases for adverse underwriting decisions.

A. No insurance institution or agent may base an adverse underwriting decision in whole or in part:

1. On the fact of a previous adverse underwriting decision or on the fact that an individual previously obtained insurance coverage through a residual market mechanism. However, an insurance institution or agent may base an adverse underwriting decision on further information obtained from an insurance institution or agent responsible for a previous adverse underwriting decision;

2. On personal information received from an insurance-support organization whose primary source of information is insurance institutions. However, an insurance institution or agent may base an adverse underwriting decision on further personal information obtained as the result of information received from an insurance-support organization; or

3. On the fact that an individual previously obtained insurance coverage from a particular insurance institution or agent.

B. No insurance institution or agent may base an adverse underwriting decision solely on the loss history of a previous owner of the property to be insured.

1981, c. 389, § 38.1-57.15; 1986, c. 562; 1990, c. 524; 2003, c. 415.

§ 38.2-612.1. Special requirements for providing financial information to nonaffiliated third parties.

A. Except as otherwise provided in § 38.2-613, no insurance institution, agent, or insurance-support organization may, directly or through an affiliate, disclose to a nonaffiliated third party financial information about an individual collected or received in connection with an insurance transaction, unless:

1. The individual has been given a clear and conspicuous notice in writing, or in electronic form if the individual agrees, stating that such financial information may be disclosed to such nonaffiliated third party;

2. The individual is given an opportunity, before such financial information is initially disclosed, to direct that such information not be disclosed, and in no case shall the individual be given less than 30 days from the date of notice to direct that such information not be disclosed;

3. The individual is given a reasonable means by which to exercise the right to direct that such information not be disclosed as well as an explanation that such right may be exercised at any time and that such right remains effective until revoked by the individual; and

4. The nonaffiliated third party agrees not to disclose such financial information to any other person unless such disclosure would otherwise be permitted by this article if made by the insurance institution, agent, or insurance-support organization.

B. 1. No insurance institution, agent, or insurance-support organization may disclose to a nonaffiliated third party, directly or through an affiliate, other than to a consumer reporting agency, a policy number or similar form of access number or transaction account of a policyholder or applicant for use in telemarketing, direct mail marketing or other marketing through electronic mail to an applicant or policyholder, other than to:

a. An agent or other person solely for the purpose of marketing the insurance institution's own products or services as long as the agent or other person is not authorized to directly initiate charges to the account; or

b. A participant in a private label credit card program or an affinity or similar program where the participants in the program are identified to the policyholder or applicant at the time the policyholder or applicant enters the program.

2. A policy or transaction account shall not include an account to which third parties cannot initiate charges.

C. No insurance institution or agent shall unfairly discriminate against an individual because (i) the individual has directed that his personal information not be disclosed pursuant to subsection A or (ii) the individual has refused to grant authorization of the disclosure of his privileged information or medical record information by an insurance institution, agent or insurance support organization pursuant to subsection A of § 38.2-613.

D. The requirements of subsection A may be satisfied by providing a single notice if two or more applicants or policyholders jointly obtain or apply for an insurance product. Such notice shall allow one applicant or policyholder to direct that financial information not be disclosed to nonaffiliated third parties on behalf of all of the joint applicants or policyholders, provided that each applicant or policyholder may separately direct that his financial information not be disclosed to nonaffiliated third parties.

E. An insurance agent shall not be subject to the requirements of subsection A in any instance where the insurance institution on whose behalf the agent is acting otherwise complies with the requirements

contained herein, and the agent does not disclose any financial information to any person other than the insurance institution or its affiliates, or as permitted by § 38.2-613.

F. An insurance agent seeking to place coverage on behalf of a current policyholder shall be deemed to be in compliance with the requirements of this section in any instance where the agent has provided the notice required by this section within the previous 12 months.

2001, c. 371; 2003, c. 266; 2020, c. 264.

§ 38.2-612.2. Protection of the Fair Credit Reporting Act.

Nothing in this article shall be construed to modify, limit, or supersede the operation of the federal Fair Credit Reporting Act (15 U.S.C. § 1681 et seq.), and no inference shall be drawn on the basis of the provisions of this article regarding whether information is transaction or experience information under Section 603 of that Act.

2001, c. 371; 2020, c. 264.

§ 38.2-613. Disclosure limitations and conditions.

A. An insurance institution, agent, or insurance-support organization shall not disclose any medical-record information or privileged information about an individual collected or received in connection with an insurance transaction unless the disclosure is with the written authorization of the individual, provided:

1. If the authorization is submitted by another insurance institution, agent, or insurance-support organization, the authorization meets the requirements of § 38.2-606; or

2. If the authorization is submitted by a person other than an insurance institution, agent, or insurance-support organization, the authorization is:

a. Dated,

b. Signed by the individual, and

c. Obtained two years or less prior to the date a disclosure is sought pursuant to this subdivision.

B. Notwithstanding the provisions of subsection A, an insurance institution, agent, or insurance-support organization may disclose personal or privileged information about an individual collected or received in connection with an insurance transaction, without written authorization, if the disclosure is:

1. To a person other than an insurance institution, agent, or insurance-support organization, provided the disclosure is reasonably necessary:

a. To enable that person to perform a business, professional or insurance function for the disclosing insurance institution, agent, or insurance-support organization and that person agrees not to disclose the information further without the individual's written authorization unless the further disclosure:

(1) Would otherwise be permitted by this section if made by an insurance institution, agent, or insurance-support organization; or

(2) Is reasonably necessary for that person to perform its function for the disclosing insurance institution, agent, or insurance-support organization; or

b. To enable that person to provide information to the disclosing insurance institution, agent, or insurance-support organization for the purpose of:

(1) Determining an individual's eligibility for an insurance benefit or payment; or

(2) Detecting or preventing criminal activity, fraud, material misrepresentation, or material nondisclosure in connection with an insurance transaction; or

2. To an insurance institution, agent, or insurance-support organization, or self-insurer, provided the information disclosed is limited to that which is reasonably necessary:

a. To detect or prevent criminal activity, fraud, material misrepresentation, or material nondisclosure in connection with insurance transactions; or

b. For either the disclosing or receiving insurance institution, agent or insurance-support organization to perform its function in connection with an insurance transaction involving the individual; or

3. To a medical-care institution or medical professional for the purpose of (i) verifying insurance coverage or benefits, (ii) informing an individual of a medical problem of which the individual may not be aware or (iii) conducting an operations or services audit, provided only that information is disclosed as is reasonably necessary to accomplish the foregoing purposes; or

4. To an insurance regulatory authority; or

5. To a law-enforcement or other government authority:

a. To protect the interests of the insurance institution, agent or insurance-support organization in preventing or prosecuting the perpetration of fraud upon it; or

b. If the insurance institution, agent, or insurance-support organization reasonably believes that illegal activities have been conducted by the individual; or

c. Upon written request of any law-enforcement agency, for all insured or claimant information in the possession of an insurance institution, agent, or insurance-support organization which relates an ongoing criminal investigation. Such insurance institution, agent, or insurance-support organization shall release such information, including, but not limited to, policy information, premium payment records, record of prior claims by the insured or by another claimant, and information collected in connection with an insurance company's investigation of an application or claim. Any information released to a law-enforcement agency pursuant to such request shall be treated as confidential criminal investigation information and not be disclosed further except as provided by law. Notwithstanding any provision in this article, no insurance institution, agent, or insurance-support organization shall notify any insured or claimant that information has been requested or supplied pursuant to this section prior to notification from the requesting law-enforcement agency that its criminal investigation is completed. Within ninety days following the completion of any such criminal investigation, the law-

enforcement agency making such a request for information shall notify any insurance institution, agent, or insurance-support organization from whom information was requested that the criminal investigation has been completed; or

6. Otherwise permitted or required by law; or

7. In response to a facially valid administrative or judicial order, including a search warrant or subpoena; or

8. Made for the purpose of conducting actuarial or research studies, provided:

a. No individual may be identified in any actuarial or research report, and

b. Materials allowing the individual to be identified are returned or destroyed as soon as they are no longer needed, and

c. The actuarial or research organization agrees not to disclose the information unless the disclosure would otherwise be permitted by this section if made by an insurance institution, agent, or insurance-support organization; or

9. To a party or a representative of a party to a proposed or consummated sale, transfer, merger, or consolidation of all or part of the business of the insurance institution, agent, or insurance-support organization, provided:

a. Prior to the consummation of the sale, transfer, merger, or consolidation only such information is disclosed as is reasonably necessary to enable the recipient to make business decisions about the purchase, transfer, merger, or consolidation, and

b. The recipient agrees not to disclose the information unless the disclosure would otherwise be permitted by this section if made by an insurance institution, agent, or insurance-support organization; or

10. To a nonaffiliated third party whose only use of such information will be in connection with the marketing of a nonfinancial product or service, provided:

a. No medical-record information, privileged information, or personal information relating to an individual's character, personal habits, mode of living, or general reputation is disclosed, and no classification derived from the information is disclosed,

b. The individual has been given an opportunity, in accordance with the provisions of subsection A of § 38.2-612.1, to indicate that he does not want financial information disclosed for marketing purposes and has given no indication that he does not want the information disclosed, and

c. The nonaffiliated third party receiving such information agrees not to use it except in connection with the marketing of the product or service; or

11. (i) To a consumer reporting agency in accordance with the Fair Credit Reporting Act (15 U.S.C. § 1681 et seq.) or (ii) from a consumer report reported by a consumer reporting agency; or

12. To a group policyholder for the purpose of reporting claims experience or conducting an audit of the insurance institution's or agent's operations or services, provided the information disclosed is reasonably necessary for the group policyholder to conduct the review or audit; or

13. To a professional peer review organization for the purpose of reviewing the service or conduct of a medical-care institution or medical professional; or

14. To a governmental authority for the purpose of determining the individual's eligibility for health benefits for which the governmental authority may be liable; or

15. To a certificate holder or policyholder for the purpose of providing information regarding the status of an insurance transaction; or

16. To a lienholder, mortgagee, assignee, lessor or other person shown on the records of an insurance institution or agent as having a legal or beneficial interest in a policy of insurance, or to persons acting in a fiduciary or representative capacity on behalf of the individual, provided that:

a. No medical record information is disclosed unless the disclosure would be permitted by this section; and

b. The information disclosed is limited to that which is reasonably necessary to permit such person to protect his interest in the policy; or

17. Necessary to effect, administer, or enforce a transaction requested or authorized by the individual, or in connection with servicing or processing an insurance product or service requested or authorized by the individual, or necessary for reinsurance purposes, or for stop loss or excess loss agreements provided for in subsection B of § 38.2-109; or

18. Pursuant to any federal Health Insurance Portability and Accountability Act privacy rules promulgated by the United States Department of Health and Human Services.

C. An insurance institution, agent, or insurance-support organization may disclose information about an individual collected or received in connection with an insurance transaction, without written authorization, if the disclosure is:

1. To a nonaffiliated third party whose only use of such information will be to perform services for or functions on behalf of the insurance institution in connection with the marketing of the insurance institution's product or service or the marketing of products or services offered pursuant to a joint marketing agreement, provided:

a. No medical-record information or privileged information is disclosed without the individual's written authorization unless such disclosure is otherwise permitted by subsection B,

b. With respect to financial information, the individual has been given the notice required by subsection B of § 38.2-604.1, and

c. The person receiving such financial information agrees, by contract, (i) not to use it except to perform services for or functions on behalf of the insurance institution in connection with the marketing of

the insurance institution's product or service or the marketing of products or services offered pursuant to a joint marketing agreement, or as permitted under subsection B and (ii) to maintain the confidentiality of such information and not disclose it to any other nonaffiliated third party unless such disclosure would otherwise be permitted by this section if made by the insurance institution, agent, or insurance-support organization;

2. To an affiliate, provided:

a. No medical-record information or privileged information is disclosed without the individual's written authorization unless such disclosure is otherwise permitted by subsection B, and

b. The affiliate receiving the information does not disclose the information except as would otherwise be permitted by this section if such disclosure were made by the insurance institution, agent, or insurance-support organization.

D. 1. No person proposing to issue, re-issue, or renew any policy, contract, or plan of accident and sickness insurance defined in § 38.2-109, but excluding disability income insurance, issued by any (i) insurer providing hospital, medical and surgical or major medical coverage on an expense incurred basis, (ii) corporation providing a health services plan, or (iii) health maintenance organization providing a health care plan for health care services shall disclose any genetic information about an individual or a member of such individual's family collected or received in connection with any insurance transaction unless the disclosure is made with the written authorization of the individual.

2. For the purpose of this subsection, "genetic information" means information about genes, gene products, or inherited characteristics that may derive from an individual or a family member.

3. Agents and insurance support organizations shall be subject to the provisions of this subsection to the extent of their participation in the issue, re-issue, or renewal of any policy, contract, or plan of accident and sickness insurance defined in § 38.2-109, but excluding disability income insurance.

E. Any notices, disclosures, or authorizations required by this section may be provided electronically if the individual agrees.

F. Any privileged information about an individual that is disclosed in violation of this section shall be available to that individual in accordance with the provisions of §§ 38.2-608 and 38.2-609.

G. Except in the case of disclosures made pursuant to subdivision B 10, the requirements of subsection A of § 38.2-612.1 shall not apply when information is disclosed pursuant to this section.

1981, c. 389, § 38.1-57.16; 1986, c. 562; 1987, c. 325; 1996, c. 704; 2001, c. 371; 2020, c. 264.

§ 38.2-613.01. Commission to promulgate regulations on disclosure of certain medical test results to insurance applicants.

Pursuant to the authority granted by §§ 38.2-223 and 38.2-3100.1, the Commission shall promulgate such regulations as may be necessary or appropriate to ensure that applicants for life or accident and sickness insurance coverage or for modifications to existing coverage are notified of test results

whenever insurers require such applicants to submit to testing for human immunodeficiency viruses (HIV).

1997, c. 290.

§ 38.2-613.1. Disclosure of agent's moratorium required.

If a duly appointed agent of an insurer proposes to place a policy of motor vehicle insurance as defined in § 38.2-2212 with another insurer or proposes to submit an application to the Virginia Automobile Insurance Plan solely because of a moratorium on such agent's selling, soliciting, or negotiating new motor vehicle insurance that would otherwise be acceptable to such insurer and such placement or submission would result in the applicant's being charged a higher rate, the agent shall disclose to the applicant the existence of the moratorium prior to such placement or submission.

1991, c. 269; 2001, c. 706.

§ 38.2-613.2. Repealed.

Repealed by Acts 2020, c. 264, cl. 2.

§ 38.2-614. Powers of Commission.

A. The Commission shall have the power to examine and investigate the affairs of any insurance institution or agent doing business in the Commonwealth to determine whether the insurance institution or agent has been or is engaged in any conduct in violation of this article.

B. The Commission shall have the power to examine and investigate the affairs of any insurance-support organization that acts on behalf of an insurance institution or agent and that either (i) transacts business in the Commonwealth, or (ii) transacts business outside the Commonwealth and has an effect on a person residing in the Commonwealth, in order to determine whether the insurance-support organization has been or is engaged in any conduct in violation of this article.

1981, c. 389, § 38.1-57.17; 1986, c. 562; 2020, c. 264.

§ 38.2-615. Hearings and procedures.

A. Whenever the Commission has reason to believe that an insurance institution, agent or insurance-support organization has been or is engaged in conduct in the Commonwealth that violates this article, or whenever the Commission has reason to believe that an insurance-support organization has been or is engaged in conduct outside the Commonwealth that has an effect on a person residing in the Commonwealth and that violates this article, the Commission may issue and serve upon the insurance institution, agent, or insurance-support organization a statement of charges and notice of hearing to be held at a time and place fixed in the notice. The date for such hearing shall be at least ten days after the date of service.

B. At the time and place fixed for the hearing, the insurance institution, agent, or insurance-support organization charged shall have an opportunity to answer the charges against it and present evidence on its behalf. Upon good cause shown, the Commission shall permit any adversely affected person to intervene, appear, and be heard at the hearing by counsel or in person.

C. In all matters in connection with such investigation, charge, or hearing the Commission shall have the jurisdiction, power and authority granted or conferred upon it by Title 12.1.

1981, c. 389, § 38.1-57.18; 1986, c. 562; 2020, c. 264.

§ 38.2-616. Service of process on insurance-support organizations.

For the purpose of this article, an insurance-support organization transacting business outside the Commonwealth that has an effect on a person residing in the Commonwealth and which is alleged to violate this article shall be deemed to have appointed the clerk of the Commission to accept service of process on its behalf. Service on the clerk shall be made in accordance with § 12.1-19.1.

1981, c. 389, § 38.1-57.19; 1986, c. 562; 1991, c. 672; 2020, c. 264.

§ 38.2-617. Individual remedies.

A. If any insurance institution, agent, or insurance-support organization fails to comply with §§ 38.2-608, 38.2-609, or § 38.2-610, any person whose rights granted under those sections are violated may apply to a court of competent jurisdiction for appropriate equitable relief.

B. An insurance institution, agent, or insurance-support organization that discloses information in violation of § 38.2-613 shall be liable for damages sustained by the individual to whom the information relates. No individual, however, shall be entitled to a monetary award that exceeds the actual damages sustained by the individual as a result of a violation of § 38.2-613.

C. In any action brought pursuant to this section, the court may award the cost of the action and reasonable attorney's fees to the prevailing party.

D. An action under this section must be brought within two years from the date the alleged violation is or should have been discovered.

E. Except as specifically provided in this section, there shall be no remedy or recovery available to individuals, in law or in equity, for occurrences constituting a violation of any provision of this article.

1981, c. 389, § 38.1-57.24; 1986, c. 562; 2020, c. 264.

§ 38.2-618. Immunity of persons disclosing information.

No cause of action in the nature of defamation, invasion of privacy, or negligence shall arise against any person for disclosing personal or privileged information in accordance with this article, nor shall such a cause of action arise against any person for furnishing personal or privileged information to an insurance institution, agent, or insurance-support organization. However, this section shall provide no immunity for disclosing or furnishing false information with malice or willful intent to injure any person.

1981, c. 389, § 38.1-57.25; 1986, c. 562; 2020, c. 264.

§ 38.2-619. Obtaining information under false pretenses.

Any person who knowingly and willfully obtains information about an individual from an insurance institution, agent or insurance-support organization under false pretenses shall be fined not more than $10,000 or punished by confinement in jail for not more than 12 months, or both.

1981, c. 389, § 38.1-57.26; 1986, c. 562.

§ 38.2-620. Repealed.

Repealed by Acts 2020, c. 264, cl. 2.

Article 2 - Insurance Data Security Act

§ 38.2-621. Definitions.

As used in this article:

"Authorized person" means a person known to and authorized by the licensee and determined to be necessary and appropriate to have access to the nonpublic information held by the licensee and its information systems.

"Consumer" means an individual, including applicants, policyholders, insureds, beneficiaries, claimants, and certificate holders, who is a resident of the Commonwealth and whose nonpublic information is in the possession, custody, or control of a licensee or an authorized person.

"Cybersecurity event" means an event resulting in unauthorized access to, disruption of, or misuse of an information system or nonpublic information in the possession, custody, or control of a licensee or an authorized person. "Cybersecurity event" does not include (i) the unauthorized acquisition of encrypted nonpublic information if the encryption, process, or key is not also acquired, released, or used without authorization or (ii) an event in which the licensee has determined that the nonpublic information accessed by an unauthorized person has not been used or released and has been returned or destroyed.

"Encrypted" means the transformation of data into a form that results in a low probability of assigning meaning without the use of a protective process or key.

"HIPAA" means the federal Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d et seq.).

"Home state" means the jurisdiction in which the producer maintains its principal place of residence or principal place of business and is licensed by that jurisdiction to act as a resident insurance producer.

"Information security program" means the administrative, technical, and physical safeguards that a licensee uses to access, collect, distribute, process, protect, store, use, transmit, dispose of, or otherwise handle nonpublic information.

"Information system" means a discrete set of electronic information resources organized for the collection, processing, maintenance, use, sharing, dissemination, or disposition of electronic information, as well as any specialized system such as industrial or process control systems, telephone switching and private branch exchange systems, and environmental control systems.

"Insurance-support organization" has the same meaning as provided in § 38.2-602.

"Licensee" means any person licensed, authorized to operate, or registered, or required to be licensed, authorized, or registered pursuant to the insurance laws of the Commonwealth. "Licensee" does not include a purchasing group or a risk retention group chartered and licensed in a state other than the Commonwealth or a person that is acting as an assuming insurer that is domiciled in another state or jurisdiction.

"Nonpublic information" means information that is not publicly available information and is:

1. Business-related information of a licensee the tampering with which, or the unauthorized disclosure, access, or use of which, would cause a material adverse impact to the business, operations, or security of the licensee;

2. Any information concerning a consumer that because of name, number, personal mark, or other identifier can be used to identify such consumer, in any combination with a consumer's (i) social security number; (ii) driver's license number or nondriver identification card number; (iii) financial account, credit card, or debit card number; (iv) security code, access code, or password that would permit access to a consumer's financial account; (v) passport number; (vi) military identification number; or (vii) biometric records; or

3. Any information or data, except age or gender, in any form or medium created by or derived from a health care provider or a consumer that can be used to identify a particular consumer, and that relates to (i) the past, present, or future physical, mental, or behavioral health or condition of any consumer or a member of the consumer's family; (i) the provision of health care to any consumer; or (iii) payment for the provision of health care to any consumer.

"Nonpublic information" does not include a consumer's personally identifiable information that has been anonymized using a method no less secure than the safe harbor method under HIPAA.

"Person" means any individual or any nongovernmental entity, including any nongovernmental partnership, corporation, branch, agency, or association.

"Publicly available information" means any information that a licensee has a reasonable basis to believe is lawfully made available to the general public from federal, state, or local government records; widely distributed media; or disclosures to the general public that are required to be made by federal, state, or local law. A licensee has a reasonable basis to believe that information is lawfully made available to the general public if the licensee has taken steps to determine (i) that the information is of the type that is available to the general public and (ii) whether a consumer can direct that the information not be made available to the general public and, if so, that such consumer has not done so.

"Third-party service provider" means (i) a person, not otherwise defined as a licensee, that contracts with a licensee to maintain, process, or store nonpublic information, or otherwise is permitted access to nonpublic information through its provision of services to the licensee or (ii) an insurance-support organization.

2020, c. 264.

§ 38.2-622. Private cause of action; neither created nor curtailed.

Nothing in this article shall be construed to create or imply a private cause of action for violation of its provisions, nor shall it be construed to curtail a private cause of action which would otherwise exist in the absence of this article.

2020, c. 264.

§ 38.2-623. Information security program.

A. Commensurate with the size and complexity of the licensee; the nature and scope of the licensee's activities, including its use of third-party service providers; and the sensitivity of the nonpublic information used by the licensee or in the licensee's possession, custody, or control, each licensee shall develop, implement, and maintain a comprehensive written information security program based on the licensee's assessment of the licensee's risk and that contains administrative, technical, and physical safeguards for the protection of nonpublic information and the licensee's information system.

B. Each licensee's information security program shall be designed to:

1. Protect the security and confidentiality of nonpublic information and the security of the information system;

2. Protect against any reasonably foreseeable threats or hazards to the security or integrity of nonpublic information and the information system;

3. Protect against unauthorized access to or use of nonpublic information, and minimize the likelihood of harm to any consumer; and

4. Define and periodically reevaluate a schedule for retention of nonpublic information and a mechanism for its destruction.

C. Each licensee shall:

1. Designate one or more employees, an affiliate, or an outside vendor designated to act on behalf of the licensee who is responsible for the information security program;

2. Design its information security program to mitigate the identified risks, commensurate with the size and complexity of the licensee; the nature and scope of the licensee's activities, including its use of third-party service providers; and the sensitivity of the nonpublic information used by the licensee or in the licensee's possession, custody, or control;

3. Place access controls on information systems, including controls to authenticate and permit access only to authorized persons to protect against the unauthorized acquisition of nonpublic information;

4. At physical locations containing nonpublic information, restrict access to nonpublic information to authorized persons only;

5. Implement measures to protect against destruction, loss, or damage of nonpublic information due to environmental hazards, such as fire and water damage or other catastrophes or technological failures;

6. Develop, implement, and maintain procedures for the secure disposal of nonpublic information in any format;

7. Stay informed regarding emerging threats or vulnerabilities and utilize reasonable security measures when sharing information relative to the character of the sharing and the type of information shared; and

8. Provide its personnel with cybersecurity awareness training.

D. 1. If a licensee has a board of directors, the board or an appropriate committee of the board shall, at a minimum, require the licensee's information executive management or its delegates to (i) develop, implement, and maintain the licensee's information security program and (ii) report in writing (a) the overall status of the information security program and the licensee's compliance with this article and (b) material matters related to the information security program, addressing issues such as risk assessment, risk management and control decisions, third-party service provider arrangements, results of testing, cybersecurity events or violations and management's responses thereto, and recommendations for changes in the information security program.

2. If executive management delegates any of its responsibilities under this section, it shall oversee the development, implementation, and maintenance of the licensee's information security program prepared by the delegate and shall receive a report from the delegate complying with the requirements of subdivision 1.

E. Beginning July 1, 2022, if a licensee utilizes a third-party service provider, the licensee shall:

1. Exercise due diligence in selecting its third-party service provider; and

2. Require a third-party service provider to implement appropriate administrative, technical, and physical measures to protect and secure the information systems and nonpublic information that are accessible to, or held by, the third-party service provider.

F. Each licensee shall monitor, evaluate, and adjust, as appropriate, the information security program consistent with any relevant changes in technology, the sensitivity of its nonpublic information, internal or external threats to information, and the licensee's own changing business arrangements, such as mergers and acquisitions, alliances and joint ventures, outsourcing arrangements, and changes to information systems.

G. As part of its information security program, each licensee shall establish a written incident response plan designed to promptly respond to, and recover from, any cybersecurity event that compromises the confidentiality, integrity, or availability of nonpublic information in its possession; the licensee's information systems; or the continuing functionality of any aspect of the licensee's business or operations. Such incident response plan shall address:

1. The internal process for responding to a cybersecurity event;

2. The goals of the incident response plan;

3. The definition of clear roles, responsibilities, and levels of decision-making authority;

4. External and internal communications and information sharing;

5. Identification of requirements for the remediation of any identified weaknesses in information systems and associated controls;

6. Documentation and reporting regarding cybersecurity events and related incident response activities; and

7. The evaluation and revision, as necessary, of the incident response plan following a cybersecurity event.

H. Beginning in 2023 and annually thereafter, each insurer domiciled in the Commonwealth shall, by February 15, submit to the Commissioner a written statement certifying that the insurer is in compliance with the requirements set forth in this section, any rules adopted pursuant to this article, and any requirements prescribed by the Commission. Each insurer shall maintain for examination by the Bureau all records, schedules, and data supporting this certificate for a period of five years. To the extent an insurer has identified areas, systems, or processes that require material improvement, updating, or redesign, the insurer shall document the identification and the remedial efforts planned and underway to address such areas, systems, or processes. Such documentation must be available for inspection by the Commissioner.

2020, c. 264.

§ 38.2-624. Investigation of a cybersecurity event.

A. If a licensee learns that a cybersecurity event has or may have occurred, the licensee or an investigator shall conduct a prompt investigation.

B. During the investigation, the licensee or an investigator shall, at a minimum, determine as much of the following information as possible:

1. Determine whether a cybersecurity event has occurred;

2. Assess the nature and scope of the cybersecurity event;

3. Identify any nonpublic information that may have been involved in the cybersecurity event; and

4. Perform or oversee reasonable measures to restore the security of the information systems compromised in the cybersecurity event in order to prevent further unauthorized acquisition, release, or use of nonpublic information in the licensee's possession, custody, or control.

C. If a licensee learns that a cybersecurity event has or may have occurred in a system maintained by a third-party service provider, the licensee will complete the steps listed in subsection B or make reasonable efforts to confirm and document that the third-party service provider has completed those steps.

D. Each licensee shall maintain records concerning all cybersecurity events for a period of at least five years from the date of the cybersecurity event and shall produce those records upon demand of the Commissioner.

2020, c. 264.

§ 38.2-625. Notice to Commissioner.

A. If a licensee has determined that a cybersecurity event has actually occurred, such licensee shall notify the Commissioner, in accordance with requirements prescribed by the Commission, as promptly as possible but in no event later than three business days from such determination if:

1. The licensee is a domestic insurance company, or in the case of a producer, the Commonwealth is the licensee's home state and the cybersecurity event meets threshold and other requirements prescribed by the Commission; or

2. The licensee reasonably believes that the nonpublic information involved is of 250 or more consumers residing in the Commonwealth or the licensee is required under federal law or the laws of another state to provide notice of the cybersecurity event to any government body, self-regulatory agency, or other supervisory body.

B. Notice provided pursuant to this section shall be in electronic form and shall include as much of the following information as possible:

1. The date of the cybersecurity event;

2. A description of how the nonpublic information was exposed, lost, stolen, or breached, including the specific roles and responsibilities of third-party service providers, if any;

3. How the cybersecurity event was discovered;

4. Whether any lost, stolen, or breached information has been recovered and, if so, how this was done;

5. The identity of the source of the cybersecurity event;

6. Whether the licensee has filed a police report or has notified any regulatory, government, or law-enforcement agencies and, if so, when such notification was provided;

7. A description of the specific types of information acquired without authorization. Specific types of information include particular data elements such as medical information, financial information, or other information allowing identification of the consumer;

8. The period during which the information system was compromised by the cybersecurity event;

9. The number of consumers in the Commonwealth affected by the cybersecurity event. The licensee shall provide the best estimate in the initial report to the Commissioner and update this estimate with each subsequent report to the Commissioner pursuant to this section;

10. The results of any internal review identifying a lapse in either automated controls or internal procedures, or confirming that all automated controls or internal procedures were followed;

11. A description of efforts being undertaken to remediate the situation that permitted the cybersecurity event to occur;

12. A copy of the licensee's consumer privacy policy and a statement outlining the steps the licensee will take to investigate and notify consumers affected by the cybersecurity event; and

13. The name of a contact person who is both familiar with the cybersecurity event and authorized to act for the licensee.

C. A licensee shall have a continuing obligation to update and supplement initial and subsequent notifications to the Commissioner concerning the cybersecurity event.

D. Each licensee shall notify consumers in compliance with § 38.2-626, and provide a copy of the notice sent to consumers under such section to the Commissioner, when a licensee is required to notify the Commissioner under this section.

E. If there is a cybersecurity event in a system maintained by a third-party service provider, the licensee, once it has become aware of such cybersecurity event, shall treat such event as it would under this section, unless the third-party service provider provides notice in accordance with this section. The computation of a licensee's deadlines shall begin on the day after the third-party service provider notifies a licensee of the cybersecurity event or the licensee otherwise has actual knowledge of the cybersecurity event, whichever is sooner.

F. If a cybersecurity event involves nonpublic information that is used by a licensee that is acting as an assuming insurer or is in the possession, control, or custody of a licensee that is acting as an assuming insurer or its third-party service provider and the licensee does not have a direct contractual relationship with the affected consumers, the licensee shall notify its affected ceding insurers and the head of its supervisory state agency of its state of domicile within three business days of making the determination or receiving notice from its third-party service provider that a cybersecurity event has occurred. Ceding insurers that have a direct contractual relationship with affected consumers shall fulfill the consumer notification requirements imposed under § 38.2-626 and any other notification requirements relating to a cybersecurity event imposed under this section.

G. If there is a cybersecurity event involving nonpublic information that is in the possession, custody, or control of a licensee that is an insurer or its third-party service provider and for which a consumer accessed the insurer's services through an independent insurance producer, the insurer shall notify the producers of record of all affected consumers as soon as practicable as directed by the Commissioner. The insurer is excused from this obligation for those instances in which it does not have the current producer of record information for any individual consumer.

H. Nothing in this article shall prevent or abrogate an agreement between a licensee and another licensee, a third-party service provider, or any other party to fulfill any of the investigation requirements imposed under § 38.2-624 or notice requirements imposed under this section.

2020, c. 264.

§ 38.2-626. Notice to consumers.

A. A licensee that maintains consumers' nonpublic information shall notify the consumer of any cybersecurity event without unreasonable delay after making a determination or receiving notice the cybersecurity event has occurred, if consumers' nonpublic information was accessed and acquired by an unauthorized person or such licensee reasonably believes consumers' nonpublic information was accessed and acquired by an unauthorized person and the cybersecurity event has a reasonable likelihood of causing or has caused identity theft or other fraud to such consumers. Such notice shall include a description of the following:

1. The incident in general terms;

2. The type of nonpublic information that was subject to the unauthorized access and acquisition;

3. The general acts of the licensee to protect the consumer's nonpublic information from further unauthorized access;

4. A telephone number that the consumer may call for further information and assistance, if one exists; and

5. Advice that directs the consumer to remain vigilant by reviewing account statements and monitoring the consumer's credit reports.

B. Notice to consumers under this section shall be given as written notice to the last known postal address in the records of the licensee, telephone notice, or electronic notice. However, if the licensee required to provide notice demonstrates that the cost of providing notice will exceed $50,000, the affected class of consumers to be notified exceeds 100,000 consumers, or the licensee does not have sufficient contact information or consent to provide notice, substitute notice may be provided. Substitute notice shall consist of (i) e-mail notice if the licensee has e-mail addresses for the members of the affected class of consumers; (ii) conspicuous posting of the notice on the website of the licensee if the licensee maintains a website; and (iii) notice to major statewide media.

C. In the event that a licensee provides notice to more than 1,000 consumers at one time pursuant to this section, the licensee shall also notify, without unreasonable delay, all consumer reporting agencies that compile and maintain files on consumers on a nationwide basis, as defined in 15 U.S.C. § 1681a (p), of the timing, distribution, and content of the notice.

D. Notice required by this section shall not be considered a debt communication as defined by the Fair Debt Collection Practices Act in 15 U.S.C. § 1692a.

E. Notice required by this section and § 38.2-625 may be delayed if, after the person notifies a law-enforcement agency, the law-enforcement agency determines and advises the person that the notice will impede a criminal or civil investigation or jeopardize national or homeland security. Notice shall be made without unreasonable delay after the law-enforcement agency determines that the notification will no longer impede the investigation or jeopardize national or homeland security.

F. If there is a cybersecurity event in a system maintained by a third-party service provider, the licensee, once it has become aware of such cybersecurity event, shall treat such event as it would under this section, unless the third-party service provider provides notice in accordance with this section. The computation of a licensee's deadlines shall begin on the day after the third-party service provider notifies a licensee of the cybersecurity event or the licensee otherwise has actual knowledge of the cybersecurity event, whichever is sooner.

2020, c. 264.

§ 38.2-627. Powers and duties of the Commission; exclusive state standards.

A. The Commissioner may examine and investigate the affairs of any licensee to determine whether a licensee has been or is engaged in any conduct in violation of this article. This power is in addition to the powers that the Commissioner has under Article 4 of Chapter 13 (38.2-1300 et seq.) and Chapter 18 (38.2-1800 et seq.). Any such investigation or examination shall be conducted pursuant to Chapters 13 and 18.

B. Whenever the Commissioner has reason to believe that a licensee has been or is engaged in conduct in the Commonwealth that violates this article, the Commissioner may take action that is necessary or appropriate to enforce the provisions of this article.

C. The Commission may examine and investigate the affairs of any insurance-support organization that acts on behalf of an insurance institution or agent as defined in § 38.2-602 and that either (i) transacts business in the Commonwealth or (ii) transacts business outside the Commonwealth and has an effect on a person residing in the Commonwealth, in order to determine whether the insurance-support organization has been or is engaged in any conduct in violation of this article.

D. The Commission shall adopt rules and regulations implementing the provisions of this article.

E. This article and any rules adopted pursuant to this article establish the exclusive state standards applicable to licensees for data security, the security of nonpublic information, the investigation of cybersecurity events, and notification of cybersecurity events for those individuals and entities subject to this article.

2020, c. 264.

§ 38.2-628. Confidentiality.

A. Any documents, materials, or other information in the control or possession of the Bureau that are furnished by a licensee or an employee or agent thereof acting on behalf of licensee pursuant to subsection H of § 38.2-623 or subdivisions B 2, 3, 4, 5, 8, 10, and 11 § 38.2-625, or that are obtained by

the Commissioner in an investigation or examination pursuant to § 38.2-627, shall be confidential by law and privileged, shall not be subject to § 12.1-19, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the Commissioner is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the Commissioner's duties.

B. Neither the Commissioner nor any person who received documents, materials, or other information while acting under the authority of the Commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection A.

C. In order to assist in the performance of the Commissioner's duties under this article, the Commissioner may:

1. Share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to subsection A, with other state, federal, and international regulatory agencies; with the National Association of Insurance Commissioners (NAIC), its affiliates, or its subsidiaries; and with state, federal, and international law-enforcement authorities, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the documents, materials, or other information;

2. Receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information, from the NAIC, its affiliates, or its subsidiaries and from regulatory and law-enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any documents, materials, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the documents, materials, or information;

3. Share documents, materials, or other information subject to subsection A with a third-party consultant or vendor provided the consultant agrees in writing to maintain the confidentiality and privileged status of the documents, materials, or other information; and

4. Enter into agreements governing sharing and use of information consistent with this subsection.

D. No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the Commissioner under this section or as a result of sharing as authorized in subsection C.

E. Documents, materials, or other information in the possession or control of the NAIC or a third-party consultant or vendor as a result of an examination or investigation pursuant to subsection H of § 38.2-623 or subdivisions B 2, 3, 4, 5, 8, 10, and 11 of § 38.2-625 shall be confidential by law and privileged, shall not be subject to § 12.1-19, shall not be subject to subpoena, and shall not be subject to discovery in any private civil action.

F. Nothing in this article shall prohibit the Commissioner from releasing final, adjudicated actions that are open to public inspection to a database or other clearinghouse service maintained by the NAIC, its affiliates, or its subsidiaries.

2020, c. 264.

§ 38.2-629. Exceptions.

A. The following exceptions shall apply to this article:

1. A licensee subject to HIPAA that has established and maintains an information security program pursuant to such statutes, rules, regulations, or procedures established thereunder shall be considered to meet the requirements of § 38.2-623, provided that licensee is compliant with, and submits a written statement certifying its compliance with, the same, and certifies that it will protect nonpublic information not subject to HIPAA in the same manner it protects information that is subject to HIPAA, and any such licensee that investigates a cybersecurity event and notifies consumers in accordance with HIPAA and any HIPAA-established rules, regulations, or procedures shall be considered compliant with the requirements of §§ 38.2-624 and 38.2-626.

2. An employee, agent, representative or designee of a licensee, who is also a licensee, is exempt from §§ 38.2-623, 38.2-624, 38.2-625, and 38.2-626 and need not develop its own information security program or conduct an investigation of or provide notices to the Commissioner and consumers relating to a cybersecurity event, to the extent that the employee, agent, representative, or designee is covered by the information security program, investigation, and notification obligations of the other licensee.

3. A licensee affiliated with a depository institution that maintains an information security program in compliance with the Interagency Guidelines Establishing Standards for Safeguarding Customer Information (Interagency Guidelines) as set forth pursuant to §§ 501 and 505 of the federal Gramm-Leach-Bliley Act, P.L. 106-102, shall be considered to meet the requirements of § 38.2-623 and any rules, regulations, or procedures established thereunder, provided that the licensee produces, upon request, documentation satisfactory to the Commissioner that independently validates the affiliated depository institution's adoption of an information security program that satisfies the Interagency Guidelines.

B. If a licensee ceases to qualify for an exception, such licensee shall have 180 days from the date it ceases to qualify to comply with this article.

2020, c. 264.

Chapter 7 - ANTITRUST PROVISIONS

§ 38.2-700. When domestic insurer may hold stock of another insurer.

Subject to Article 6 (§ 38.2-1335 et seq.) of Chapter 13 and Chapter 14 (§ 38.2-1400 et seq.) of this title, any domestic insurer may retain, invest in or acquire the whole or any part of the capital stock of

any other insurer, unless the effect of such action (i) substantially lessens competition generally or (ii) tends to create a monopoly, in the business of insurance.

1952, c. 317, § 38.1-58; 1983, c. 457; 1986, c. 562.

§ 38.2-701. When director of a domestic insurer may be a director of another insurer.

Any domestic insurer may have a director who is also a director of another domestic, foreign or alien insurer, unless the effect thereof (i) substantially lessens competition generally or (ii) tends to create a monopoly, in the business of insurance.

1952, c. 317, § 38.1-59; 1986, c. 562.

§ 38.2-702. Violations; procedure; cease and desist orders.

If the Commission has reason to believe that there is a violation of either § 38.2-700 or § 38.2-701, it shall issue and serve upon the insurer or the director concerned a statement of the charges and a notice of a hearing to be held at a time and place fixed in the notice, which shall not be less than thirty days after notice is served. The notice shall require the insurer or director to show cause why an order should not be issued directing the alleged offender to cease and desist from the violation. At such hearing, the insurer or director shall have an opportunity to be heard and to show cause why an order should not be issued requiring the insurer or director to cease and desist from the violation. In all matters in connection with such charges or hearing, the Commission shall have the jurisdiction, power, and authority granted or conferred upon it by Title 12.1, and, except as otherwise provided in this chapter, the procedure shall conform to and the right of appeal shall be the same as that provided in that title.

1952, c. 317, § 38.1-60; 1971, Ex. Sess., c. 1; 1986, c. 562.

§ 38.2-703. Cease and desist orders may be entered.

If, after a hearing, the Commission finds that there has been a violation of § 38.2-700 or § 38.2-701, it may issue an order reciting its findings and directing the insurer or director to cease and desist from the violation.

1952, c. 317, § 38.1-61; 1986, c. 562.

§ 38.2-704. Penalties.

A. Any person who violates a cease and desist order entered under § 38.2-703 shall be subject to the provisions of § 38.2-218.

B. Any person convicted of violating this chapter may, in addition, be punished under the provisions of Chapter 1.1 (§ 59.1-9.1 et seq.) of Title 59.1.

1952, c. 317, § 38.1-62; 1986, c. 562.

§ 38.2-705. Antitrust provision.

Conduct subject to regulation, review or examination pursuant to this title shall, in addition, be subject to the provisions of the Virginia Antitrust Act (§ 59.1-9.1 et seq.).

1986, c. 562.

Chapter 8 - SERVICE OF PROCESS

Article 1 - UNLICENSED INSURERS PROCESS

§ 38.2-800. Definition.

For the purposes of this article, "insurer" includes health services plans, health maintenance organizations, legal services plans, dental or optometric services plans, and unlicensed insurers approved by the Commission to issue surplus lines coverage as respectively provided for in Chapters 42, 43, 44, 45, and 48 of this title.

1986, c. 562; 2007, c. 157.

§ 38.2-801. What constitutes appointment of agent for service of process.

A. The clerk of the Commission shall be deemed to be appointed by any insurer unlicensed in this Commonwealth as its agent for the service of process in accordance with § 13.1-758 if any of the following acts are effected by mail or otherwise in this Commonwealth:

1. The issuance or delivery of insurance contracts to residents of this Commonwealth or to corporations authorized to do business in this Commonwealth;

2. The solicitation of applications for these insurance contracts;

3. The collection of premiums, membership fees, assessments or other considerations for these insurance contracts; or

4. The transaction of any other insurance business in connection with these insurance contracts.

1952, c. 317, § 38.1-64; 1956, c. 431; 1958, c. 597; 1986, c. 562.

§ 38.2-802. How process served.

Service of process or notice upon any unlicensed insurer in any suit, action or proceeding arising out of or in connection with the acts listed in § 38.2-801 in this Commonwealth shall be made in the manner prescribed in § 13.1-758.

1952, c. 317, § 38.1-65; 1956, c. 431; 1958, c. 597; 1986, c. 562.

§ 38.2-803. Alternate method of service.

A. Service of process or notice in any action, suit or proceeding shall be valid if:

1. Served upon any person within this Commonwealth who, in this Commonwealth on behalf of the unlicensed insurer, is (i) soliciting insurance, (ii) making, issuing, or delivering any insurance contract, or (iii) collecting or receiving any premium, membership fee, assessment or other consideration for insurance; and

2. A copy of the process or notice is sent within ten days thereafter by registered mail to the unlicensed insurer at its last known principal place of business.

B. A post-office receipt showing the sender's name, and the unlicensed insurer's name and address, and the plaintiff's or plaintiff's attorney's affidavit of compliance with the procedures set out in

subsection A of this section shall be filed with the clerk of the court in which the proceeding is pending on or before the date the unlicensed insurer is required to appear, or within such further time as the court allows.

1952, c. 317, § 38.1-66; 1986, c. 562.

§ 38.2-804. Other legal service not limited.

Nothing in this article shall limit the right to serve any process or notice upon any licensed insurer in any other manner permitted by law.

1952, c. 317, § 38.1-67; 1986, c. 562.

§ 38.2-805. When judgment may be entered.

No judgment based on default of appearance shall be entered against any defendant served pursuant to § 38.2-803 until the expiration of thirty days from the date that the affidavit of compliance is filed.

1952, c. 317, § 38.1-68; 1986, c. 562.

§ 38.2-806. Defense of action by unlicensed insurer.

A. Before any unlicensed insurer files or causes to be filed any pleading in any action, suit or proceeding instituted against it, that insurer shall either:

1. Deposit cash or securities with the clerk of the court in which the action, suit or proceeding is pending, or file with the clerk a bond in an amount to be fixed by the court which shall be sufficient to secure the payment of any final judgment; or

2. Procure a certificate of authority and a license to transact the business of insurance in this Commonwealth.

B. The court may order a postponement in any action, suit or proceeding in which service is made in the manner provided in § 38.2-802 or § 38.2-803 to afford the unlicensed insurer reasonable opportunity to comply with the provisions of subsection A of this section and to defend the action.

C. Nothing in subsection A of this section shall be construed to prevent any unlicensed insurer from appearing specially in the suit or other proceeding in which service was made in the manner provided in this article on the ground either that (i) the insurer has not done any of the acts listed in § 38.2-801, or (ii) the person on whom service was made pursuant to § 38.2-803 was not doing any of the acts listed in § 38.2-803.

1952, c. 317, § 38.1-69; 1986, c. 562.

§ 38.2-807. Attorney fees.

A. In any action against an unlicensed insurer upon an insurance contract issued or delivered in this Commonwealth to a resident of this Commonwealth or to a corporation authorized to do business in this Commonwealth, the court may allow the plaintiff a reasonable attorney fee if (i) the insurer has failed to make payment in accordance with the terms of the contract for 30 days after demand prior to the commencement of the action and (ii) the court concludes that the refusal was vexatious and

without reasonable cause. The fee shall not exceed 33 1/3 percent of the amount that the court or jury finds the plaintiff is entitled to recover against the insurer, but shall be at least $200.

B. Failure of the insurer to defend the action shall be deemed prima facie evidence that its failure to make payment was vexatious and without reasonable cause.

1952, c. 317, § 38.1-70; 1986, c. 562; 2010, c. 343.

Article 2 - UNLICENSED NONRESIDENT BROKERS AND AGENTS PROCESS

§ 38.2-808. Definition.

For the purposes of this article, "agent" shall have the meaning as set forth in § 38.2-1800 which shall include a legal services agent, a health agent and a dental or optometric services agent.

1986, c. 562.

§ 38.2-809. What constitutes appointment of agent for service of process.

The clerk of the Commission shall be deemed to be appointed by any unlicensed nonresident broker or agent as its agent for the service of process pursuant to § 13.1-758 if any of the following acts are effected by mail or otherwise in this Commonwealth by such unlicensed nonresident broker or agent: (i) the issuance or delivery of insurance contracts to residents of this Commonwealth or to corporations authorized to do business in this Commonwealth, (ii) the solicitation of applications for such contracts, (iii) the collection of premiums, membership fees, assessments or other considerations for such contracts, or (iv) the transaction of any other insurance business in connection with such contracts.

1958, c. 180, § 38.1-70.2; 1986, c. 562.

§ 38.2-810. How process or notice served.

Service of process or notice upon any unlicensed nonresident broker or agent in any suit, action or proceeding arising out of or in connection with the acts enumerated in § 38.2-809 in this Commonwealth shall be made in the manner prescribed in § 13.1-758.

1958, c. 180, § 38.1-70.3; 1986, c. 562.

§ 38.2-811. Other legal service not limited.

Nothing in this article shall limit the right to serve any process or notice upon any unlicensed nonresident broker or agent in any other manner permitted by law.

1958, c. 180, § 38.1-70.4; 1986, c. 562.

Article 3 - UNLICENSED PUBLIC ADJUSTERS

§ 38.2-812. Definition.

For the purposes of this article, "public adjuster" shall have the meaning as set forth in § 38.2-1845.1.

2012, cc. 734, 735.

§ 38.2-813. What constitutes appointment of agent for service of process.

The Clerk of the Commission shall be deemed to be appointed by any unlicensed public adjuster as its agent for the service of process pursuant to § 13.1-758 if any of the following acts are effected by mail or otherwise in the Commonwealth by such unlicensed public adjuster: (i) the investigation, negotiation, adjustment, or provision of advice to insureds in relation to first party claims arising under insurance contracts that insure real or personal property located in the Commonwealth; (ii) the solicitation of public adjusting for such contracts; (iii) the collection of fees, commissions, salaries, or other considerations for such contracts; or (iv) the transaction of any other insurance business in connection with such contracts.

2012, cc. 734, 735.

§ 38.2-814. How process or notice served.

Service of process or notice upon any unlicensed public adjuster in any suit, action, or proceeding arising out of or in connection with the acts enumerated in § 38.2-813 in the Commonwealth shall be made in the manner prescribed in § 13.1-758.

2012, cc. 734, 735.

§ 38.2-815. Other legal service not limited.

Nothing in this article shall limit the right to serve any process or notice upon any unlicensed public adjuster in any other manner permitted by law.

2012, cc. 734, 735.

Chapter 9 - TRANSITION PROVISIONS

§ 38.2-900. Workers' compensation.

All acts and parts of acts inconsistent with the provisions of this title are hereby repealed to the extent of the inconsistency. However, the provisions of this title shall not amend or repeal any provisions of Title 65.2 relating to workers' compensation.

1952, c. 317, § 38.1-43.1; 1986, c. 562.

§ 38.2-901. References to former sections of Title 38 or Title 38.1.

Wherever any of the conditions, requirements, provisions or contents of any section of Title 38 as such title existed prior to July 1, 1952, or Title 38.1, as that title existed before July 1, 1986, are transferred to a new or different section, and wherever any such old section is given a new section number in this title, all references to the former section of Title 38 or Title 38.1 appearing elsewhere in this Code than in this title shall be construed to apply to the new or renumbered section containing the conditions, requirements, provisions or contents.

1952, c. 317, § 38.1-43.2; 1986, c. 562.

§ 38.2-902. Existing licenses.

Each license of an insurer, agent, surplus lines broker, or other person, issued and in force immediately before July 1, 1986, shall continue in force until its date of expiration or until terminated as provided in this title.

1952, c. 317, § 38.1-43.3; 1986, c. 562.

§ 38.2-903. Existing form of policy, contract, certificate, application, rider or endorsement.

If any form does not comply with the provisions of this title but did comply with the provisions of any regulation or statute repealed by this Act of Assembly, it may continue to be used for a period of twelve months following July 1, 1986, unless the Commission prescribes otherwise pursuant to authority conferred by law.

1952, c. 317, § 38.1-43.4; 1986, c. 562.

§ 38.2-904. Existing rates.

Every rate filed and presently in effect is continued and made effective until new rates are filed and become effective in accordance with the provisions of this title.

1952, c. 317, § 38.1-43.5; 1972, c. 836; 1973, c. 504; 1986, c. 562.

Chapter 10 - ORGANIZATION, ADMISSION AND LICENSING OF INSURERS

Article 1 - ORGANIZATION OF DOMESTIC INSURERS

§ 38.2-1000. Incorporation of domestic stock insurers.

Domestic stock insurers shall be incorporated under the provisions of Article 3 (§ 13.1-618 et seq.) of Chapter 9 of Title 13.1. A foreign insurer may become a domestic insurer under the provisions of Article 11 (§ 13.1-705 et seq.) or Article 12 (§ 13.1-715.1 et seq.) of Chapter 9 of Title 13.1. Except as otherwise provided in this title, domestic stock insurers shall be subject to all the general restrictions and shall have all the general powers imposed and conferred by law.

Code 1950, §§ 38-27, 38-28; 1952, c. 317, § 38.1-71; 1956, c. 431; 1986, c. 562; 1995, c. 69; 2005, c. 765.

§ 38.2-1001. Incorporation of domestic mutual insurers.

Domestic mutual insurers shall be incorporated under the provisions of Article 3 (§ 13.1-818 et seq.) of Chapter 10 of Title 13.1. A foreign insurer may become a domestic insurer under the provisions of Article 10 (§ 13.1-884 et seq.) or Article 11 (§ 13.1-893.1 et seq.) of Chapter 10 of Title 13.1. Except as otherwise provided in this title, domestic mutual insurers shall be subject to all the general restrictions and shall have all the general powers imposed and conferred by law.

Code 1950, §§ 38-27, 38-497, 38-498, 38-500, 38-501, 38-502; 1952, c. 317, § 38.1-74; 1956, c. 431; 1986, c. 562; 1995, c. 69.

§ 38.2-1002. Additional requirements of articles of incorporation; name.

The articles of incorporation for a domestic mutual insurer shall be signed by at least twenty natural persons, a majority of whom are legal residents of this Commonwealth. The articles shall, in addition

to complying with the requirements of Article 3 (§ 13.1-818 et seq.) of Chapter 10 of Title 13.1, set forth the classes of insurance the insurer proposes to write.

Code 1950, §§ 38-28, 38-497, 38-498, 38-499; 1952, c. 317, § 38.1-75; 1956, c. 431; 1958, c. 596; 1986, c. 562.

§ 38.2-1003. When corporate status attained; bylaws filed with Commission.

A domestic mutual insurer shall have legal existence as soon as the charter has been recorded with the Commission, after which the board of directors named in the charter may adopt bylaws and accept applications for insurance. However, no insurance shall be put in force until the insurer has been licensed to transact the business of insurance as provided by this chapter. The bylaws and any amendments shall be filed with the Commission within thirty days after adoption.

Code 1950, § 38-503; 1952, c. 317, § 38.1-76; 1986, c. 562.

§ 38.2-1004. Voting.

Each member of a domestic mutual insurer shall have one vote, or a number of votes based upon the insurance in force, the number of policies held, or the amount of premiums paid, as provided in the bylaws of the insurer.

Code 1950, § 38-507; 1952, c. 317, § 38.1-77; 1986, c. 562.

§ 38.2-1005. Certain mutual companies and societies not to become stock companies without approval of Commission.

No mutual insurance company, mutual assessment property and casualty insurer, cooperative non-profit life benefit company, mutual assessment life, accident and sickness company, burial society, or fraternal benefit society shall be converted into a stock corporation unless such conversion and the plan for conversion are approved by the Commission. The insurer shall comply with § 38.2-1028 before approval for conversion is granted by the Commission unless the Commission finds that the insurer will have the required capital and surplus within a reasonable time after conversion. A society or other nonstock company licensed under any chapter of this title except Chapter 10 (§ 38.2-1000 et seq.) shall be licensed as a mutual insurer subject to § 38.2-1029 prior to seeking approval for conversion under § 38.2-1005.1 or § 38.2-1005.1:9.

1952, c. 317, § 38.1-79; 1970, c. 636; 1986, c. 562; 2001, c. 726.

§ 38.2-1005.1. Conversion of a domestic mutual insurer to a domestic stock insurer.

A. Any domestic mutual insurer may convert to a domestic stock insurer pursuant to a plan of conversion approved by the Commission.

B. The Commission shall approve any such plan of conversion if, after giving notice and an opportunity to be heard to the policyholders of the domestic mutual insurer, the Commission determines that:

1. The terms and conditions of the plan are fair and equitable to the policyholders of the domestic mutual insurer;

2. The plan is subject to approval by a vote of more than two-thirds of all votes cast on the plan at a meeting of the members of the domestic mutual insurer called for that purpose at which a quorum is present;

3. Except as otherwise provided in subdivision 4 of this subsection, the plan allocates and directs that the entire stock ownership interests and other consideration to be distributed pursuant to the plan of conversion be distributed to the policyholders of the domestic mutual insurer;

4. In the case of a domestic mutual insurer that converted from a health services plan that was in existence prior to December 31, 1987, the plan of conversion allocates and distributes to the State Treasurer, in addition to any shares of stock that the Commonwealth may be entitled to receive as a policyholder, shares of stock or cash or both with a value equal to the surplus, computed in accordance with generally accepted accounting principles, of such health services plan on December 31, 1987, plus ten million dollars; and

5. Immediately after the conversion, the insurer will have the fully paid capital stock and surplus required by applicable law.

C. A plan of conversion that utilizes a statutory merger in order to effect a conversion may be approved in accordance with this section and § 38.2-1005.1:9, and the provisions of § 38.2-1018 shall not be applicable to such plan of conversion.

1996, cc. 801, 831; 2001, c. 726.

Article 1.1 - FORMATION OF MUTUAL INSURANCE HOLDING COMPANY; CONVERSION OF MUTUAL HOLDING COMPANY TO STOCK HOLDING COMPANY

§ 38.2-1005.1:1. Definitions.

As used in this article:

"Converted company" means a stock insurance company incorporated and organized under the laws of this Commonwealth that continues in existence after a reorganization under this article in connection with the formation of a mutual holding company.

"Converted mutual holding company" means the stock corporation into which a mutual holding company has been converted pursuant to § 38.2-1005.1:9.

"Eligible member" means a member as of the date the board of directors of a mutual company adopts a plan of MHC conversion under this article. For the conversion of a mutual holding company, the term eligible member means a member of the mutual holding company who is of record on the date the board of directors of the mutual holding company adopts a plan of conversion authorized pursuant to this article.

"Intermediate holding company" means a corporation authorized to issue one or more classes of capital stock, the corporate purposes of which include holding, directly or indirectly, the voting stock of a converted company.

"Member" means a person who, on the records of a mutual company and pursuant to the articles of incorporation or bylaws of a mutual company, is deemed to be the holder of a membership interest in a mutual company. The term member also includes a person insured under a group policy if:

1. The person is insured or covered under a group life insurance policy or group annuity contract under which funds are accumulated and allocated to the respective persons covered under such policy or contract;

2. The person has the right to direct the application of the funds so allocated;

3. The group policyholder does not pay any portion of the premiums or deposits for the policy or contract; and

4. The mutual company has the names and addresses of the persons covered under the group life insurance policy or group annuity contract.

When a plan of MHC conversion has become effective under this article, the term "member" shall mean a member of the mutual holding company created by such plan.

"Mutual company" means a mutual insurance company incorporated and organized under the laws of this Commonwealth and licensed pursuant to Chapter 10 (§ 38.2-1000 et seq.) of this title.

"Mutual holding company" or "MHC" means a corporation organized under the provisions of the Virginia Nonstock Corporation Act (§ 13.1-801 et seq.) in connection with the reorganization of a mutual company under this article. A MHC shall be subject to the provisions of this article and any other provisions of this title that are applicable to mutual companies and not inconsistent with the provisions of this article. The articles of incorporation of a MHC shall state:

1. That the corporation is organized under this article as a MHC;

2. That the MHC shall hold not less than a majority of the shares of voting stock of a converted company or an intermediate holding company that, in turn, directly or indirectly holds all of the voting shares of a converted company;

3. That the corporation is not authorized to issue capital stock except in accordance with the provisions of § 38.2-1005.1:9;

4. That its members shall have the rights specified in this article and its articles of incorporation and bylaws; and

5. That its assets shall be subject to inclusion in the estate of the converted company in any proceeding initiated against the converted company under Chapter 15 (§ 38.2-1500 et seq.) of this title.

"Plan of MHC conversion" or "plan" means a plan adopted pursuant to this article by the board of directors of a mutual company for the conversion of a mutual company into a direct or indirect stock subsidiary of a mutual holding company.

"Policy" includes any group or individual policy or contract issued by a mutual company, including an annuity contract, but does not include a certificate of insurance issued in connection with a group policy or contract.

"Policyholder" means the holder of a policy other than a reinsurance contract.

2001, c. 726.

§ 38.2-1005.1:2. Formation of mutual holding company and conversion of mutual company.

A mutual company, upon approval of the Commission, may reorganize by forming a mutual holding company and continue the corporate existence of the reorganizing mutual company as a stock insurance company in accordance with the provisions of this article. At the time a plan of MHC conversion becomes effective and without any further action:

1. The mutual company shall become a stock corporation, the membership interests of the policyholders in the mutual company shall be deemed extinguished and all eligible members of the mutual company shall become members of the mutual holding company in accordance with the articles of incorporation and bylaws of the mutual holding company and the applicable provisions of this article and Chapter 10 (§ 38.2-1000 et seq.) of this title; and

2. All of the shares of capital stock of the converted company shall be issued to the mutual holding company that, at all times thereafter, shall own not less than a majority of the issued shares of the voting stock of the converted company; however, either at the time the conversion becomes effective or, with the Commission's approval, at any later time, the voting shares of the converted company may be held by one or more intermediate holding companies so long as the mutual holding company at all times owns, directly or indirectly, a majority of the voting shares of the converted company.

2001, c. 726.

§ 38.2-1005.1:3. Mutual holding company membership interest.

A. A member of a mutual holding company shall not transfer membership in the company or any right arising from membership.

B. A member of a mutual holding company shall not, as a member, be personally liable for or subject to assessment on account of any act, debt, liability or obligation of the MHC or of any entity owned or controlled by the MHC.

C. A membership interest in a mutual holding company shall not constitute a security under the laws of the Commonwealth.

2001, c. 726.

§ 38.2-1005.1:4. Contents of plan of MHC conversion.

A plan of MHC conversion shall:

A. Include:

1. The reasons for the proposed conversion; and

2. The effect of the proposed conversion on the mutual company's existing policies.

B. Provide that:

1. All policies of the converted company in force on the effective date of the conversion shall continue in force under the terms of those policies, except that all voting and other membership rights of the policyholders provided for under the policies or under the laws of this Commonwealth and any provisions for contingent liability of members shall be extinguished on the effective date of the plan of MHC conversion.

2. The holders of participating policies in force on the date of conversion shall continue to have the right to receive dividends as provided in such policies, if any. However, except in the case of a mutual company's life insurance policies, guaranteed renewable accident and sickness insurance policies, and non-cancelable accident and sickness insurance policies, if any, a plan may provide that the converted stock company will issue the insured a nonparticipating policy as a substitute for the participating policy on the renewal date of the participating policy next following the date the plan becomes effective.

3. If a mutual life insurance company has participating life insurance policies in force on the effective date of the plan of conversion, the converted company will maintain such participating life policies as a closed block of business for dividend purposes, except that any or all classes of group participating policies may be excluded from the closed block. The plan shall provide for the establishment of one or more segregated accounts in connection with the closed block of business and shall allocate to such segregated accounts sufficient assets of the mutual company so that the assets so allocated, together with the revenue for the closed block of business, are sufficient to support the closed block including, but not limited to, the payment of claims, expenses, taxes and any dividends that are provided for under the terms of the participating policies with appropriate adjustments in the dividends for experience changes. The plan shall be accompanied by an opinion of a qualified actuary or appointed actuary who meets the standards provided in this title or the Commission's regulations for the submission of actuarial opinions as to the adequacy of reserves or assets. The actuarial opinion shall relate to the adequacy of the assets allocated to the segregated accounts of the closed block and shall be based on methods of analysis deemed appropriate for such purposes by the Actuarial Standards Board. The amount of assets allocated to the segregated accounts of the closed block shall be based upon the mutual company's most recent annual statement updated to the effective date of the conversion. After the effective date of the conversion, the converted company shall keep a separate accounting for the closed block and shall make and include in each annual statement to be filed with the Commission a separate statement showing gains, losses and expenses properly attributable to the closed block. With the Commission's prior approval, assets allocated to the closed block of business that are in excess of the amount of assets necessary to support the policies then remaining in the closed block

shall revert to the benefit of the converted company. Notwithstanding the provisions of this subdivision, the Commission may waive the requirement for the establishment of a closed block of participating policies when it deems a waiver to be in the best interests of the participating policyholders of the mutual company.

C. Include the requirements for granting membership interest to persons who become policyholders of the converted company subsequent to the effective date of the conversion.

D. Include information sufficient to demonstrate that the financial condition of the converted company will not be diminished by the plan of MHC conversion.

E. Include a description of any current proposal to issue shares of the converted company or an intermediate holding company to the public or to other persons or entities who are not direct or indirect subsidiaries of the mutual holding company.

F. Include the identity of each of the proposed directors and officers of the mutual holding company and each intermediate holding company, if any, together with such biographical information the Commission may require.

G. Include such other information as the Commission considers appropriate for inclusion in the plan of MHC conversion.

2001, c. 726.

§ 38.2-1005.1:5. Adoption and approval of plan of MHC conversion.

A. The board of directors of a mutual company may adopt a plan of MHC conversion that is consistent with the provisions of § 38.2-1005.1:4 by the affirmative vote of not less than two-thirds of the members of the board. At any time before approval of the plan by the mutual company's eligible members, the board of directors, by affirmative vote of not less than two-thirds of its members, may amend or withdraw the plan.

B. After a plan of MHC conversion has been adopted by the board of directors, the plan and all amendments subsequently adopted shall be filed with the Commission for review and approval. In addition to the plan and supporting documents, the filing shall include (i) the form of notice to eligible members required by subdivision E 1 of this section, (ii) the form of any proxy to be solicited from eligible members together with all material to be distributed in connection with such solicitation, (iii) the proposed articles of incorporation and bylaws of the mutual holding company and each intermediate holding company, if any, and (iv) the revised articles of incorporation and bylaws of the converted company.

C. Upon receipt of the plan and other documents specified in subsection B of this section, the Commission shall conduct a review of the plan. The Commission shall approve the plan if it determines that the provisions of this article have been complied with and that the plan is fair and equitable as regards the interests of the members of the mutual company. The Commission may in its discretion order a public hearing for the purpose of determining whether the plan complies with the conditions lis-

ted in the preceding sentence. The Commission may retain, at the mutual company's expense, any qualified expert not a member of its staff to assist in its review of the plan.

D. The Commission may condition approval of the plan upon such conditions, stipulations or provisions as it determines are reasonably necessary to protect policyholder interests of the converted company, including, but not limited to:

1. Its prior approval of:

a. Any acquisition or formation of affiliate entities of the mutual holding company;

b. The capital structure of any intermediate holding company or any subsequent change thereto;

c. Any initial public offering or other issuance of equity or debt securities of an intermediate holding company or the converted company by private sale or public offering; and

d. Expansion of the activities of the mutual holding company into lines of business, industries or operations not identified or apparent at the time of approval of the plan.

2. Limitations on:

a. Dividends and distributions, in addition to those otherwise provided by law, if their effect would be to reduce the capital and surplus of the converted company; and

b. The pledge, encumbrance or transfer of the stock of the converted company.

E. 1. Upon approval of a plan of MHC conversion by the Commission, the plan shall be submitted to a vote of the eligible members at an annual or special meeting of the members of the mutual company held not less than twenty-five nor more than sixty days from the date notice of the meeting is given. Notice of the members' meeting to act on the plan shall be given to each eligible member at the member's address as shown on the company's records not later than forty-five days following the date of the Commission's approval of the plan. The notice shall identify in reasonable detail the benefits and risks of the plan of MHC conversion and shall be accompanied by a copy of the plan or, if authorized by the Commission, a summary thereof; provided, however, that if a summary of the plan is sent with the notice, members shall be advised that a complete copy of the plan will be available without charge upon request. The notice shall state that the Commission has approved the plan but that such approval does not constitute a recommendation that members vote to adopt the plan.

2. Approval of the plan shall be by the affirmative vote of more than two-thirds of the votes cast by eligible members at a meeting at which a quorum is present. Eligible members may vote in person or by proxy. The number of votes an eligible member may cast shall be determined by the bylaws of the mutual company. If the bylaws contain no such provisions, each eligible member shall be entitled to cast one vote.

3. Upon approval of the plan by the eligible members of the mutual company, the articles of incorporation of the mutual holding company, any intermediate holding company, and the converted company shall be adopted and filed with the Commission. In addition, the converted company shall file

with the Commission a copy of the minutes of the meeting at which the members approved the plan together with a copy of the bylaws of the mutual holding company, any intermediate holding company, and the converted company. The plan of MHC conversion shall become effective on the date that all of the provisions of this section have been complied with and the new and revised articles of incorporation have been filed and admitted to record in the office of the clerk of the Commission in the manner provided by Chapter 9 (§ 13.1-601 et seq.) of Title 13.1.

2001, c. 726.

§ 38.2-1005.1:6. Corporate existence.

A. Upon conversion of a mutual company to a converted company in accordance with the provisions of this article, the corporate existence of the mutual company shall be continued in the converted company with the original date of incorporation of the mutual company. All rights, franchises and interests of the mutual company in and to any type of property, real, personal, mixed, tangible or intangible, held immediately prior to the effective date of the conversion shall be deemed transferred to and vested in the converted company without further act or deed. Simultaneously, the converted company shall be deemed to have assumed all obligations and liabilities of the mutual company that existed immediately prior to the conversion.

B. Unless otherwise provided in the plan of MHC conversion, the directors and officers of the mutual company shall serve as the directors and officers of the converted company until new directors and officers of the converted company are elected in accordance with the articles of incorporation and bylaws of the converted company.

2001, c. 726.

§ 38.2-1005.1:7. Regulation and authority of a mutual holding company.

A. A mutual holding company organized under Title 13.1 pursuant to the authority granted by this article shall have all of the powers granted to a domestic mutual insurance company licensed under Chapter 10 (§ 38.2-1000 et seq.) and shall be subject to the same limitations and restrictions imposed on insurance holding companies by Article 5 (§ 38.2-1322 et seq.), Article 5.1 (§ 38.2-1334.3 et seq.), Article 5.2 (§ 38.2-1334.11 et seq.), and Article 6 (§ 38.2-1335 et seq.) of Chapter 13 as well as all requirements and provisions of the laws of this Commonwealth that are not inconsistent with the provisions of this article except that a mutual holding company shall not have authority to transact insurance pursuant to this title.

B. Neither the mutual holding company nor any intermediate holding company shall issue or reinsure policies of insurance.

C. A mutual holding company may enter into an affiliation agreement or merger agreement either at the time of the conversion, or at some later time with the approval of the Commission, with any mutual insurance company licensed to transact insurance in this Commonwealth or another mutual holding company. Any such merger agreement may authorize members of the mutual insurance company or other mutual holding company to become members of the mutual holding company. Any such

affiliation or merger agreement shall be subject to the provisions of this title relating to transactions entered into by a mutual insurance company organized and licensed under the laws of this Commonwealth.

D. The assets of the mutual holding company shall be held in trust under such arrangements and on such terms as the Commission may approve for the benefit of the policyholders of the converted company. Any residual rights of the MHC in such assets or any of the assets of the MHC determined not to be held in trust shall be subject to a lien in favor of the policyholders of the converted company under such terms as the Commission may approve. Upon conversion of the mutual holding company as provided for in § 38.2-1005.1:9, such assets shall be released from trust in accordance with the plan of conversion approved by the Commission.

2001, c. 726; 2014, c. 248; 2017, c. 643.

§ 38.2-1005.1:8. Diversion of business to affiliates.

Without prior approval of the Commission, neither the converted company nor any person affiliated with or controlling the converted company shall divert business from the converted company to any insurance company affiliated with the converted company if the purpose or effect of such diversion would be to reduce significantly the number of members of the mutual holding company.

2001, c. 726.

§ 38.2-1005.1:9. Conversion of mutual holding company.

A mutual holding company may reorganize as a stock holding company by complying with the applicable provisions of § 38.2-1005.1. For the purposes of effecting such conversion, the mutual holding company shall be deemed a mutual insurer and the converted mutual holding company shall be deemed a stock insurer. Notwithstanding any provision of § 38.1-1005.1 to the contrary, the Commission shall approve the reorganization of the mutual holding company as a stock holding company if the Commission determines that the provisions of applicable law have been complied with and that the reorganization is fair and equitable as regards the interests of the members of the mutual holding company. The Commission may in its discretion order a public hearing for the purpose of determining whether the reorganization complies with such conditions.

2001, c. 726.

§ 38.2-1005.1:10. Conflicts of interest.

No director, officer, agent or employee of a mutual company or other person shall receive any fee, commission or other valuable consideration, other than such person's regular salary or compensation, for in any manner aiding, promoting, arranging, or assisting in a conversion except as set forth in the plan of MHC conversion approved by the Commission. This provision shall not prohibit the payment of reasonable fees and compensation to attorneys, accountants or actuaries for services performed in the independent practice of their professions notwithstanding the fact that such attorney, accountant or actuary is a director of the mutual company.

2001, c. 726.

§ 38.2-1005.1:11. Costs and expenses.

All costs and expenses incurred in connection with a plan of MHC conversion shall be paid either by the mutual company or the converted company.

2001, c. 726.

§ 38.2-1005.1:12. Failure to give notice.

If a mutual company complies substantially and in good faith with the notice requirements in this article, its failure to give any member a required notice shall not impair the validity of any action taken under this article.

2001, c. 726.

§ 38.2-1005.1:13. Limitation on actions.

Any action challenging the validity of or arising out of any act taken or proposed to be taken under this article shall be commenced within thirty days after the date the plan of MHC conversion becomes effective.

2001, c. 726.

Article 2 - CONVERSION OF DOMESTIC STOCK INSURER TO MUTUAL INSURER

§ 38.2-1006. Conversion of a domestic stock insurer to a mutual insurer.

A. Any domestic stock life insurer may become a mutual life insurer, and to that end may carry out a plan for the acquisition of shares of its capital stock by purchase, gift or bequest, if the plan:

1. Has been adopted by a vote of a majority of the directors of the insurer;

2. Has been approved by a vote of the holders of at least two-thirds of the stock outstanding at a meeting called for that purpose;

3. Has been submitted to and approved by the Commission; and

4. Has been approved by a majority vote of the policyholders voting at a meeting called for that purpose. Only those policyholders whose insurance is then in force and has been in force for at least one year before the meeting shall be entitled to vote.

B. For the purpose of this article, "policyholder" shall include the employer, or the president, secretary or other executive officer of any corporation or association, to which a master group policy has been issued, but shall exclude the holders of certificates or policies issued under or in connection with a master group policy.

Code 1950, §§ 38-420, 38-424; 1952, c. 317, §§ 38.1-489, 38.1-493; 1986, c. 562.

§ 38.2-1007. Notice to policyholders of meeting to approve conversion.

At least thirty days before the meeting of policyholders required by § 38.2-1006, the insurer shall mail notice of the meeting to each policyholder at the last known address or shall deliver the notice in person to the policyholder.

Code 1950, § 38-421; 1952, c. 317, § 38.1-490; 1986, c. 562.

§ 38.2-1008. Conduct of and voting at meeting.

The meeting required by § 38.2-1006 shall be conducted in the manner provided in the plan, subject to the following requirements:

1. Policyholders may vote in person, by proxy, or by mail, but all votes shall be cast by ballot; and

2. A representative of the Commission shall supervise the procedure of the meeting and shall appoint an adequate number of inspectors to oversee the voting at the meeting. The inspectors, acting under any rules and regulations prescribed by the Commission, shall have power to determine all questions concerning the verification and validity of the ballots, the qualifications of the voters, and the canvass of the vote. The inspectors shall certify the results of the voting to the representative of the Commission and to the insurer.

All necessary expenses incurred by the Commission or its representative in connection with the meeting shall be paid by the insurer.

Code 1950, § 38-422; 1952, c. 317, § 38.1-491; 1986, c. 562.

§ 38.2-1009. Payment for shares pursuant to conversion plan.

Every payment for the acquisition of any shares of the capital stock of the insurer, the purchase price of which is not fixed by the plan, shall be subject to the approval of the Commission. Neither the plan, nor any payment under the plan, nor any payment not fixed by the plan, shall be approved by the Commission if the making of the payment reduces the surplus to policyholders to an amount less than that required at that time for the licensure of domestic mutual insurers.

Code 1950, § 38-423; 1952, c. 317, § 38.1-492; 1986, c. 562.

§ 38.2-1010. How acquired shares held.

Until all shares are acquired, the acquired shares shall be held in trust for the policyholders of the insurer as provided in this article and shall be assigned and transferred on the books of the insurer to not less than three nor more than five trustees and shall be held by them in trust. Shares transferred to the trustees shall be voted by them at all corporate meetings at which stockholders have the right to vote until all of the capital stock of the insurer is acquired. The trustees shall be appointed and vacancies in the office of trustee shall be filled as provided in the plan adopted under § 38.2-1006. The trustees shall file with the insurer and with the Commission a verified acceptance of their appointment and a declaration that they will faithfully discharge their duties as such trustees.

Code 1950, § 38-425; 1952, c. 317, § 38.1-494; 1986, c. 562.

§ 38.2-1011. Disposition of dividends after payments provided in conversion plan.

After the payment of stockholder dividends as provided in the plan adopted under § 38.2-1006, and after paying the necessary expenses of executing the trust all dividends and other sums received by the trustees on the shares of acquired stock, shall be immediately repaid to the insurer for the benefit of those who are or may become policyholders of the insurer and entitled to participate in the profits of the insurer. These payments shall be added to and become a part of the earned surplus of the insurer.

Code 1950, § 38-426; 1952, c. 317, § 38.1-495; 1986, c. 562.

§ 38.2-1012. Jurisdiction to compel completion of mutualization.

Whenever (i) a plan of mutualization approved in accordance with the laws of this Commonwealth has been in effect for more than five years, and (ii) the insurer has acquired in the name of its trustees under the plan at least ninety percent of its outstanding stock, and (iii) the plan itself contains no provision for the compulsory completion of mutualization inconsistent with the terms of this article, circuit courts shall have jurisdiction to compel completion of the mutualization of the insurer upon the petition of either the insurer or any stockholder of the insurer.

1954, c. 20, § 38.1-495.1; 1986, c. 562.

§ 38.2-1013. Venue of proceedings.

The petition may be filed in the circuit court of record with general equity jurisdiction in the county or city in which the principal office of the insurer is located.

1954, c. 20, § 38.1-495.2; 1986, c. 562.

§ 38.2-1014. Parties and process.

Necessary parties to the proceeding shall be (i) the insurer, (ii) the registered holders of all its stock still outstanding in the hands of the public, and (iii) its policyholders as a class. Process may be served on the policyholders as a class by publication but any policyholder may, on motion, be admitted as an individual party. The court shall appoint an attorney to represent all other policyholders.

1954, c. 20, § 38.1-495.3; 1986, c. 562.

§ 38.2-1015. Determining value of stock outstanding; dismissal of petition or entry of decree requiring payment for and transfer of stock.

The court shall determine the per share fair cash value as of the date of the filing of the petition of the stock remaining in the hands of the public. If the court finds that on that basis, completion of mutualization may not be effected without jeopardizing the solvency of the insurer or the security of its policyholders, the petition shall be dismissed. Otherwise, the court shall enter an appropriate decree to require (i) the payment into court by the insurer of the aggregate amount due the remaining stockholders, with any interest and costs, which may include attorneys' fees that the court may require, and (ii) the transfer and delivery to the insurer of all stock certificates still outstanding in the hands of the public. Upon payment by the insurer, the trustees under the plan of mutualization shall be considered, for all purposes of the plan of mutualization, to have acquired all of its outstanding stock. The holders of the stock shall possess no further right with respect to the stock, except to receive its fair cash value as determined by the court. The court shall retain jurisdiction over the distribution of the funds.

1954, c. 20, § 38.1-495.4; 1986, c. 562.

§ 38.2-1016. Amendment of charter and bylaws; change of name; retirement and cancellation of stock; when mutualization effective; assets and liabilities; officers and directors; general restrictions and powers.

A. Upon acquisition by the trustees of all of the capital stock of the insurer pursuant to the provisions of this article, the charter of the insurer shall be amended to reflect its mutualization. The charter may be amended in any other respect considered necessary by the board of directors and trustees of the insurer in accordance with the provisions of this article and Article 11 (§ 13.1-705 et seq.) of Chapter 9 of Title 13.1. Upon the amendment of the charter of the insurer, the board of directors named in the amendment shall adopt any changes in the bylaws considered necessary, and the bylaws and any amendments to them shall be filed with the Commission within thirty days after adoption.

B. As soon as the charter of the insurer has been amended as provided in this section, the capital stock of the insurer held by the trustees shall be assigned to the insurer and shall be retired and cancelled. Certification of that action by the proper officers of the insurer shall be made to the Commission, and the trustees acting under the plan shall be discharged. The insurer shall then immediately become a mutual insurer owning all the assets of the converted stock insurer and subject to all its liabilities.

C. The officers and directors of the insurer named in the amended charter shall continue as the officers and directors of the mutual insurer until their successors are duly elected in accordance with the provisions of the amended charter and the bylaws adopted under it.

D. The converted mutual insurer, except as otherwise provided in this title, shall be subject to all the general restrictions and have all the general powers imposed and conferred upon nonstock corporations by law.

1954, c. 20, § 38.1-495.5; 1956, c. 431; 1986, c. 562.

Article 2.1 - CONVERSION OF HEALTH MAINTENANCE ORGANIZATION TO ACCIDENT AND SICKNESS INSURER

§ 38.2-1016.1. Conversion of a health maintenance organization to an accident and sickness insurer.

A. Any health maintenance organization domiciled in the Commonwealth and subject to the provisions of Chapter 43 (§ 38.2-4300 et seq.) may, at its option and without reincorporation, convert to an insurer licensed to write accident and sickness insurance, hereinafter referred to as the "converted insurer," by following the procedures set forth in this section. A health maintenance organization that becomes a converted insurer under this section shall have all of the rights to and titles and interests in the assets of the original health maintenance organization, as well as all of its liabilities and obligations.

B. A health maintenance organization eligible to become a converted insurer under subsection A may effect such conversion by (i) complying with the requirements for formation of a domestic insurer under Article 1 (§ 38.2-1000 et seq.); (ii) promptly filing with the Commission any necessary amendments to its articles of incorporation, bylaws, and other corporate documents pursuant to the provisions of Chapter 9 (§ 13.1-601 et seq.) of Title 13.1; and (iii) filing with the Commission such other information as the Commission may require to meet all of the requirements of an insurer in Virginia. When those requirements have been met, the Commission shall issue a license in accordance with the provisions of Article 5 (§ 38.2-1024 et seq.) to permit the converted insurer to conduct the business of accident and sickness insurance in the Commonwealth. Upon the issuance of the converted insurer's license, and except as provided in this section, the converted insurer shall be subject to all of the provisions of this title that pertain to insurers licensed pursuant to Article 5 (§ 38.2-1024 et seq.) of this chapter and the business of accident and sickness insurance.

C. After the effective date of the health maintenance organization's conversion to and licensure as an insurer, all of the converted insurer's individual and group health care plans, contracts, and evidences of coverage shall remain valid and in force in accordance with their terms until the earlier of (i) the expiration or termination of the plans, contracts, or evidences of coverage; or (ii) the last day of the eighteenth month after the effective date of conversion. For the period during which the converted insurer continues to provide or arrange for health care services under such health care plan or plans, the insurer's obligation to pay license taxes under Chapter 25 (§ 58.1-2500 et seq.) of Title 58.1 and fees for maintaining the Bureau of Insurance under Chapter 4 (§ 38.2-400 et seq.), which are, in all cases, attributable to such health care plan or plans, shall be the same as the license taxes and fees required of health maintenance organizations generally.

D. Except as provided herein, a converted insurer shall not, after the effective date of its conversion, use in its accident and sickness insurance policies, contracts or other literature (i) the words "health maintenance organization" or "HMO" or (ii) any other words descriptive of a health maintenance organization or deceptively similar to the name or description of any health maintenance organization then doing business in the Commonwealth in any manner that misrepresents the benefits, advantages, conditions, or terms of the converted insurer's insurance policies, contracts, or other literature.

E. For the purposes of handling the rehabilitation, liquidation, or conservation of a converted insurer, the provisions of Chapter 15 (§ 38.2-1500 et seq.) shall apply. Whenever an order has been entered pursuant to Chapter 15 authorizing the Commission or other receiver to proceed with the rehabilitation, liquidation, or conservation of a converted insurer, the Commission may utilize the provisions of § 38.2-4310, to protect the interests of enrollees in the converted insurer's health care plans. If a receivership occurs in a converted insurer that continues to provide or arrange for health care services under such health care plan or plans, contracts, or policies, the receiver shall consider these plans, contracts, or policies as existing in the converted insurer. The Commission or other receiver appointed pursuant to Chapter 15 shall allocate the assets, liabilities, and obligations of the insolvent converted insurer in the manner that the Commission or other receiver determines is fair and equitable to the

insurer's accident and sickness insurance policyholders, health care plan enrollees, and other creditors. The accident and sickness insurance contracts and policies issued by the converted insurer shall be governed by the provisions applicable to the Virginia Life, Accident and Sickness Insurance Guaranty Association pursuant to Chapter 17 (§ 38.2-1700 et seq.). The health care plans, contracts, or policies of the converted insurer, associated with the business written as a health maintenance organization, shall be governed by the provisions of § 38.2-4310.

2007, c. 579; 2018, c. 706.

Article 3 - MERGERS

§ 38.2-1017. Applicability of Title 13.1.

Except as otherwise provided in this title, Article 12 (§ 13.1-715.1 et seq.) of Chapter 9 of Title 13.1 shall apply to mergers involving a domestic stock insurer and Article 11 (§ 13.1-893.1 et seq.) of Chapter 10 of Title 13.1 shall apply to mergers involving a domestic mutual insurer.

1952, c. 317, § 38.1-80; 1956, c. 431; 1986, c. 562; 2005, c. 765.

§ 38.2-1018. Plan of merger to be approved by Commission.

Before any joint agreement for the merger of domestic insurers is submitted to the stockholders or members, it shall first be submitted to and approved by the Commission. The Commission shall not approve the agreement unless, after a hearing, it finds that the plan of merger is fair, equitable, consistent with law, and that no reasonable objection to the plan exists. If the Commission fails to approve the plan it shall state the reasons in its order.

1952, c. 317, § 38.1-81; 1956, c. 431; 1986, c. 562.

Article 4 - REDOMESTICATION OF INSURERS

§ 38.2-1019. Change of status from foreign to domestic insurer.

A. Any foreign insurer licensed to transact the business of insurance in this Commonwealth may become a domestic insurer upon (i) complying with the requirements for formation of a domestic insurer under Article 1 (§ 38.2-1000 et seq.) of this chapter at the date of redomestication, and (ii) promptly filing any necessary amendments to its articles of incorporation, charters, bylaws and other corporate documents. When those requirements have been met, the Commission may issue a license dated as of the date of redomestication in accordance with the provisions of Article 5 (§ 38.2-1024 et seq.) of this chapter to permit the company to transact the business of insurance in the Commonwealth as a domestic insurer. Such insurer shall be recognized under the laws of this Commonwealth as an insurer initially licensed in another jurisdiction, as of the date it was first licensed as an insurer in its original domiciliary state.

B. An insurer that changes its status from foreign to domestic in accordance with subsection A of this section has all the rights, titles and interests in the assets of the original corporation, as well as all of its liabilities and obligations.

1983, c. 441, § 38.1-949; 1986, c. 562; 2000, c. 169.

§ 38.2-1020. Transfer of domicile from Virginia to another state.

Any domestic insurer, upon the approval of the Commission, may transfer its domicile from this Commonwealth to any other state in which it is licensed to transact the business of insurance. The Commission may approve the proposed transfer of domicile if it determines that the transfer is in the best interests of the insurer's policyholders and this Commonwealth. If the Commission does not approve the transfer, it shall give the insurer written notice of the refusal and the reasons for it within thirty days after the date the request for transfer was made. If the request for transfer is granted and the insurer is otherwise qualified, it may transact the business of insurance in this Commonwealth as a foreign insurer without interruption in licensing.

1983, c. 441, § 38.1-950; 1986, c. 562.

§ 38.2-1021. Change of domicile of foreign insurer to another foreign state.

Any foreign insurer licensed to transact the business of insurance in this Commonwealth, upon proper notice to the Commission, may change its domicile to another foreign state without interruption in licensing and without reapplying as a foreign insurer if:

1. For a foreign stock insurer, the change in domicile does not result in a reduction in its capital and surplus to policyholders below the capital and surplus requirements for licensure specified in § 38.2-1028;

2. For a foreign mutual insurer, the change in domicile does not result in a reduction in its surplus below the surplus requirements for licensure specified in § 38.2-1029;

3. There is no substantial change in the lines of insurance to be written by the insurer;

4. There is no substantial change in the nature of the insurer or its method of operations and there is no deterioration in its financial condition; and

5. The change in domicile has been approved by the supervising regulatory officials of both the former and new state of domicile.

1983, c. 441, § 38.1-951; 1986, c. 562.

§ 38.2-1022. Commission to be notified of proposed transfer of domicile.

Each insurer licensed to transact the business of insurance in this Commonwealth that transfers its domicile to any other state shall notify the Commission of the proposed transfer and shall file promptly with it any necessary amendments to articles of incorporation, charters, and other corporate documents.

1983, c. 441, § 38.1-952; 1986, c. 562; 2006, c. 329.

§ 38.2-1023. Effect of transfer of domicile on certificate of authority, agents' appointments and licenses, etc.

When any insurer licensed to transact the business of insurance in this Commonwealth transfers its domicile to this or any other state, its certificate of authority, agents' appointments and licenses, policy

forms, rates, authorizations, and other filings and approvals that existed at the time of the transfer shall remain in effect after the transfer of domicile occurs.

1983, c. 441, § 38.1-953; 1986, c. 562.

Article 5 - LICENSING OF INSURERS

§ 38.2-1024. License required to transact the business of insurance; application fee requirements for license.

A. No insurer unless authorized pursuant to Chapter 48 (§ 38.2-4805.1 et seq.) of this title shall transact the business of insurance in this Commonwealth until it has obtained a license from the Commission. For a foreign or alien insurer or reciprocal, this license shall be in addition to the certificate of authority required by § 38.2-1027. Each application for a license to transact the business of insurance in this Commonwealth shall be accompanied by a nonrefundable license application fee of $500. The fee shall be collected by the Commission and paid directly into the state treasury and credited to the Bureau of Insurance's maintenance fund as provided in subsection B of § 38.2-400. The license shall be signed by a member or other duly authorized agent of the Commission and shall expire on the next June 30 after the date on which it becomes effective, subject to renewal pursuant to § 38.2-1025.

B. The Commission shall not grant a license to do the business of insurance in this Commonwealth to any insurer until it is satisfied that, from the evidence it requires under uniform procedures suitable to and applied equally to all classes of insurers, the insurer:

1. Has paid all fees, taxes, and charges required by law;

2. Has made any deposit required by this title;

3. Has the minimum capital and surplus if a stock insurer, the minimum surplus if a mutual or a reciprocal insurer, and the minimum trusteed surplus if an alien insurer, prescribed in this title for insurers transacting the same class of insurance;

4. Has filed a financial statement or statements and any reports, certificates or other documents the Commission considers necessary to secure a full and accurate knowledge of its affairs and financial condition;

5. Is solvent and its financial condition, method of operation, and manner of doing business are such as to satisfy the Commission that it can meet its obligations to all policyholders; and

6. Has otherwise complied with all the requirements of law.

Code 1950, §§ 38-31 to 38-33, 38-505, 38-514; 1952, c. 317, §§ 38.1-85, 38.1-86; 1978, cc. 4, 20; 1981, c. 605; 1986, c. 562; 1994, c. 316; 2017, c. 655.

§ 38.2-1025. Annual renewal of license.

Each insurer licensed to transact the business of insurance in this Commonwealth shall obtain an annual renewal of its license from the Commission. The Commission may refuse to renew the license of any insurer or may renew the license, subject to any restrictions considered appropriate by the

Commission, if it finds an impairment of required capital and surplus or if it finds that the insurer has not satisfied all the conditions set forth in subsection B of § 38.2-1024. The Commission shall not fail to renew the license of any insurer to transact the business of insurance without giving the insurer ten days' notice and giving it an opportunity to be heard. The hearing may be informal, and the required notice may be waived by the Commission and the insurer.

Code 1950, § 38-57; 1952, c. 317, § 38.1-98; 1986, c. 562.

§ 38.2-1026. Retaliatory provisions as to taxes, fees, deposits and other requirements.

A. When a domestic insurer or its agents are subject to regulatory costs in another state that are greater than those imposed in this Commonwealth upon insurers domiciled in that state or their agents, then the regulatory costs imposed by this Commonwealth on those foreign insurers or their agents shall be increased to equal the regulatory costs imposed by the other state on the domestic insurer or its agents. For the purpose of this section, regulatory cost includes (i) any deposits of securities, (ii) payment of taxes, fines, penalties or fees exacted for the privilege of doing business or (iii) any restitutions, obligations or conditions necessary for doing business.

B. For the purposes of this section an alien insurance company shall be considered domiciled in the state wherein it has the largest amount of its assets held in trust and on deposit for the benefit of its policyholders, or of its policyholders and creditors in the United States. An insurance company incorporated in Canada shall be considered domiciled in Canada.

C. Any foreign or alien insurance company subject to this section shall annually, on or before March 1, file a report with the Department of Taxation which compares the regulatory costs imposed on such insurer by this Commonwealth during the preceding calendar year to the regulatory costs that would have been imposed on a similar insurer domiciled in this Commonwealth by such insurer's state of domicile during the preceding calendar year. This report shall be filed on a form and in such detail as prescribed by the Department of Taxation. Amounts owed due to the equalization of the regulatory costs imposed on such insurer by this Commonwealth and the regulatory costs of such insurer's state of domicile shall be remitted to the Department of Taxation on or before March 1 of each year. Upon the failure of any insurance company to pay amounts due under this section before the date herein prescribed, the Department of Taxation shall impose a penalty of 10 percent of the amount due and interest shall be charged at a rate established pursuant to § 58.1-15 for the period between the due date and the date of full payment.

Code 1950, §§ 38-12, 38-13; 1952, c. 317, § 38.1-87; 1986, c. 562; 1998, c. 60; 2011, c. 850.

§ 38.2-1027. Admission of foreign and alien insurers.

Before transacting any insurance business in this Commonwealth, each foreign or alien insurer or reciprocal shall obtain a certificate of authority and shall comply with the applicable provisions of Article 17 (§ 13.1-757 et seq.) of Chapter 9 of Title 13.1 in the case of a stock insurer, of Article 14 (§ 13.1-919 et seq.) of Chapter 10 of Title 13.1 in the case of a mutual insurer, and of Article 1 (§ 38.2-

1200 et seq.) of Chapter 12 in the case of a reciprocal. The certificate shall be in addition to the license to transact the business of insurance required by § 38.2-1024.

Code 1950, §§ 38-32, 38-34; 1952, c. 317, § 38.1-83; 1956, c. 431; 1986, c. 562; 2017, c. 655.

§ 38.2-1028. Additional licensing requirements for stock insurers.

No stock insurer shall be licensed to transact the business of insurance in this Commonwealth unless it has fully paid in capital stock of at least one million dollars and surplus of at least three million dollars.

Code 1950, §§ 38-29, 38-33, 38-36, 38-330; 1952, c. 317, §§ 38.1-88, 38.1-89; 1966, c. 580; 1977, c. 322; 1978, c. 20; 1986, c. 562; 1991, c. 261.

§ 38.2-1029. Additional licensing requirements for mutual insurers.

No mutual insurer shall be licensed to transact the business of insurance in this Commonwealth unless it has a surplus of at least $1,600,000.

Code 1950, § 38-514; 1952, c. 317, § 38.1-94; 1966, c. 580; 1978, c. 20; 1986, c. 562; 1991, c. 261.

§ 38.2-1030. Surplus requirements for issuing policies without contingent liability.

No domestic or foreign mutual insurer shall issue policies without contingent liability unless, at the time of issue, the insurer has at least four million dollars of surplus. In the case of an alien insurer, policies without contingent liability shall not be issued unless, at the time of issue, the insurer has at least four million dollars of trusteed surplus.

However, any mutual insurer that on June 30, 1991, was authorized to issue and was engaged in issuing policies without contingent liability may continue to do so, until July 1, 1994, by maintaining at all times the minimum surplus if a domestic or foreign insurer, and the minimum trusteed surplus if an alien insurer, required at the time of authorization.

Code 1950, § 38-508; 1952, c. 317, § 38.1-95.1; 1966, c. 580; 1977, c. 322; 1986, c. 562; 1987, c. 520; 1991, c. 261.

§ 38.2-1031. Additional requirements, alien insurers.

A. No alien insurer shall be licensed to transact the business of insurance in this Commonwealth unless it (i) has a "trusteed surplus," as defined in subsection B of this section, of at least four million dollars and (ii) has filed with the Commission a certificate from the supervising insurance official of the state of entry certifying that it is authorized to write the classes of insurance it proposes to write in this Commonwealth or it has filed with the Commission a certificate of the supervising insurance official of its domiciliary country that it is authorized there to transact the kind of insurance business it proposes to transact in this Commonwealth.

B. "Trusteed surplus" of an alien insurer means the excess of the aggregate value of the assets set forth in subsection C of this section over the aggregate net amount of all of its liabilities in the United States.

C. 1. General state deposits are all of the alien insurer's assets within the United States on deposit with officers of any state for the benefit and security of all of its policyholders and creditors in the United States.

2. Special state deposits are all of the alien insurer's assets in the United States, other than general state deposits, which are on deposit with officers of any state for the benefit and security of its policyholders and creditors in the state of deposit, or for the benefit and security of certain classes of its policyholders and creditors either in the state of deposit or in the United States. The value of special state deposits shall in no event exceed the value of the liability secured by the special state deposits.

3. Trusteed assets are all of its assets in the United States, other than general state deposits and special state deposits, held by any trustee for the benefit and security of all of its policyholders and creditors in the United States.

4. Interest receivable includes any interest collectable by the state or trustee that is receivable, due and accrued on the general state deposits, the special state deposits, and the trusteed assets of the alien insurer.

D. An alien insurer's liabilities in the United States are all of the reserves and other liabilities incurred by the alien insurer in the United States, from which may be deducted:

1. An amount equal to the reinsurance credits allowed by Article 3.1 (§ 38.2-1316.1 et seq.) of Chapter 13;

2. From the amount of such liabilities for unearned premiums, the unearned portion of premiums receivable by an alien insurer from its agents or policyholders under policies issued by it in the United States and not more than ninety days past due on the date of such statement;

3. Those liabilities in the United States pertaining to any asset in the United States of the alien insurer other than the assets described in subsection C of this section. This deduction shall be allowed only to the extent considered appropriate by the Commission and shall in no case exceed that portion of the value of the asset that is applicable to the liability pertaining to the asset; and

4. The amount of the unpaid principal and interest of any loan made by the alien insurer to the holder of, and solely on the security of, any life insurance policy or annuity contract issued or assumed by it on the life of or to any person in the United States. This amount shall in no case exceed the amount of the reserve it is required to maintain on the policy or annuity contract.

Code 1950, §§ 38-38, 38-514; 1952, c. 317, § 38.1-95; 1966, c. 580; 1977, c. 322; 1978, c. 20; 1985, c. 243; 1986, c. 562; 1991, c. 261.

§ 38.2-1032. Additional licensing requirements for domestic insurers.

No domestic insurer shall be licensed to transact the business of insurance in this Commonwealth until it has furnished the Commission with a statement under the seal of the insurer, verified by the president or treasurer or two of its directors, showing (i) the amount of surplus, (ii) the amount of capital stock fully paid in, (iii) the amount of actual cash in its treasury, (iv) the amount invested with a list of

the investments and their cash value, and (v) any other information the Commission requires. In its discretion the Commission may make or direct to be made an examination of the insurer to ascertain if it is entitled to the license.

Code 1950, § 38-505; 1952, c. 317, § 38.1-91; 1960, c. 289; 1966, c. 580; 1986, c. 562.

§ 38.2-1033. Additional licensing requirements for foreign insurers.

No foreign insurer shall be licensed to transact the business of insurance in this Commonwealth until it has filed with the Commission a certificate from the supervising insurance official of the state in which it is incorporated certifying that it is authorized to write the classes of insurance it proposes to write in this Commonwealth.

Code 1950, §§ 38-36, 38-330; 1952, c. 317, § 38.1-89; 1966, c. 580; 1977, c. 322; 1978, c. 20; 1986, c. 562.

§ 38.2-1034. How domestic mutual insurers may acquire initial surplus.

Any domestic mutual insurer or mutual assessment property and casualty insurer may, without pledging any of its assets, provide a guaranty fund sufficient to defray the expenses of its organization and its initial minimum surplus required to obtain a license to do the business of insurance. The fund may be increased with the prior approval of the Commission by receiving advances or by borrowing funds upon an agreement that the funds, including interest at a rate not exceeding the one-year treasury bill interest rate plus three percentage points at the time the loan is made or renewed, shall be repaid only if the insurer has sufficient earned surplus. The agreement shall provide that the insurer may repay the advances or loans or any part of them whenever it is able to do so in accordance with the requirements of this article. No commission or brokerage shall be paid in acquiring the funds. No repayments of principal, either in whole or in part, and no payments of interest, shall be made without the prior written approval of the Commission. Neither the principal advanced or borrowed nor any interest accrued thereon under this provision shall form a part of the legal liabilities of the insurer until the Commission approves the repayment of such principal or the payment of interest thereon. However, all statements published or filed by the insurer shall show accrued interest and the amount of principal remaining unpaid. All claims under the instrument shall be subordinated to policyholder, claimant and beneficiary claims as well as debts owed to all other classes of creditors.

Code 1950, § 38-512; 1952, c. 317, § 38.1-92; 1960, c. 291, § 38.1-92.1; 1970, c. 595; 1980, c. 187; 1986, c. 562; 1994, c. 503.

§ 38.2-1035. Domestic insurers to maintain minimum capital and surplus; proceedings by Commission if impairment found.

A. Each domestic insurer shall maintain at all times the minimum surplus if a mutual insurer, and the minimum capital and surplus if a stock insurer, required by §§ 38.2-1028, 38.2-1029 or § 38.2-1030. If the Commission finds that (i) the minimum capital and surplus of a domestic stock insurer is impaired or (ii) the minimum surplus of a domestic mutual insurer is impaired, the Commission shall issue an order requiring the insurer to eliminate the impairment within a period not exceeding ninety days. The

Commission may by order served upon the insurer prohibit the insurer from issuing any new policies while the impairment exists.

B. Any domestic mutual insurer may make an assessment upon its assessable members for an amount that will provide funds to cover all or any part of the impairment. However, no member shall be liable for an assessment exceeding the limit specified in his policy, and no assessment shall be made upon any member under a nonassessable policy. The assessment shall be made upon each assessable member in proportion to the liability as expressed in the policy. With the prior approval of the Commission, the deficiency may be made up from advances or borrowed funds and subject to the restrictions provided in § 38.2-1034 for obtaining guaranty funds.

C. If at the expiration of the designated period the insurer has not satisfied the Commission that the impairment has been eliminated, an order for the rehabilitation or liquidation of the insurer may be entered as provided in Chapter 15 (§ 38.2-1500 et seq.) of this title.

Code 1950, § 38-511; 1952, c. 317, §§ 38.1-90, 38.1-93; 1966, c. 580; 1977, c. 322; 1986, c. 562.

§ 38.2-1036. Impairment of capital and surplus of foreign and alien company ground for suspension or revocation of license.

Each foreign and each alien insurer shall maintain at all times the minimum surplus, capital and surplus, or trusteed surplus required by §§ 38.2-1028, 38.2-1029, 38.2-1030 or § 38.2-1031. If the Commission finds an impairment of (i) the required minimum capital and surplus of any foreign stock insurer, (ii) the required minimum surplus of any foreign mutual insurer, or (iii) the required minimum trusteed surplus of any alien insurer, the Commission may order the insurer to eliminate the impairment and restore the minimum capital and surplus, minimum surplus or minimum trusteed surplus, to the amount required by law. The Commission may, by order served upon the insurer, prohibit the insurer from issuing any new policies while the impairment exists. If the insurer fails to comply with the Commission's order within a period of not more than ninety days, the Commission may, in the manner set out in Article 6 (§ 38.2-1040 et seq.) of this chapter, suspend or revoke the license of the insurer to transact the business of insurance in this Commonwealth.

Code 1950, § 38-511; 1952, c. 317, § 38.1-96; 1978, c. 20; 1986, c. 562.

§ 38.2-1037. Exceptions for licensed and operating insurers.

A. Notwithstanding the other provisions of this chapter with respect to minimum required capital and surplus, any insurer which, on June 30, 1991, was licensed to write and was writing any class of insurance in this Commonwealth may continue to write that class of insurance under the appropriate license from the Commission, until July 1, 1994, if it maintains at all times (i) the minimum capital and surplus if a stock insurer, (ii) the minimum surplus if a mutual insurer, and (iii) the minimum trusteed surplus if an alien insurer, required of the insurer as of June 30, 1991.

B. Any insurer not licensed to write a class of insurance in this Commonwealth on June 30, 1991, shall meet all the capital surplus and trusteed surplus requirements of this article before it obtains a license to write that class of insurance.

1952, c. 317, § 38.1-97; 1966, c. 580; 1977, c. 322; 1978, c. 20; 1986, c. 562; 1987, c. 520; 1991, c. 261.

§ 38.2-1038. Authority of Commission to issue orders covering insurers in hazardous financial condition.

If, after reviewing an insurer's financial condition, method of operation, or manner of doing business, the Commission finds that (i) the insurer cannot, or there is a reasonable expectation that the insurer will not be able to, meet its obligations to all policyholders or (ii) the insurer's continued operation in this Commonwealth is hazardous to policyholders, creditors and the public in this Commonwealth the Commission may order the insurer to take appropriate action to remedy the Commission's concerns. The insurer shall be given ten days' notice prior to issuing the order and shall be given the opportunity to be heard and introduce evidence on its behalf. The hearing may be informal, and the required notice may be waived by the Commission and the insurer. If the insurer fails to comply with the Commission's order within the prescribed time, the Commission may suspend or revoke the license of the insurer to transact the business of insurance in this Commonwealth as set forth in Article 6 (§ 38.2-1040 et seq.) of this chapter.

1978, c. 20, § 38.1-97.2; 1986, c. 562; 1991, c. 261.

§ 38.2-1039. Enjoining unlicensed foreign or alien insurers from transacting the business of insurance in Commonwealth.

A. For the purposes of issuing a temporary or permanent injunction under § 38.2-220 to restrain unlicensed foreign or alien insurers from transacting the business of insurance in this Commonwealth, the following acts, effected by mail or otherwise, shall constitute transacting the business of insurance in this Commonwealth:

1. The issuance or delivery of insurance contracts to residents of this Commonwealth or to corporations authorized to do business in this Commonwealth;

2. The solicitation of applications for such contracts;

3. The collection of premiums, membership fees, assessments or other considerations for such contracts; or

4. The transaction of any other insurance business in connection with such contracts.

B. Process may be served in accordance with § 13.1-758 or in any other manner prescribed by law.

C. This section shall not apply to any nonprofit life insurance or annuity company which is organized and operated for the purpose of issuing insurance and annuity contracts, exclusively to or for the benefit of nonprofit educational or scientific institutions and individuals engaged in the service of those institutions. The clerk of the Commission shall be considered the attorney for service of process in this Commonwealth for all of such insurer's policy and contract holders in this Commonwealth. The appointment shall (i) be irrevocable, (ii) bind the insurer and any successors in interest, and (iii)

remain in effect as long as there is in force in this Commonwealth any contract made by the insurer or any obligation arising from the contract.

D. This section shall not apply to the following acts:

1. The procuring of a policy of insurance upon a risk within this Commonwealth in compliance with Chapter 48 of this title;

2. Issuance of contracts of reinsurance;

3. Acts in this Commonwealth involving a policy lawfully solicited, written and delivered outside this Commonwealth covering only subjects of insurance not resident, located, or to be performed in this Commonwealth at the time of issuance of the policy;

4. Acts in this Commonwealth involving a group or blanket insurance policy or a group annuity lawfully issued and delivered in a state where the insurer was licensed to transact the business of insurance;

5. Acts in the Commonwealth involving insurance contracts issued to an "industrial insured." For the purposes of this section, an "industrial insured" is an insured (i) who procures the insurance of any risk or risks other than life and annuity contracts by use of the services of a full-time employee acting as an insurance manager or buyer or the services of a regularly and continuously retained licensed insurance consultant, (ii) whose aggregate annual premiums for insurance on all risks, except for life, annuity, and accident and sickness insurance, total at least $100,000, (iii) who has at least 25 full-time employees, and (iv) either has gross assets in excess of $3 million or has annual gross revenues in excess of $5 million.

E. Nothing in this section shall apply to nonprofit Railroad Brotherhood or other similar fraternal organizations.

1968, c. 266, § 38.1-98.1; 1986, c. 562; 2008, c. 95.

§ 38.2-1039.1. Risk retention groups.

Except in the case of a risk retention group all of whose members are insurers, no risk retention group, as defined in Chapter 51 of this title, shall be licensed in this Commonwealth if an insurer is directly or indirectly a member or owner of such risk retention group.

1987, c. 585.

Article 6 - REFUSAL, SUSPENSION OR REVOCATION OF INSURER'S LICENSE

§ 38.2-1040. Refusal, suspension or revocation of license.

A. The Commission may refuse to issue a license to any domestic, foreign or alien insurer to transact the business of insurance in this Commonwealth, and may suspend or revoke the license of any licensee, whenever it finds that the applicant or licensee:

1. Has refused to submit its books, papers, accounts, or affairs to the reasonable inspection of the Commission or its representative;

2. Has refused, or its officers or agents have refused, to furnish satisfactory evidence of its financial and business standing or solvency;

3. Is insolvent, or is in a condition that any further transaction of business in this Commonwealth is hazardous to its policyholders, creditors and public in this Commonwealth;

4. Has failed to pay a final judgment against it within sixty days after (i) the judgment became final, (ii) the time for making an appeal has expired, or (iii) the dismissal of an appeal before final determination, whichever date is the latest;

5. Has violated any law of this Commonwealth, or has in this Commonwealth violated its charter or exceeded its corporate powers;

6. Has failed to pay any fees, taxes or charges imposed in this Commonwealth within sixty days after they are due and payable, or within sixty days after final disposition of any legal contest with respect to liability for the fees, taxes or charges;

7. Has had its corporate existence dissolved or its certificate of authority revoked in the state in which it was organized or in this Commonwealth;

8. Has been found insolvent by a court of any other state, or by the Commission or other proper officer or agency of any other state, and has been prohibited from doing business in that state;

9. Has had all its risks reinsured in their entirety in another insurer; or

10. Has notified the insured in writing or by any other means that any policy of insurance covering the ownership or operation of a motor vehicle issued by the insurer will be cancelled if the insured institutes any legal action against the insurer to pursue any rights of the insured under the policy.

B. The grounds for suspension or revocation of licenses in subsection A of this section are in addition to those provided for elsewhere in this title.

Code 1950, §§ 38-68, 38-132, 38-133, 38-134, 38-169, 38-370; 1952, c. 317, § 38.1-99; 1966, c. 457; 1986, c. 562; 1987, c. 431.

§ 38.2-1041. Notice to company of proposed suspension or revocation.

The Commission shall not revoke or suspend the license of any insurer to do the business of insurance in this Commonwealth upon any of the grounds set out in § 38.2-1040 until it has given the insurer ten days' notice of the reasons for the proposed revocation or suspension and has given the insurer an opportunity to introduce evidence and be heard. However, the Commission may immediately suspend the license on any of the grounds specified in subdivisions 7 and 8 of subsection A of § 38.2-1040 without prior notice to the insurer. The suspension shall remain in force until the hearing is held. Any hearing authorized by this section may be informal, and the required notice may be waived by the Commission and the insurer.

Code 1950, §§ 38-132, 38-169, 38-370; 1952, c. 317, § 38.1-100; 1986, c. 562.

§ 38.2-1042. Agent's authority likewise suspended or revoked.

Upon the suspension or revocation of the license of any insurer, the Commission shall suspend or revoke the authority of the insurer's agents in this Commonwealth to act for the insurer.

1952, c. 317, § 38.1-101; 1986, c. 562.

§ 38.2-1043. Suspension or revocation published.

Unless an appeal is taken within thirty days, the Commission shall have published in one or more newspapers having general circulation in this Commonwealth a notice of any final order that suspends or revokes the license of an insurer.

Code 1950, §§ 38-68, 38-133, 38-169; 1952, c. 317, § 38.1-102; 1986, c. 562.

§ 38.2-1044. New business prohibited.

No new business shall be done by any insurer or its agents on behalf of that insurer while its license to do business is suspended or revoked.

Code 1950, §§ 38-68, 38-135; 1952, c. 317, § 38.1-103; 1986, c. 562.

Article 7 - DEPOSITS

§ 38.2-1045. Deposits required of insurers generally.

A. Except as otherwise provided in this title, before the Commission issues a license to transact the business of insurance in this Commonwealth to any insurer, that insurer shall deposit with the State Treasurer securities that (i) are legal investments under the laws of this Commonwealth for public sinking funds or for other public funds, (ii) are not in default as to principal or interest, (iii) have a current market value of not less than $50,000 nor more than $500,000, and (iv) are issued pursuant to a system of book-entry evidencing ownership interests of the securities with transfers of ownership interests effected on the records of a depository and its participants pursuant to rules and procedures established by the depository.

B. The Commission may require a reasonable amount of additional deposits in securities that meet the requirements of clauses (i), (ii) and (iv) of subsection A of this section, whenever the Commission determines that the insurer's financial condition, method of operation, or manner of doing business is such that the Commission is not satisfied that it can meet its obligations to all policyholders.

C. Neither the deposit referred to in this section nor the alternate deposit permitted by § 38.2-1049 shall be required of (i) any mutual assessment property and casualty insurance company, (ii) any fraternal benefit society, or (iii) any insurer transacting exclusively an ocean marine business in this Commonwealth.

D. Any insurer which on June 30, 1991, instead of the deposit of securities required by subsection A, has entered into a bond with surety, approved by the Commission, with any conditions the Commission requires, shall have until the next renewal, anniversary, or expiration date of such bond, or until June 30, 1992, whichever comes first, to comply with the deposit provisions of subsection A. The surety shall be licensed in this Commonwealth to transact the business of suretyship and shall not be directly or indirectly under the same ownership or management as the principal on the bond.

E. Every insurer subject to the provisions of this section having physical securities deposited with the State Treasurer on or before June 30, 1992, shall comply with the provisions of clause (iv) in subsection A not later than January 1, 1993.

Code 1950, § 38-39; 1952, c. 317, § 38.1-108; 1956, c. 234; 1960, c. 558; 1964, c. 605; 1973, c. 178; 1975, c. 556; 1986, c. 562; 1991, c. 261; 1992, c. 14.

§ 38.2-1046. Purpose of deposits; enforcement of lien.

A. An insurer's deposits required by § 38.2-1045 shall be held as a special fund in trust for the insurer's liabilities which are incurred or which may be incurred as a result of a loss sustained by (i) this Commonwealth or any of its political subdivisions, (ii) any citizen or inhabitant of this Commonwealth, or (iii) any other person owning property in this Commonwealth, when the insurer fails to meet its obligations incurred in this Commonwealth. Policyholders, without preference, shall have a lien on the deposits for the amounts due or which may become due as a result of any failure of the insurer to meet its obligations. General creditors, without preference, shall be entitled to have a similar lien on the deposits which shall be subordinate to the claims of the policyholders.

B. Whenever any such insurer becomes insolvent or bankrupt, or makes an assignment for the benefit of its creditors, any person given a lien by this section may file a bill in the Circuit Court of the City of Richmond for the benefit of himself and all others given a lien by this section to subject such securities as may be on deposit with the State Treasurer or its agent to the payment of the liens thereon. The State Treasurer shall be made a party to such suit and a copy of such bill shall be served upon the Commissioner of Insurance as if he were a party to such suit. The funds shall be distributed by the court.

Code 1950, § 38-50; 1952, c. 317, § 38.1-110; 1981, c. 208; 1986, c. 562; 1988, c. 298; 1992, c. 20; 1995, c. 60.

§ 38.2-1047. How deposits applied to payment of claims; deficit to be made good.

A. This section shall apply only where:

1. The insurer has failed to pay any of its liabilities after the liabilities have been ascertained (i) by any agreement of the parties binding the insurer, or (ii) by judgment, order or decree of a court of competent jurisdiction which has not been appealed, superseded or stayed; and

2. The provisions of subsection B of § 38.2-1046 are not applicable.

B. Upon application of the person to whom the debt or money is due and after giving notice as provided in subsection C of this section, the State Treasurer shall (i) sell an amount of securities with accrued interest that provides sufficient funds to pay the sums due and the expenses of the sale and (ii) pay the sums due and expenses out of the available funds. This shall be subject to the approval of the Commission.

C. The State Treasurer shall give the insurer or its agent ten days' notice, either by mail or personally, of the time and place of the sale. The sale shall be advertised daily for ten days in a newspaper of general circulation published in the City of Richmond.

D. The insurer shall immediately make good any deficit in its deposit resulting from a sale. The State Treasurer shall report to the Commission in writing (i) the amount and kind of securities sold in accordance with the provisions of this section and (ii) the amount and kind of securities deposited to make good the deficit.

Code 1950, § 38-49; 1950, p. 996; 1952, c. 317, § 38.1-111; 1986, c. 562; 1988, c. 298.

§ 38.2-1048. Return of deposits.

A. The Commission, at its discretion, may direct the State Treasurer to return to any insurer all or a part of the deposit made by it under § 38.2-1045 if the insurer (i) has complied with § 38.2-1049, or (ii) has ceased to transact business in this Commonwealth. In the case of the latter, the fixed or contingent liabilities secured by the deposit shall have been satisfied or terminated or shall have been assumed by another insurer licensed to transact the business of insurance in this Commonwealth. If the Commission finds that any voluntary deposit of any insurer made under § 38.2-1050 no longer is required in whole or in part to comply with the laws of this or any other state, it may to such extent direct the return of that deposit. The Commission, before directing the return of any deposit, may require evidence it considers satisfactory that the insurer is entitled to the return of all or part of the deposit.

B. Notwithstanding the provisions in § 38.2-1046 and subsection A of this section, if an insurer domiciled in this Commonwealth is placed in receivership, and a receiver is appointed, pursuant to the provisions of Chapter 15 (§ 38.2-1500 et seq.) of this title, the Commission shall direct the State Treasurer to return any deposit made with it by the insurer to such receiver for distribution, disbursement, or other application in accordance with provisions set forth in Chapter 15 (§ 38.2-1500 et seq.) of this title and any applicable order of liquidation, conservation or rehabilitation.

Code 1950, § 38-52; 1952, c. 317, § 38.1-112; 1986, c. 562; 1988, c. 298; 1995, c. 60.

§ 38.2-1049. Alternate deposit requirements.

A. The insurer, at the discretion of the Commission, may be relieved of making the deposit required by § 38.2-1045 if the insurer makes deposits according to the following provisions:

1. Acceptable securities as defined in subsection B of this section are deposited with the State Treasurer in the form prescribed in clause (iv) of subsection A of § 38.2-1045 or with the insurance commissioner, treasurer or other officer or official body of any other state first for the protection of the insurer's policyholders.

2. The securities are not to be in default as to principal and interest.

3. The securities have a market value of at least $500,000.

4. A certificate is furnished to the Commission and authenticated by the appropriate state official holding the deposit that the requirements of this subsection have been met.

B. For the purpose of this section, acceptable securities are defined as bonds of the United States, or of any state, or of any city, county or town of any state, or bonds or notes secured by mortgages or deeds of trust on otherwise unencumbered real estate of a market value in each case of not less than double the amount loaned, or other securities approved by the Commission.

Code 1950, §§ 38-37, 38-40, 37-175, 38-516; 1952, c. 317, § 38.1-113; 1964, c. 605; 1975, c. 556; 1986, c. 562; 1992, c. 14.

§ 38.2-1050. Voluntary deposit in excess of amount required.

Any domestic insurer, in order to comply with the laws of any other state or of the United States, may make a voluntary deposit with the State Treasurer in excess of the amount required by § 38.2-1045. This excess deposit shall be subject to all other applicable provisions of the laws of this Commonwealth relating to the deposits of insurers. However, this excess deposit shall be for the protection of all the insurer's policyholders and general creditors, notwithstanding the provisions of § 38.2-1046.

Code 1950, § 38-41; 1952, c. 317, § 38.1-114; 1966, c. 263; 1986, c. 562.

§ 38.2-1051. Repealed.

Repealed by Acts 1992, c. 14.

§ 38.2-1052. Exchange of securities.

A depositing insurer may from time to time exchange for any of the deposited securities other securities eligible for deposit under this article if in the opinion of the Commission the aggregate value of the deposit will not be reduced below the amount required by law.

1952, c. 317, § 38.1-116; 1986, c. 562.

§ 38.2-1053. Interest on deposits; to whom paid.

The State Treasurer, at the time of receiving any securities deposited under this title, shall give the insurer authority to collect the interest for its own use as the interest is paid. This authority shall continue in force until the insurer fails to pay any of its liabilities for which the deposit is security. In that case, the party paying interest shall be notified of the failure, and thereafter the interest shall be payable to the State Treasurer, and shall be applied, if necessary, to the payment of the liabilities.

Code 1950, § 38-48; 1952, c. 317, § 38.1-117; 1986, c. 562.

§ 38.2-1054. Duty of State Treasurer when securities deposited are paid.

When the principal of any securities deposited under this title is paid to the State Treasurer, the money received shall be paid to the insurer. However, if the securities were required to be deposited under § 38.2-1045, the payment shall not be made until the insurer deposits an equal amount of other securities of the character required for similar deposits. If the insurer fails to deliver to the State Treasurer, within thirty days after receiving notice of this requirement, the securities necessary to maintain its required deposit, the State Treasurer with the approval in writing of the Commission, may use the money to purchase and hold other securities of the required character.

Code 1950, § 38-51; 1952, c. 317, § 38.1-118; 1986, c. 562.

§ 38.2-1055. Annual report of State Treasurer to Commission.

Each January the State Treasurer shall certify to the Commission the kind and face value of all securities, bonds, notes, mortgages or deeds of trust deposited under this title and held at the end of the preceding calendar year.

Code 1950, § 38-45; 1952, c. 317, § 38.1-119; 1986, c. 562.

§ 38.2-1056. Treasurer to receipt for deposits; responsibility of Commonwealth; taxation of deposited bonds.

The State Treasurer shall provide receipts to the insurer for all securities deposited with him under the provisions of this title. The Commonwealth shall be responsible for the safekeeping of the securities. If some or all of the securities are lost, destroyed or misappropriated, the Commonwealth shall pay or satisfy the loss to the insurer making the deposit. Securities deposited with the State Treasurer shall not be subject to taxation.

Code 1950, §§ 38-42, 38-46; 1952, c. 317, § 38.1-120; 1986, c. 562.

§ 38.2-1057. Assessment for expense of holding deposits; Insurance Collateral Assessment Fund.

A. For the purpose of defraying the expense of the State Treasurer's office in the safekeeping and handling of the securities or surety bonds deposited under the provisions of this title, the State Treasurer shall levy annually against each insurer an assessment. The assessment shall be a percentage of the par or face value of the securities or surety bonds on deposit with the State Treasurer's office in each insurer's account at the end of each calendar year. The percentage shall be determined annually by the State Treasurer as the amount necessary to meet the estimated annual expenses incurred by the State Treasurer to meet the provisions of this title. The percentage shall not exceed one-fourth of one percent of the par or face value of the securities or surety bonds on deposit with the State Treasurer's office. Assessment collections that are more than actual expenses in any year shall be added to the next year's assessment calculation. The assessment shall be collected every January. No part of the amount collected shall be used to increase the compensation of any person connected with the office of the State Treasurer.

B. All moneys collected from the annual assessment imposed under subsection A shall be paid into the state treasury and credited to a special, nonreverting fund known as the Insurance Collateral Assessment Fund which is hereby established. The Fund shall be established on the books of the Comptroller and be administered by the State Treasurer's office. Disbursements from the Fund shall be on warrants issued by the Comptroller to pay expenses associated with the safekeeping and handling of the securities or surety bonds deposited under the provisions of this title. Any moneys remaining in the Fund at the end of a fiscal year shall not revert to the general fund but shall remain in the Fund and be used to offset subsequent years' expenses as provided in subsection A.

Code 1950, § 38-43; 1952, c. 317, § 38.1-121; 1973, c. 173; 1986, c. 562; 2005, c. 38.

§ 38.2-1058. Felony for State Treasurer to dispose of securities illegally.

If the State Treasurer disposes of any securities deposited with him under this title, other than as provided in this title, he shall be guilty of a Class 3 felony, and, upon conviction, shall be punished by a fine double the amount of the disposed securities.

Code 1950, § 38-53; 1952, c. 317, § 38.1-122; 1986, c. 562.

Chapter 11 - CAPTIVE INSURERS

§ 38.2-1100. Scope of chapter.

The provisions of this chapter shall apply solely to captive insurers or association captive insurers domiciled in this Commonwealth.

1980, c. 665, § 38.1-916; 1986, c. 562.

§ 38.2-1101. Definitions.

As used in this chapter:

"Affiliated company" means (i) any company that directly or indirectly owns, controls, or holds, with power to vote, ten percent or more of the outstanding voting securities of a pure captive insurer, or (ii) any company of which ten percent or more of the voting securities are directly or indirectly owned, controlled, or held, with power to vote, by a parent, subsidiary, or associated company.

"Associated company" means any company in the same corporate system with a pure captive insurer.

"Association captive insurer" means any domestic insurer transacting the business of insurance and reinsurance only on risks, hazards, and liabilities of the members of an insurance association.

"Captive insurer" means any pure captive insurer or any association captive insurer.

"Insurance association" means any group of individuals, corporations, partnerships, associations, or governmental units or agencies whose members collectively own, control, or hold with power to vote all of the outstanding voting securities of an association captive insurer.

"Parent" means a corporation, partnership, governmental unit or agency, or individual who directly or indirectly owns, controls or holds, with power to vote, more than fifty percent of the outstanding voting securities of a pure captive insurer.

"Pure captive insurer" means any domestic insurer transacting the business of insurance and reinsurance only on risks, hazards, and liabilities of its parent, subsidiary companies of its parent, and associated and affiliated companies.

"Subsidiary company" means any corporation of which fifty percent or more of the outstanding voting securities are directly or indirectly owned, controlled, or held, with power to vote, by a parent or by a company that is a subsidiary of the parent.

1980, c. 665, § 38.1-917; 1981, c. 494; 1986, c. 562.

§ 38.2-1102. Application for license; limitations on authority.

A. No captive insurer shall transact any insurance business in this Commonwealth unless (i) it is permitted to do so by its articles of incorporation or charter and (ii) it procures a license to transact the business of insurance from the Commission in accordance with Article 5 (§ 38.2-1024 et seq.) of Chapter 10 of this title. The license shall be renewed in accordance with § 38.2-1025. A captive insurer may only be licensed to write the classes of insurance described in §§ 38.2-110 through 38.2-120, 38.2-124, 38.2-126 and reinsure in accordance with § 38.2-136.

B. 1. The Commission shall not issue a license to transact the business of insurance in this Commonwealth to any pure captive insurer until it is satisfied that the total insurance coverage necessary to insure all risks, hazards, and liabilities would develop, in the aggregate, gross annual premiums of at least $500,000.

2. The Commission shall not issue a license to transact the business of insurance in this Commonwealth to any association captive insurer until it is satisfied (i) that the total insurance coverage necessary to insure all risks, hazards, and liabilities would develop, in the aggregate, gross annual premiums of at least one million dollars and (ii) that its insurance association has been in existence for at least one year. The Commission may waive the requirement that the insurance association be in existence for at least 1 year if the association captive insurer satisfies the Commission that each member of the insurance association would have a gross annual premium in excess of $100,000.

C. No captive insurer may write classes of personal insurance coverage for individuals unless the individual is a parent.

D. No captive insurer may write insurance or reinsurance on personally owned motor vehicles or homeowners' insurance or any component of them.

1980, c. 665, § 38.1-918; 1986, c. 562.

§ 38.2-1103. Name.

A captive insurer shall not adopt the name of any existing company transacting a similar business or any name so familiar that it may mislead the public.

1980, c. 665, § 38.1-919; 1986, c. 562.

§ 38.2-1104. Formation; licensure after examination; amendment of articles; principal and home office.

A. Captive insurers with shares of capital stock shall be incorporated under Article 3 (§ 13.1-618 et seq.) of Chapter 9 of Title 13.1 as modified by this title and, except as provided in this title, shall be subject to all the general restrictions and shall have all the general powers imposed and conferred upon such corporations by law.

B. Captive insurers without shares of capital stock shall be incorporated under Article 3 (§ 13.1-818 et seq.) of Chapter 10 of Title 13.1, as modified by this title and, except as provided in this title, shall be subject to all the general restrictions and shall have all the general powers imposed and conferred upon such corporations by law.

C. 1. No charter shall be granted to any captive insurer until the Commission receives a certificate from the State Treasurer showing that (i) cash, bonds or other securities in the amount required by § 38.2-1105 have been deposited or (ii) an irrevocable letter of credit in that amount has been deposited and is to be held under the provisions, terms and conditions set forth in § 38.2-1105.

2. When the certificate has been presented to the Commission, the Commission may make or direct to be made an examination of the captive insurer.

3. The Commission shall issue a license if the captive insurer complies with this chapter.

D. Any amendment of the articles of incorporation of a captive insurer shall be pursuant to Article 11 (§ 13.1-705 et seq.) of Chapter 9 or of Article 10 (§ 13.1-884 et seq.) of Chapter 10 of Title 13.1.

E. The principal and home office of every captive insurer shall be in this Commonwealth.

1980, c. 665, § 38.1-920; 1986, c. 562.

§ 38.2-1105. Deposit of minimum capital; letter of credit instead of deposit.

A. No captive insurer shall be issued a license to transact the business of insurance in this Commonwealth until it has met the requirements of Article 5 (§ 38.2-1024 et seq.) of Chapter 10 of this title.

B. The captive insurer shall deposit with the State Treasurer cash, bonds, or securities equal to the minimum capital or, if a mutual insurer, fifty percent of the minimum surplus, as required by Article 5 (§ 38.2-1024 et seq.) of Chapter 10 of this title. The State Treasurer shall accept an irrevocable letter of credit, in a form acceptable to the Commission, on behalf of a captive insurer instead of requiring the above-mentioned deposit. The letter of credit shall be issued by a national or state bank and approved by the Commission.

C. The deposit or letter of credit shall be held by the State Treasurer for the benefit of all policyholders and creditors wherever located and shall be administered as provided in Article 7 (§ 38.2-1045 et seq.) of Chapter 10 of this title.

D. The State Treasurer shall furnish to the captive insurer a certificate certifying that the State Treasurer holds the securities or letters of credit in trust for the benefit of the policyholders and creditors of the captive insurer.

1980, c. 665, § 38.1-921; 1986, c. 562.

§ 38.2-1106. Minimum surplus in form of letter of credit.

A. Any licensed captive insurer may, subject to the approval of the Commission, hold all or a portion of (i) the minimum surplus as set forth in Article 5 (§ 38.2-1024 et seq.) of Chapter 10 in the form of an irrevocable letter of credit, if a stock insurer, or (ii) fifty percent of minimum surplus not subject to subsection B of § 38.2-1105, if a mutual insurer. The letter of credit shall be issued by a national or state bank and approved by the Commission.

B. Any letter of credit permitted pursuant to this section shall be held by the State Treasurer for the benefit of all policyholders and creditors and shall be administered as provided in Article 7 (§ 38.2-1045 et seq.) of Chapter 10 of this title.

1980, c. 665, § 38.1-922; 1986, c. 562.

§ 38.2-1107. Membership in rating organizations.

No captive insurer shall be required to join a rating organization.

1980, c. 665, § 38.1-926; 1986, c. 562.

§ 38.2-1108. Tax on premiums collected.

All captive insurers transacting business in this Commonwealth shall pay taxes as provided for in Chapter 25 of Title 58.1, except that taxes shall be paid on risks and property situated in any state in which the captive insurer is not licensed and upon which no premium tax is otherwise paid or payable.

1980, c. 665, § 38.1-928; 1986, c. 562.

§ 38.2-1109. Applicability of other provisions of title.

Except as otherwise provided, all laws of this title that apply to insurers writing the same classes of insurance that captive insurers are permitted to write, shall apply in every respect to captive insurers.

1980, c. 665, § 38.1-930; 1986, c. 562.

Chapter 12 - RECIPROCAL INSURANCE

Article 1 - General Provisions

§ 38.2-1200. Scope of chapter.

This chapter applies to all reciprocals and reciprocal insurance as defined in § 38.2-1201.

1952, c. 317, § 38.1-688; 1986, c. 562.

§ 38.2-1201. Definitions.

A. As used in this title:

"Reciprocal" means the aggregation of subscribers under a common name.

"Reciprocal insurance" means insurance resulting from the mutual exchange of insurance contracts among persons in an unincorporated association under a common name through an attorney-in-fact having authority to obligate each person both as insured and insurer.

B. As used in this chapter:

"Attorney" means the person designated and authorized by subscribers as the attorney-in-fact having authority to obligate them on reciprocal insurance contracts.

"Subscriber" means a person obligated under a reciprocal insurance agreement.

1952, c. 317, § 38.1-689; 1986, c. 562.

§ 38.2-1202. Insuring power of reciprocals.

A reciprocal licensed to transact the business of insurance in this Commonwealth may write the classes of insurance enumerated in Article 2 (§ 38.2-101 et seq.) of Chapter 1 of this title, except life insurance, annuities, and title insurance.

Code 1950, § 38-543; 1952, c. 317, § 38.1-690; 1986, c. 562.

§ 38.2-1203. What laws applicable to reciprocals; compliance with § 38.2-208.

A. Except as otherwise provided, all the provisions of this title relating to insurers generally, and those relating to insurers writing the same classes of insurance that reciprocals are permitted to write, are applicable to reciprocals.

B. A reciprocal shall be deemed to have complied with § 38.2-208 if:

1. It issues policies containing a contingent assessment liability as provided for in § 38.2-1212; and

2. It has and maintains reinsurance in an amount that the Commission considers adequate to reasonably limit the reciprocal's aggregate losses to the lesser of:

a. Ten percent of the surplus to policyholders of the reciprocal multiplied by the number of subscribers;

b. The surplus to policyholders of the reciprocal multiplied by three; or

c. Five million dollars.

Code 1950, § 38-543; 1952, c. 317, § 38.1-691; 1977, c. 58; 1986, c. 562.

§ 38.2-1204. Power to enter into reciprocal insurance contracts.

A. Persons of this Commonwealth may enter into reciprocal insurance contracts with each other and with persons of other states and countries. For the purposes of this chapter, the definition of "person" shall also include any county, city, or town, school board, Transportation District Commission, or any other local governmental authority or local agency or public service corporation owned, operated or controlled by a locality or local government authority, with power to enter into contractual undertakings within or without the Commonwealth.

B. For any corporation now existing or hereafter organized under the laws of this Commonwealth, the power and authority to enter into reciprocal insurance contracts shall be in addition to the powers conferred upon it in its certificate of incorporation, and shall be incidental to the purposes for which the corporation is organized.

Code 1950, §§ 38-543, 38-550; 1952, c. 317, §§ 38.1-692, 38.1-693; 1986, c. 562.

§ 38.2-1205. Name.

Every reciprocal shall have and use a business name that includes the word "reciprocal," "interinsurer," "interinsurance," "exchange," "underwriters," or "underwriting."

Code 1950, § 38-546; 1952, c. 317, § 38.1-694; 1986, c. 562.

§ 38.2-1206. License required of reciprocals; surplus.

A. No reciprocal shall engage in any insurance transaction in this Commonwealth until it has obtained a license to do so in accordance with the applicable provisions of Articles 5 (§ 38.2-1024 et seq.) and 7 (§ 38.2-1045 et seq.) of Chapter 10 of this title.

B. No domestic or foreign reciprocal shall be licensed to transact the business of insurance in this Commonwealth unless it has a surplus to policyholders of at least $1,600,000, and no alien reciprocal shall be so licensed unless it has a trusteed surplus, as defined in § 38.2-1031, of at least $1,600,000.

Code 1950, § 38-549; 1952, c. 317, § 38.1-695; 1977, c. 322; 1986, c. 562; 1991, c. 261.

§ 38.2-1207. Exceptions as to reciprocals licensed and operating.

A. Notwithstanding other provisions of this chapter regarding minimum required surplus, any reciprocal that was licensed to write and was writing any class of insurance in this Commonwealth on June 30, 1991, may continue to write that class of insurance under the appropriate license from the Commission until July 1, 1994. The reciprocal shall maintain at all times the minimum surplus, and the minimum trusteed surplus if an alien reciprocal, required on June 30, 1991.

B. Before any reciprocal obtains a license to write in this Commonwealth any class of insurance that it was not writing and licensed to write in this Commonwealth on June 30, 1991, it shall comply with all the requirements of this article regarding surplus.

1977, c. 322, § 38.1-695.1; 1986, c. 562; 1991, c. 261.

§ 38.2-1208. Additional requirements, foreign and alien reciprocals.

No foreign reciprocal shall be licensed to transact the business of insurance in this Commonwealth unless it has filed with the Commission a certificate of the supervising insurance official of the state in which it is organized. The certificate shall show that the foreign reciprocal is licensed to write and is writing actively in that state or an affiliate of the foreign reciprocal is licensed to write and is writing actively in its state of domicile or at least two other states the class of insurance it proposes to write in this Commonwealth. No alien reciprocal shall be licensed to transact the business of insurance until it has filed with the Commission a certificate of the supervising insurance official of (i) the state through which it entered the United States or (ii) the alien reciprocal's domiciliary country. The certificate shall show that the alien reciprocal is licensed to write and is writing actively in that state or country the class of insurance it proposes to write in this Commonwealth.

1952, c. 317, § 38.1-696; 1986, c. 562; 2017, c. 655.

§ 38.2-1209. Residence and office of attorney of foreign and alien reciprocals.

Nothing in this title regarding the admission and licensing of foreign and alien insurers requires that the attorney of a foreign or alien reciprocal be resident or domiciled in this Commonwealth, or that the principal office of the attorney be maintained in this Commonwealth. The office or offices of the attorney shall be determined by the subscribers through the power of attorney.

Code 1950, § 38-545; 1952, c. 317, § 38.1-698; 1986, c. 562.

§ 38.2-1210. Contracts executed by attorney.

Reciprocal insurance contracts shall be executed by the attorney of the reciprocal.

Code 1950, § 38-545; 1952, c. 317, § 38.1-699; 1986, c. 562.

§ 38.2-1211. License required of agent.

No person shall act in this Commonwealth as an agent of a reciprocal in the selling, solicitation or negotiation of applications for insurance, subscriber's agreements and powers of attorney, or in the collection of premiums in connection with the reciprocal insurer, without first procuring a license from the Commission pursuant to the requirements in Chapter 18 of this title. An agent shall be appointed by each reciprocal the agent represents.

1977, c. 313, § 38.1-700.1; 1986, c. 562; 2001, c. 706.

§ 38.2-1212. Subscribers' liability.

A. Each subscriber insured under an assessable policy shall have a contingent assessment liability for payment of actual losses and expenses incurred while his policy was in force. This shall be in the amount provided for in the power of attorney or subscriber's agreement.

B. The contingent assessment liability on any one policy in any one calendar year shall equal the premiums earned, as defined in § 38.2-1226, on the policy for that year multiplied by not less than one nor more than ten.

C. The contingent assessment liability shall not be joint, but shall be individual and several.

D. Each assessable policy issued by the insurer shall plainly set forth a statement of the contingent assessment liability on the front of the policy in capital letters in no less than ten point type.

1952, c. 317, §§ 38.1-702, 38.1-716; 1986, c. 562.

§ 38.2-1213. Nonassessable policies.

A. The Commission may issue a certificate authorizing the reciprocal to reduce or extinguish the contingent assessment liability of subscribers under its policies then in force in this Commonwealth, and to omit provisions imposing contingent assessment liability in all policies delivered or issued for delivery in this Commonwealth for as long as all such surplus to policyholders remains unimpaired. The certificate may be issued if, in the case of a domestic or foreign reciprocal, the reciprocal has surplus to policyholders of at least four million dollars, or, if in the case of an alien reciprocal, the reciprocal has a trusteed surplus, as defined in § 38.2-1031, of at least four million dollars. No certificate may be issued until an application of the attorney has been approved by the subscribers' advisory committee.

However, any reciprocal that on June 30, 1991, was authorized to issue and was engaged in issuing policies without contingent liability may continue to do so until July 1, 1994, by maintaining at all times the minimum surplus to policyholders if a domestic or foreign reciprocal, and the minimum trusteed surplus if an alien reciprocal, required at the time of authorization.

B. The Commission shall issue this certificate if it determines that the reciprocal's surplus to policyholders is reasonable in relation to the reciprocal's outstanding liabilities and adequate to meet its financial needs. In making that determination the following factors, among others, shall be considered:

1. The size of the reciprocal as measured by its assets, capital and surplus, reserves, premium writings, insurance in force and other appropriate criteria;

2. The extent to which the reciprocal's business is diversified among different classes of insurance;

3. The number and size of risks insured in each class of insurance;

4. The extent of the geographical dispersion of the reciprocal's insured risks;

5. The nature and extent of the reciprocal's reinsurance program;

6. The quality, diversification, and liquidity of the reciprocal's investment portfolio;

7. The recent past and trend in the size of the reciprocal's surplus to policyholders;

8. The surplus to policyholders maintained by other comparable insurers; and

9. The adequacy of the reciprocal's reserves.

C. Upon impairment of the surplus to policyholders, the Commission shall revoke the certificate. After revocation, the reciprocal shall not issue or renew any policy without providing for the contingent assessment liability of subscribers.

D. The Commission shall not authorize a domestic reciprocal to extinguish the contingent assessment liability of any of its subscribers or in any of its policies to be issued, unless it has the required surplus to policyholders and extinguishes the contingent assessment liability of all of its subscribers and in all policies to be issued for all classes of insurance written by it. However, if required by the laws of another state in which the domestic reciprocal is transacting the business of insurance as a licensed insurer, it may issue policies providing for the contingent assessment liability of its subscribers acquiring policies in that state and need not extinguish the contingent assessment liability applicable to policies already in force in that state.

1952, c. 317, § 38.1-703; 1977, cc. 58, 322; 1986, c. 562; 1991, c. 261.

§ 38.2-1214. Savings returned to subscribers.

A reciprocal may return to its subscribers any savings or credits accruing to their accounts. Any such distribution shall not unfairly discriminate between classes of risks or policies, or between subscribers. However, the distribution may vary for classes of subscribers based upon the experience of those classes.

1952, c. 317, § 38.1-704; 1986, c. 562.

§ 38.2-1215. Reserves.

Each reciprocal shall maintain the same unearned premium and loss or claim reserves required for stock and mutual companies writing the same classes of insurance.

Code 1950, §§ 38-558, 38-559; 1952, c. 317, § 38.1-705; 1986, c. 562.

§ 38.2-1216. Clerk of Commission to be appointed agent for service of process; procedure thereafter.

A. Each attorney of a domestic reciprocal who files the declaration required by § 38.2-1219, and each attorney of a foreign or alien reciprocal who applies for a license to transact the business of insurance in this Commonwealth shall file with the Commission a written power of attorney executed in duplicate by the attorney appointing the clerk of the Commission as agent of the reciprocal. Upon the appointment, the clerk of the Commission (i) may be served all lawful process against or notice to such reciprocal, and (ii) shall be authorized to enter an appearance in behalf of the reciprocal. A copy of the power of attorney, duly certified by the Commission, shall be received in evidence in all courts of this Commonwealth. Any domestic, foreign or alien reciprocal that, on July 1, 1986, has appointed the Secretary of the Commonwealth as its agent for service of process shall comply with the requirements of this section within six months of July 1, 1986.

B. Whenever any such process or notice is served upon the clerk of the Commission, a copy of the process or notice shall be mailed to the attorney at the address shown on the power of attorney. Nothing in this section shall limit the right to serve any process or notice upon any reciprocal in any other manner permitted by law.

Code 1950, § 38-547; 1952, c. 317, § 38.1-706; 1968, c. 125; 1976, c. 559; 1986, c. 562.

§ 38.2-1217. Reciprocal may be sued as such; where action or suit may be brought; upon whom service of process had.

A. Any reciprocal doing business in this Commonwealth may sue or be sued in the name or designation under which its insurance contracts are effected.

B. Any action or suit against a reciprocal may be brought in any county or city (i) where its principal office is located, or (ii) where the cause of action or any part of the cause of action arose. If the action or suit is to recover a loss under a policy of insurance, it may also be brought in the county or city where the property insured was situated at the date of the policy. Any action or suit against a foreign or alien reciprocal may also be brought in any county or city of this Commonwealth in which it has any debts owed to it.

C. In an action or suit against a reciprocal, process against or notice to the reciprocal may be served upon the clerk of the Commission. If the defendant in the action or suit is a domestic reciprocal, process against or notice to that domestic reciprocal shall be served upon the attorney for that domestic reciprocal unless service upon that attorney is not feasible.

Code 1950, § 38-547; 1952, c. 317, § 38.1-707; 1986, c. 562.

§ 38.2-1218. Effect of judgment against reciprocal.

Any judgment against a reciprocal based upon legal process duly served as provided in this chapter shall be binding upon the reciprocal and upon each of the reciprocal's subscribers as their respective interests may appear, in an amount not exceeding their respective contingent assessment liabilities.

1952, c. 317, § 38.1-708; 1986, c. 562.

Article 2 - Domestic Reciprocals

§ 38.2-1219. Organization of reciprocals; what declaration to contain.

A. Twenty-five or more persons domiciled in this Commonwealth and designated as subscribers may organize a domestic reciprocal and apply to the Commission for a license to transact the business of insurance. The original subscribers and the proposed attorney shall execute and file with the Commission a declaration setting forth:

1. The name of the attorney, and the name of the reciprocal;

2. The location of the reciprocal's principal office, which shall be the same as that of the attorney, and shall be in this Commonwealth;

3. The classes of insurance proposed to be written;

4. The names and addresses of the original subscribers;

5. The designation and appointment of the attorney, and a copy of the power of attorney and subscriber's agreement;

6. The names and addresses of the officers and directors of the attorney if a corporation, or of its members if not a corporation;

7. The powers of the subscribers' advisory committee, and the names and terms of office of its members;

8. A statement that each of the original subscribers has in good faith applied for insurance of the class proposed to be written and that the reciprocal has received from each original subscriber the anticipated premium or premium deposit for a term of not less than six months for the policy for which application is made;

9. A statement of the financial condition of the reciprocal including a schedule of its assets;

10. A statement that the reciprocal has the surplus to policyholders required by § 38.2-1206; and

11. A copy of each policy, endorsement and application form it proposes to issue or use.

B. The declaration shall be acknowledged by each original subscriber and by the attorney in the manner required for the acknowledgment of deeds in § 55.1-612.

Code 1950, § 38-546; 1952, c. 317, § 38.1-709; 1986, c. 562.

§ 38.2-1220. Attorney to file bond.

A. Concurrent with the filing of the declaration provided for in § 38.2-1219, the attorney of a domestic reciprocal shall certify to the Commission, and thereafter for each year in which the reciprocal is licensed under this chapter shall keep in force, a bond payable to this Commonwealth that complies with the requirements of this chapter.

B. The bond shall be in an amount established at the discretion of the Commission, which shall be at least $50,000. The bond shall be on the condition that the attorney will faithfully account for all

moneys and other property of the reciprocal coming into the attorney's control and that the attorney will not withdraw or appropriate for his own use from the funds of the reciprocal any moneys or property to which he is not entitled under the power of attorney.

C. The bond shall provide that it is not subject to cancellation unless thirty days' written notice of intent to cancel is given to both the attorney and the Commission.

D. The bond shall be executed by the attorney and by a fidelity insurer licensed in this Commonwealth and shall be subject to the approval of the Commission.

1952, c. 317, § 38.1-710; 1986, c. 562; 2001, c. 706.

§ 38.2-1221. Deposit instead of bond.

Instead of filing the bond required by § 38.2-1220, the attorney may maintain on deposit with the State Treasurer an equal amount in cash or in value of securities of the kind specified in § 38.2-1045, subject to the same conditions as the bond.

1952, c. 317, § 38.1-711; 1986, c. 562.

§ 38.2-1222. Subscribers' advisory committee.

The advisory committee exercising the subscribers' rights in a domestic reciprocal shall be selected under rules adopted by the subscribers. At least three-fourths of the committee shall be composed of subscribers other than the attorney or any person employed by, representing, or having a financial interest in the attorney. The committee shall supervise the finances of the reciprocal and the reciprocal's operations to the extent required to assure their conformity with the subscriber's agreement and power of attorney and shall exercise any other powers conferred on it by the subscriber's agreement. The committee may also be referred to as a board of directors or a board of trustees or by such other name as the committee chooses.

1952, c. 317, § 38.1-712; 1986, c. 562; 1990, c. 10.

§ 38.2-1223. Subscriber's agreement and power of attorney.

A. Every subscriber of a domestic assessable reciprocal shall execute a subscriber's agreement and power of attorney setting forth the rights, privileges and obligations of the subscriber as an underwriter and as a policyholder, and the powers and duties of the attorney. Every subscriber of a nonassessable reciprocal may execute a subscriber's agreement and power of attorney setting forth the rights, privileges, and obligations of the subscriber as an underwriter and as a policyholder, and the powers and duties of the attorney. If a nonassessable reciprocal does not require execution of a subscriber's agreement and power of attorney, the reciprocal shall include on its policies a statement that the subscriber shall be bound by the terms and conditions of the then current subscriber's agreement and power of attorney on file with the attorney and the Commission, a copy of which shall be provided to each subscriber with each new or renewal policy, and each subscriber shall by operation of law be bound by such subscriber's agreement and power of attorney as if individually executed. Without additional execution, notice or acceptance, every subscriber of a reciprocal agrees to be bound by any modification of the terms of the power of attorney and subscriber's agreement which is jointly made by

the attorney and the subscribers' advisory committee pursuant to § 38.2-1224, and which shall be on file with the attorney and the Commission. Notwithstanding the provisions of this subsection, the original organizing subscribers of a reciprocal shall be required to execute and file with the declaration referred to in § 38.2-1219 the subscriber's agreement and power of attorney when such filing is in conjunction with the original organization and licensure by the Commission of a reciprocal as provided in § 38.2-1219. The subscriber's agreement and power of attorney shall contain in substance the following provisions:

1. A designation and appointment of the attorney to act for and bind the subscriber in all transactions relating to or arising out of the operations of the reciprocal;

2. A provision empowering the attorney (i) to accept service of process on behalf of the reciprocal and (ii) to appoint the clerk of the Commission agent of the reciprocal upon whom may be served all lawful process against or notice to the reciprocal;

3. Except for nonassessable policies, a provision for a contingent assessment liability of each subscriber in a specified amount in accordance with § 38.2-1212; and

4. The maximum amount to be deducted from advance premiums or deposits to be paid the attorney, and the items of expense, in addition to losses, to be paid by the reciprocal.

B. The subscriber's agreement may:

1. Provide for the right of substitution of the attorney and revocation of the power of attorney;

2. Impose any restrictions upon the exercise of the power agreed upon by the subscribers;

3. Provide for the exercise of any right reserved to the subscribers directly or through an advisory committee; or

4. Contain other lawful provisions considered advisable.

1952, c. 317, § 38.1-700; 1986, c. 562; 1990, c. 10.

§ 38.2-1224. Modification of power of attorney and subscriber's agreement.

Modification of the terms of the power of attorney and subscriber's agreement of a domestic reciprocal shall be made jointly by the attorney and the subscribers' advisory committee. Any such modification shall be filed with the attorney and the Commission and such filing shall by operation of law bind all subscribers the same as if each subscriber individually adopted and executed the modified, altered, or amended subscriber's agreement and power of attorney, and a copy of such agreement and power of attorney shall be provided to each subscriber within ninety days of such modifications, alterations, or amendments. No modification shall be effective retroactively, nor shall it affect any insurance contract issued prior to the modification.

1952, c. 317, § 38.1-701; 1986, c. 562; 1990, c. 10.

§ 38.2-1225. Contributions.

The attorney or other interested persons may advance to a domestic reciprocal any funds required in its operations. No repayment of the principal, or any payment of interest thereon, in whole or in part, shall be made without the approval of the Commission. The principal advanced and any interest accrued thereon shall not be treated as a liability of the reciprocal until the repayment of principal or payment of interest is approved by the Commission; nonetheless, all statements published or filed shall show accrued interest and the amount of principal remaining unpaid. In the event of a liquidation or dissolution, all claims under the instrument shall be subordinated to subscriber, claimant and beneficiary claims as well as debts owed to all other classes of creditors. The principal advanced shall not be withdrawn or repaid and no payments of interest thereon shall be made unless the reciprocal has sufficient earned surplus in excess of its minimum required surplus. No commission or brokerage shall be paid in acquiring the funds. Interest on the principal advanced shall be at a rate not exceeding the one-year treasury bill interest rate plus three percentage points at the time the loan is made or renewed.

1952, c. 317, § 38.1-713; 1986, c. 562; 1994, c. 503.

§ 38.2-1226. Assessments.

A. Assessments may be levied upon the subscribers of a domestic reciprocal by the attorney in accordance with § 38.2-1212. The assessments shall be approved in advance by the subscribers' advisory committee and the Commission.

B. Each domestic reciprocal subscriber's share of a deficiency for which an assessment is made shall be computed by multiplying the premiums earned on the subscriber's policies during the period to be covered by the assessment by the ratio of the total deficiency to the total premiums earned during the period upon all policies subject to the assessment. However, no assessment shall exceed the aggregate contingent assessment liability computed in accordance with § 38.2-1212. For the purposes of this section, the premiums earned on the subscriber's policies are the gross premiums charged by the reciprocal for the policies minus any charges not recurring upon the renewal or extension of the policies. No subscriber shall have an offset against any assessment for which he is liable on account of any claim for unearned premium or losses payable.

1952, c. 317, § 38.1-714; 1986, c. 562.

§ 38.2-1227. Time limit for assessment.

Every subscriber of a domestic reciprocal having contingent assessment liability shall be liable for and shall pay his share of any assessment computed in accordance with this article if, while the policy is in force or within one year after its termination, the subscriber is notified (i) by the attorney of his intention to levy the assessment or (ii) that delinquency proceedings have been commenced against the reciprocal under the provisions of Chapter 15 of this title, and the Commission or receiver intends to levy an assessment.

1952, c. 317, § 38.1-715; 1986, c. 562.

§ 38.2-1228. Subscribers' share in assets.

Upon the liquidation of a domestic reciprocal, the assets remaining after discharge of its (i) indebtedness and policy obligations, (ii) the return of any contributions of the attorney or other person made as provided in § 38.2-1225, and (iii) the return of any unused deposits, savings or credits, shall be distributed. The distribution shall be according to a formula approved by the Commission or the court to the persons who were its subscribers within the twelve months prior to the final termination of its license.

1952, c. 317, § 38.1-717; 1986, c. 562.

§ 38.2-1229. Impaired reciprocals.

A. If (i) the assets of a domestic reciprocal are at any time insufficient to settle the sum of its liabilities, except those on account of funds contributed by the attorney or other parties, and its required surplus to policyholders, and (ii) the deficiency is not cured from other sources, its attorney shall levy an assessment upon subscribers made subject to assessment by the terms of their policies for the amount needed to make up the deficiency. However, the assessment shall be subject to § 38.2-1212.

B. If the attorney fails to make the assessment within thirty days after the Commission orders him to do so, or if the deficiency is not fully made up within sixty days after the date the assessment was made, delinquency proceedings may be instituted and conducted against the insurer as provided in Chapter 15 of this title.

C. If liquidation of the reciprocal is ordered, an assessment shall be levied upon the subscribers for the amount the Commission or the court, as the case may be, determines to be necessary to discharge all liabilities of the reciprocal. This assessment shall exclude any funds contributed by the attorney or other persons, but shall include the reasonable cost of the liquidation. However, the assessment shall be subject to § 38.2-1212.

1952, c. 317, § 38.1-718; 1986, c. 562.

§ 38.2-1230. Material transactions.

A. Prior written approval of the Commission shall be required for a material transaction between a domestic reciprocal and any of its related parties or between any two or more of the reciprocal's related parties when the material transaction occurs on or after July 1, 2004, and involves more than three percent of the domestic reciprocal's admitted assets as reported in its most recent statutory statement filed with the Commission. All other material transactions between any such parties involving more than 0.5 percent of the domestic reciprocal's admitted assets as reported in its most recent statutory statement filed with the Commission shall be reported to the Commission within 15 days after the end of the month in which the transaction occurs. In addition, all transactions shall meet the following standards:

1. The terms shall be fair and equitable;

2. Charges or fees for services performed shall be reasonable;

3. Expenses incurred and payments received shall be allocated to the reciprocal on an equitable basis in conformity with statutory insurance accounting practices consistently applied;

4. The books, accounts, and records of each party shall disclose clearly and accurately the precise nature and details of the transaction; and

5. The reciprocal's surplus following any dividends or distribution to any of the reciprocal's related parties shall be reasonable in relation to the reciprocal's outstanding liabilities and adequate to its financial needs.

B. The Commission, in reviewing a material transaction under this section, shall consider whether the material transaction complies with the standards set forth in subsection A and also whether the transaction may adversely affect the interests of the subscribers or the solvency of the reciprocal.

C. Within 60 days after written notification of any transaction requiring approval pursuant to this section, the Commission shall notify the insurer of its approval or disapproval, and, in the event of disapproval, its reason thereof. Failure of the Commission to act within 60 days of notification by the insurer shall constitute approval of the transaction.

D. For the purposes of this section:

1. "Affiliate" of a specific person means a person that directly or indirectly through one or more intermediaries, owns, is owned by, or is under common ownership with the person specified. An affiliate relationship shall be presumed to exist if any person, directly or indirectly, owns or holds with the power to vote, or holds proxies representing collectively 10 percent or more of the voting securities of the person specified.

2. "Control" means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a person or entity, whether (i) through the ownership of voting securities, (ii) by contract, other than a commercial contract for goods or nonmanagement services, (iii) by contract for goods or nonmanagement services where the volume of activity results in a reliance relationship, (iv) by common management, or (v) by any other means. Control shall be presumed to exist if a reporting entity and its affiliates directly or indirectly, own, control, hold with the power to vote, or hold proxies representing 10 percent or more of the voting interests of the entity.

3. "Material transaction" means a transaction, other than a claim payment or a premium payment, that (i) affects surplus or involves an exchange of assets or liabilities of the reciprocal, requires performance by or creates an obligation for the reciprocal, or results in transfer of the risks or rewards of ownership to or by the reciprocal and (ii) exceeds any minimum limits set forth in subsection A of this section. Any series of transactions affecting, involving, or impacting the reciprocal as described in clause (i) and occurring within a 12-month period that are sufficiently similar in nature as to be reasonably construed as a single transaction and that in the aggregate exceed any minimum limits set forth in subsection A of this section shall be deemed a material transaction.

4. "Related parties" means entities that have common interests as a result of ownership, control, or affiliation or by contract. The related parties of a domestic reciprocal include, but are not limited to: (i) an affiliate of the reciprocal; (ii) the attorney of the reciprocal; (iii) an affiliate of the attorney; (iv) any insurer or other reciprocal managed by the attorney of the reciprocal or by an affiliate of the attorney of the reciprocal; or (v) any other person who, directly or indirectly, by contract or otherwise, acts on behalf of, or at the direction of, the attorney of the reciprocal or any affiliate of the attorney of the reciprocal.

E. Any report or other information filed pursuant to this section shall not be open to public inspection and shall receive confidential treatment by the Commission consistent with the treatment described in § 38.2-1320.5.

F. A domestic reciprocal and its attorney shall annually file a related parties summary containing current information on:

1. The capital structure, general financial condition, ownership, and management of the reciprocal, its attorney, and any person controlling the reciprocal;

2. The identity of "related parties";

3. The following agreements in force, continuing relationships, and transactions currently outstanding between the reciprocal and any related party or among any two or more related parties:

a. Loans, other investments or purchases, or sales or exchanges of securities of the reciprocal or a related party made by the reciprocal or by any one or more related party;

b. Purchases, sales, or exchanges of assets;

c. Transactions not in the ordinary course of business;

d. Guarantees or undertakings by the reciprocal for the benefit of a related party or by a related party for the benefit of the reciprocal that result in an actual contingent exposure of the reciprocal's assets to liability, other than insurance contracts entered into in the ordinary course of the reciprocal's business;

e. All management and service contracts and all cost-sharing arrangements;

f. Reinsurance agreements or other risk-sharing arrangements; and

g. Dividend and other distributions to any of the reciprocal's related parties.

Unless the Commission prescribes otherwise, information about transactions that are not material transactions as defined in subsection D shall not be deemed material for purposes of this subsection and need not be disclosed in the related parties summary required by this subsection.

G. A reciprocal shall file its initial related parties summary required by subsection F with the Commission on or before the later of (i) August 15, 2004, or (ii) 15 days after initial licensure as a reciprocal by the Commission. Thereafter, a licensed domestic reciprocal shall file a related parties summary on or before April 1 of each year reporting information as of December 31 of the previous year.

1996, c. 304; 2004, c. 174.

§ 38.2-1231. Attorney's financial statement.

A. The subscribers' advisory committee of a domestic reciprocal shall annually obtain from its attorney an audited financial report of the attorney's financial position and the results of its operations as related to its management of the reciprocal. A copy of the report shall be filed with the Commission.

B. Unless the Commission provides otherwise in writing, the report required by this section shall be due within 120 days after the end of the attorney's fiscal year, shall be prepared in conformity with generally accepted accounting practices, and shall be audited by an independent certified public accountant.

C. If the attorney obtains an independent audit on a consolidated basis, the audited consolidated financial statements shall satisfy the requirements of this section provided the attorney's financial position and results of its operation as related to its management of the reciprocal are separately disclosed.

D. The report filed pursuant to this section and any information provided in connection with the preparation of such report shall not be open to public inspection and shall receive confidential treatment by the Commission.

1996, c. 304.

Chapter 13 - Reports, Reserves and Examinations, Insurance Holding Companies, Reinsurance Intermediaries, and Managing General Agents

Article 1 - ANNUAL STATEMENTS AND OTHER REPORTS

§ 38.2-1300. Annual statements.

A. Each domestic, foreign, and alien insurer licensed to transact the business of insurance in this Commonwealth shall file with the Commission annually, on or before March 1, an annual statement showing its financial condition on December 31 of the previous year. The annual statement shall be considered filed on the date the statement was sent by mail as shown by the postmark or on the date it is received electronically by the National Association of Insurance Commissioners (NAIC) in accordance with subsection D. The Commission shall prescribe the type of filing required for each type of insurer. The annual statement shall contain a detailed report of the insurer's assets and liabilities, the investment of its assets, its income and disbursements during the previous year, and all other information which the Commission considers necessary to secure a full and accurate knowledge of the affairs and condition of the insurer. The annual statement of every domestic or foreign insurer shall be signed by at least two of its principal officers subject to § 38.2-1304. No publication of the annual statement shall be required.

B. The annual statement of an alien insurer shall relate only to its transactions and affairs in the United States unless the Commission requires otherwise. The annual statement shall be verified by the alien insurer's United States manager, assistant manager, or by any of its duly authorized officers.

C. The Commission may prescribe the form of the annual statement and supplemental schedules and exhibits to include additional copies in machine-readable format, and may vary the form for different types of insurers. However, as far as practicable, the form for annual statements, supplementary schedules, and exhibits shall be the same as other such forms in general use in the United States. Unless otherwise prescribed by the Commission, such annual statements shall be prepared using an annual statement convention blank developed by the NAIC. The annual statement, and supplementary schedules and exhibits required by this section, shall be prepared in accordance with the appropriate annual statement instructions and the accounting practices and procedures manuals adopted by the NAIC, or any other successor publications.

D. Each insurer that is authorized to transact insurance in this Commonwealth shall annually on or before March 1 of each year, file electronically with the NAIC a copy of its annual statement convention blank, along with such additional filings as prescribed by the Commission for the preceding year. The information filed with the NAIC shall be in the same format and scope as that required by the Commission and shall include any actuarial certification required by the Commission. Any amendments and addenda to the annual statement filing subsequently filed with the Commission shall also be filed with the NAIC. However, an insurer may apply to the Commission for an exemption from this subsection.

E. Foreign insurers that are domiciled in a state, which has a law substantially similar to subsection D of this section, shall be deemed to be in compliance with subsection D of this section.

Code 1950, §§ 38-122, 38-516; 1952, c. 317, § 38.1-159; 1986, c. 562; 1990, c. 240; 1991, c. 312; 1992, c. 588; 1994, c. 308; 2009, c. 602.

§ 38.2-1301. Additional reports.

A. In addition to the annual statement, the Commission may require a licensed insurer to file additional reports, exhibits or statements considered necessary to secure complete information concerning the condition, solvency, experience, transactions or affairs of the insurer. The Commission shall establish deadlines for filing these additional reports, exhibits or statements and may require verification by any officers of the insurer designated by the Commission.

B. The Commission may require a domestic, foreign or alien insurer that is authorized to transact insurance in this Commonwealth to file with the National Association of Insurance Commissioners (NAIC) a copy of the insurer's financial statement required to be filed pursuant to § 38.2-1301, on a quarterly basis. Unless otherwise prescribed by the Commission, all such financial statements, whether filed with the Commission or the NAIC, shall be prepared in accordance with applicable provisions of the annual statement instructions and the accounting practices and procedures manuals adopted by the

NAIC, or any successor publications. The Commission may prescribe that additional copies of financial statements and other reports be filed in machine-readable format.

Code 1950, § 38-122; 1952, c. 317, § 38.1-160; 1986, c. 562; 1991, c. 312; 1992, c. 588; 1994, c. 308.

§ 38.2-1301.1. Material transaction disclosures.

A. Every insurer domiciled in this Commonwealth shall file a report with the Commission disclosing material acquisitions and dispositions of assets or material nonrenewals, cancellations or revisions of ceded reinsurance agreements unless such acquisitions and dispositions of assets or material nonrenewals, cancellations or revisions of ceded reinsurance agreements have been submitted to the Commission for review, approval or information purposes pursuant to other provisions of Title 38.2 or the rules and regulations of the Commission.

1. The report required by this subsection is due within fifteen days after the end of the calendar month in which any of the foregoing transactions occur.

2. One complete copy of the report, including any exhibits or other attachments filed as part thereof, shall be filed with the National Association of Insurance Commissioners unless the insurer has applied for and has been granted an exemption from this requirement by the Commission.

B. All reports obtained by or disclosed to the Commission pursuant to this section, shall be given confidential treatment, shall not be subject to subpoena, and shall not be made public by the Commission, the National Association of Insurance Commissioners, or any other person without the prior written consent of the insurer to which it pertains unless the Commission, after giving the insurer which would be affected thereby, notice and an opportunity to be heard, determines that the interest of policyholders, shareholders, or the public will be served by the publication thereof, in which event the Commission may publish all or any part thereof in such manner as it may deem appropriate. Notwithstanding the foregoing, the Commission may at its discretion disclose such reports to (i) a regulatory official of any state or country; (ii) the National Association of Insurance Commissioners, its affiliate or its subsidiary; or (iii) a law-enforcement authority of any state or country. Any such disclosure by the Commission shall not constitute a waiver of confidentiality of any such report.

C. No acquisitions or dispositions of assets need be reported pursuant to subsection A if the acquisitions or dispositions are not material. For purposes of this section, a material acquisition, or the aggregate of any series of related acquisitions during any thirty-day period, or disposition, or the aggregate of any series of related dispositions during any thirty-day period, is one that is nonrecurring and not in the ordinary course of business and involves more than five percent of the reporting insurer's total admitted assets as reported in its most recent statutory statement filed with the Commission.

1. Asset acquisitions subject to this section include every purchase, lease, exchange, merger, consolidation, succession, or other acquisition other than the construction or development of real property by or for the reporting insurer or the acquisition of materials for such purpose.

2. Asset dispositions subject to this section include every sale, lease, exchange, merger, consolidation, mortgage, pledge or hypothecation, assignment, whether for the benefit of creditors or otherwise, abandonment, destruction, or other disposition.

3. The following information is required to be disclosed in any report of a material acquisition or disposition of assets:

a. Date of the transaction;

b. Manner of acquisition or disposition;

c. Description of the assets involved;

d. Nature and amount of the consideration given or received;

e. Purpose of, or reason for, the transaction;

f. Manner by which the amount of consideration was determined;

g. Gain or loss recognized or realized as a result of the transaction; and

h. Name of all persons from whom the assets were acquired or to whom they were disposed.

4. Insurers are required to report material acquisitions and dispositions on a nonconsolidated basis unless the insurer is part of a consolidated group of insurers which utilizes a pooling arrangement or 100 percent reinsurance agreement that affects the solvency and integrity of the insurer's reserves and such insurer ceded substantially all of its direct and assumed business to the pool. An insurer is deemed to have ceded substantially all of its direct and assumed business to a pool if the insurer has less than one million dollars total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than five percent of the insurer's capital and surplus.

D. No nonrenewals, cancellations or revisions of ceded reinsurance agreements need be reported pursuant to this section if the nonrenewals, cancellations or revisions are not material. For purposes of this section, a material nonrenewal, cancellation or revision is one that affects for property and casualty business, including accident and health business when written as such, more than fifty percent of an insurer's ceded written premium, or for life, annuity and accident and health business, more than fifty percent of the total reserve credit taken for business ceded, on an annualized basis as indicated in the insurer's most recently filed statutory statement; however, no filing is required if the insurer's ceded written premium or the total reserve credit taken for business ceded represents, on an annualized basis, less than ten percent of direct plus assumed written premium or ten percent of the statutory reserve requirement prior to any cession, respectively.

1. Subject to the foregoing criteria, a report is to be filed without regard to which party has initiated the nonrenewal, cancellation or revision of ceded reinsurance whenever one or more of the following conditions exist:

a. The entire cession has been cancelled, nonrenewed or revised and ceded indemnity and loss adjustment expense reserves after any nonrenewal, cancellation or revision represent less than fifty percent of the comparable reserves that would have been ceded had the nonrenewal, cancellation or revision not occurred;

b. An authorized or accredited reinsurer has been replaced on an existing cession by an unauthorizing reinsurer; or

c. Collateral requirements previously established for unauthorized reinsurers have been reduced; e.g., the requirement to collateralize incurred but not reported (IBNR) claim reserves has been waived with respect to one or more unauthorized reinsurers newly participating in an existing cession.

Subject to the materiality criteria, for purposes of the foregoing subdivisions b and c, a report shall be filed if the result of the revision affects more than ten percent of the cession.

2. The following information is required to be disclosed in any report of a material nonrenewal, cancellation or revision of ceded reinsurance agreements:

a. Effective date of the nonrenewal, cancellation or revision;

b. The description of the transaction with an identification of the initiator thereof;

c. Purpose of, or reason for, the transaction; and

d. If applicable, the identity of the replacement reinsurers.

3. Insurers are required to report all material nonrenewals, cancellations or revisions of ceded reinsurance agreements on a nonconsolidated basis unless the insurer is part of a consolidated group of insurers which utilizes a pooling arrangement or 100 percent reinsurance agreement that affects the solvency and integrity of the insurer's reserves and such insurer ceded substantially all of its direct and assumed business to the pool. An insurer is deemed to have ceded substantially all of its direct and assumed business to a pool if the insurer has less than one million dollars total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than five percent of the insurer's capital and surplus.

1994, c. 308; 2001, c. 519.

§ 38.2-1302. Extension of filing time.

The Commission may extend an insurer's deadline for filing annual statements, other reports or exhibits provided the deadline for annual statements is not extended beyond April 30.

Code 1950, § 38-126; 1952, c. 317, § 38.1-161; 1986, c. 562.

§ 38.2-1303. Printed forms to be filed by insurers; certificates to domestic insurers.

A. The Commission shall be responsible for prescribing the type of blank or may prepare and distribute printed forms or blanks to licensed insurers for statements, reports, schedules or exhibits required by law or order.

B. The Commission shall furnish without charge to domestic insurers any certificates required to entitle them to do business in other states or countries.

Code 1950, § 38-129; 1952, c. 317, § 38.1-162; 1986, c. 562; 1994, c. 316.

§ 38.2-1304. False statements, reports, etc., deemed a Class 5 felony.

Any officer, manager, attorney, agent or employee of any insurer or surplus lines broker who is responsible for making or filing any annual or other statement, report, exhibit or other instrument required by this title and who knowingly or willfully makes or files any false or fraudulent statement, report or other instrument shall be charged with a Class 5 felony. If convicted, such person shall be guilty of a Class 5 felony.

Code 1950, § 38-123; 1952, c. 317, § 38.1-163; 1986, c. 562.

§ 38.2-1305. Voluntary reports.

Any insurer may elect to file with the Commission, in addition to the annual statement required by § 38.2-1300, a statement in condensed form of its financial condition as of the end of any calendar year or as of any other date. Any statement shall be signed by at least two of the principal officers of the insurer subject to § 38.2-1304. No insurer nor anyone on its behalf shall publish in any manner in this Commonwealth a statement purporting to show its financial condition if that statement does not correspond in substance with the verified statement last filed with the Commission by the insurer pursuant to §§ 38.2-1300, 38.2-1301, or this section.

Code 1950, § 38-23; 1952, c. 317, § 38.1-164; 1986, c. 562.

§ 38.2-1306. Reports to be open to public inspection.

The Commission shall keep on file for at least three years all reports required by law and all special reports required by it to be filed by insurers. The Commission shall keep copies of the annual statement convention blanks and the quarterly financial statements filed with the Commission and, pursuant to subsection D of § 38.2-1300 and subsection B of § 38.2-1301 respectively, with the National Association of Insurance Commissioners (NAIC), available for inspection by interested persons at any reasonable time.

For companies not required to file with the NAIC, the Commission shall make available for inspection copies of such comparable financial statements of financial condition as those companies may be required to file routinely with the Commission pursuant to the provisions of this title. Except as provided otherwise by statute, or by order, rule or regulation promulgated by the Commission, no special report shall be open to public inspection.

Code 1950, § 38-124; 1952, c. 317, § 38.1-165; 1986, c. 562; 1994, c. 308.

§ 38.2-1306.1. Insurance companies' analyses confidential.

A. All regulatory or financial analyses, ratios and examination synopses concerning insurance companies or insurance transactions that are submitted to the Commission by the National Association of Insurance Commissioners (NAIC), including information generated by any NAIC databases

developed for use by regulators, shall be given confidential treatment, are not subject to subpoena, and may not be made public by the Commission or any other person.

B. Financial analyses and test ratios generated by the Commission, pursuant to the NAIC's Insurance Regulatory Information System (IRIS) or Financial Analysis and Solvency Tracking (FAST) System, any successor program, or any similar program developed by the Commission, shall be given confidential treatment, are not subject to subpoena, and may not be made public by the Commission or any other person.

C. All working papers, recorded information, documents and copies thereof produced by, obtained by, or disclosed to the Commission or any other person pursuant to this article shall be given confidential treatment, are not subject to subpoena, and may not be made public by the Commission or any other person, except to the extent provided in § 38.2-1306.

D. Notwithstanding other provisions to the contrary, nothing contained in this chapter shall prevent or be construed as prohibiting the Commission from disclosing otherwise confidential information, administrative or judicial orders, or the content of any analysis or any matter related thereto, at any time to (i) a regulatory official of any state or country; (ii) the NAIC, its affiliate or its subsidiary; or (iii) a law-enforcement authority of any state or country, provided that those officials are required under their law to maintain its confidentiality. Any such disclosure by the Commission shall not constitute a waiver of confidentiality of any such documents or information. Any parties receiving such papers shall agree in writing prior to receiving the information to provide it the same confidential treatment as required by this section, unless the prior written consent of the company to which it pertains has been obtained.

E. Documents or information received from the insurance regulatory officials of any state or country which are confidential in those jurisdictions are not open to public inspection and shall receive confidential treatment by the Commission.

1987, c. 691; 1994, c. 308; 1996, c. 32; 2001, c. 519; 2007, c. 488.

Article 2 - VALUATION AND ADMISSIBILITY OF ASSETS

§ 38.2-1306.2. Valuation of investments and other assets.

The value of investments and other assets, other than those not admitted pursuant to § 38.2-1306.3, and their reporting as admitted or nonadmitted assets shall be determined in accordance with valuations or valuation guidance set forth in the National Association of Insurance Commissioners (NAIC) accounting practices and procedures manuals. The Commission may grant exception to or modification of NAIC accounting practices and procedures otherwise prescribed by this section upon petition from an insurer organized and operating under the laws of this Commonwealth and licensed pursuant to the provisions of Chapter 25 (§ 38.2-2500 et seq.) of this title.

1992, c. 588; 1993, c. 158; 2000, c. 46.

§ 38.2-1306.3. Nonadmitted assets.

A. "Nonadmitted assets" or "not admitted assets" means those assets identified and reported as non-admitted assets by or in accordance with the National Association of Insurance Commissioners (NAIC) accounting practices and procedures manuals, and any other asset or category of assets identified as nonadmitted in this title or which the Commission by rule or regulation identifies as an asset which shall be reported as a nonadmitted asset.

B. Goodwill, if admitted, may be admitted on or after January 1, 2001, subject to the guidance in the NAIC accounting practices and procedures manuals.

2000, c. 46.

§§ 38.2-1307 through 38.2-1309. Repealed.

Repealed by Acts 2000, c. 46, cl. 2, effective January 1, 2001.

§ 38.2-1310. Repealed.

Repealed by Acts 1993, c. 158.

§ 38.2-1310.1. Repealed.

Repealed by Acts 2000, c. 46, cl. 2, effective January 1, 2001.

Article 3 - RESERVES

§ 38.2-1311. Valuation reserves.

A. Every insurer licensed to transact the kinds of insurance specified in §§ 38.2-102, 38.2-106 and 38.2-109 and subject to the applicable provisions of this title, shall maintain:

1. Reserves on all of its life insurance policies or certificates and annuity contracts in force, computed according to the applicable tables of mortality and interest rates prescribed in this title;

2. Reserves for both reported and unreported (i) disability benefits, including reserves for disabled lives, and (ii) accidental death benefits; and

3. Any additional reserves prescribed by the Commission as necessary on account of the insurer's policies, certificates and contracts.

B. For all accident and sickness insurance policies the insurer shall maintain an active life reserve that shall (i) place a reasonable value on its liabilities under the policies, (ii) be not less than the reserve according to appropriate standards set forth in any regulations issued by the Commission and, (iii) be not less in the aggregate than the pro rata gross unearned premiums for those policies.

1952, c. 317, § 38.1-170; 1962, c. 562; 1986, c. 562.

§ 38.2-1312. Unearned premium reserves.

A. Except for risks or policies for which reserves are required under §§ 38.2-1311 and 38.2-4610.1, each insurer licensed to transact business in this Commonwealth, subject to the applicable provisions of this title, shall maintain reserves not less than the unearned portions of the gross premiums charged on unexpired or unterminated risks and policies.

B. Premiums charged for bulk assumption reinsurance assumed from other insurers shall be included in gross premiums charged on the basis of the original premiums and the original terms of the policies of the ceding insurer.

C. No deduction shall be made from the gross unearned premiums except for premiums paid or credited for risks reinsured as provided in Article 3.1 (§ 38.2-1316.1 et seq.) of this chapter.

D. Reserves required by this section shall be computed, valued, and reported in conformity with guidance set forth in the National Association of Insurance Commissioners accounting practices and procedures manuals.

Code 1950, § 38-228; 1952, c. 317, § 38.1-171; 1982, c. 430; 1986, c. 562; 2000, c. 46.

§ 38.2-1313. Loss records.

Each insurer licensed to transact business in this Commonwealth shall, except for accident and sickness insurance as defined in § 38.2-109, maintain a complete and itemized record showing all losses and claims for which notice has been given. When necessary, the insurers shall maintain a record of all notices received of the occurrence of any event that may result in a loss.

1952, c. 317, § 38.1-172; 1986, c. 562.

§ 38.2-1314. Loss or claim reserves.

Except as provided in §§ 38.2-1311 and 38.2-4609, each insurer licensed to transact the business of insurance in this Commonwealth shall maintain reserves:

1. In an amount estimated in the aggregate as being sufficient to provide for reported and unreported unpaid losses or claims arising on or prior to the date of any annual or other statement for which the insurer may be liable;

2. In an amount estimated to provide for loss adjustment expenses; and

3. For those classes of insurance specified by the Commission, any additional reserves for unpaid losses, policy obligations, or deficiencies in the unearned premium reserve as required by the Commission. Each insurer authorized to write these classes of insurance shall file with its annual statement, schedules of its experience for such insurance in the form the Commission requires and shall calculate the reserves required by this paragraph in the manner prescribed by the Commission.

Code 1950, §§ 38-229 through 38-232; 1952, c. 317, § 38.1-173; 1982, c. 430; 1986, c. 562; 1994, c. 503.

§ 38.2-1315. Mortgage guaranty insurance contingency reserve.

A. To protect against the effect of adverse economic cycles, each insurer transacting the business of mortgage guaranty insurance in this Commonwealth shall establish and maintain a contingency reserve equal to fifty percent of its earned premium.

B. Allocations to the contingency reserve shall be maintained for 120 months. That portion of the contingency reserve that has been maintained for more than 120 months shall be released and shall no longer constitute part of the contingency reserve and shall be allocated to surplus to policyholders.

C. Upon approval by the Commission, the contingency reserve shall be available for loss payments only when the incurred losses in any one twelve-month period, less any amounts already released from the contingency reserve during that period, exceed thirty-five percent of the corresponding earned premium.

D. In the event of release of the contingency reserve for payment of losses, the contributions required by subsection A of this section shall be treated on a first-in-first-out basis.

E. Whenever the laws of any other state require a greater unearned premium reserve than that set forth in § 38.2-1312, the mortgage guaranty insurance contingency reserve of mortgage guaranty insurers organized under the laws of that state may be an amount that, when added to such unearned premium reserve, will result in a reserve equal to the sum of the unearned premium reserve required by § 38.2-1312 and the contingency reserve required by this section.

F. The authority of the Commission under § 38.2-223 to issue rules and regulations includes the authority to require that a greater reserve be established for mortgage guaranty insurance on liens other than first liens.

1973, c. 250, §§ 38.1-173.1, 38.1-173.2; 1981, c. 209; 1986, c. 562; 1989, c. 236; 2000, c. 46.

§ 38.2-1315.1. Actuarial statements of opinion, reports, memoranda, and summaries.

A. Effective December 31, 2004, and except as otherwise provided by this section or Article 10 (§ 38.2-1365 et seq.) of Chapter 13, every insurer doing business in the Commonwealth shall annually submit an actuarial opinion that has been prepared by an appointed actuary and that satisfies at a minimum the standards set forth in the appropriate National Association of Insurance Commissioners (NAIC) annual statement instructions.

B. Every insurer domiciled in the Commonwealth that is required to submit an actuarial opinion pursuant to subsection A shall annually submit an actuarial opinion summary, also written by the insurer's appointed actuary. Every insurer domiciled in the Commonwealth that is required to submit an actuarial opinion pursuant to subsection A or § 38.2-1367, at the request of the Commission, shall submit underlying work papers and an actuarial report or memorandum that satisfies the minimum standards set forth in the appropriate NAIC annual statement instructions and complies with all additional standards or requirements established by statute or by the Commission in accordance with the provisions of this section or Article 10 (§ 38.2-1365 et seq.) of Chapter 13. A company licensed but not domiciled in the Commonwealth shall provide such summary, work papers, report, and memorandum upon request of the Commission. Any summary, work papers, report, or memorandum filed in accordance with the appropriate NAIC annual statement 13 instructions shall be considered as a document supporting the actuarial opinion required by subsection A or § 38.2-1367.

C. If the insurer fails to provide supporting work papers or a required report or memorandum at the request of the Commission, or the Commission determines that the work papers or report or memorandum are unacceptable, the Commission may engage a qualified actuary at the expense of the insurer to review the opinion and the basis for the opinion and to prepare supporting work papers, or a report or memorandum.

D. The appointed actuary shall not be liable for damages to any person, other than the insurer and the Commission for any act, error, omission, decision, or conduct with respect to the actuary's opinion, except in cases of fraud or willful misconduct on the part of the actuary.

E. An actuarial opinion provided with the annual statement in accordance with the appropriate NAIC annual statement instructions shall be open to public inspection in accordance with § 38.2-1306.

F. Documents, materials, or other information in the possession or control of the Commission that are considered an actuarial report, work papers, an actuarial opinion summary, or an actuarial opinion report or memorandum provided in support of the opinion, and any other material provided by the insurer to the Commission in connection with the report, work papers, or summary, shall be confidential by law and privileged, shall not be subject to inspection or review by the general public, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, this provision shall not be construed to limit the Commission's authority to release the documents to any actuarial board established for counseling or discipline so long as the material is required for the purpose of professional disciplinary proceedings and such board establishes procedures satisfactory to the Commission for preserving the confidentiality of the documents. Moreover, the Commission is authorized to use the documents, materials, or other information in furtherance of any regulatory or legal action brought as part of the Commission's official duties.

1. Neither the Commission nor any person who received documents, materials, or other information while acting under the authority of the Commission shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to this subsection.

2. In order to assist in the performance of the Commission's duties under this section, the Commission:

a. May share documents, material, or other information, including the confidential and privileged documents, materials, or information subject to this subsection, with other state, federal, and international regulatory agencies, with the NAIC, its affiliates, or subsidiaries, and with state, federal, and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material, or other information.

b. May receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information, from the NAIC, its affiliates, or subsidiaries and from regulatory and law-enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or information received with notice or the understanding

that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information.

G. The Commission may waive or modify submission requirements for a foreign insurer that has been exempted by its domiciliary commissioner from filing an actuarial opinion under a substantially similar law in its state of domicile. The Commission may modify requirements in any year for an insurer that makes application, with good cause shown, for exemption due to the nature of business written or the size and volume of business activity, or because the insurer is under supervision or an order of conservation, or if the imposition of an annual filing requirement would create a financial hardship.

2004, c. 315; 2006, c. 320; 2014, c. 571.

§ 38.2-1316. Repealed.

Repealed by Acts 1991, c. 264.

Article 3.1 - Reinsurance

§ 38.2-1316.1. Definitions.

As used in this article unless the context requires another meaning:

"Accredited reinsurer" means an assuming insurer accredited pursuant to the provisions of subdivision C 2 of § 38.2-1316.2.

"Certified reinsurer" means an insurer certified by the Commission pursuant to subsection D of § 38.2-1316.2.

"Covered agreement" means an agreement entered into pursuant to the Dodd-Frank Wall Street Reform and Consumer Protection Act, 31 U.S.C. §§ 313 and 314, that is currently in effect or in a period of provisional application and addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into any reinsurance agreement with a ceding insurer domiciled in the Commonwealth or for allowing the ceding insurer to recognize credit for reinsurance.

"Credit" includes any credit for reinsurance (i) allowed as an admitted asset or as a deduction from liability and (ii) used to compute the valuation reserves required by § 38.2-1311, unearned premium reserves required by § 38.2-1312 or 38.2-4610.1, or loss or claim reserves required by § 38.2-1314 or 38.2-4609.

"NAIC" means the National Association of Insurance Commissioners.

"Qualified United States financial institution," as used in subdivision 2 c of § 38.2-1316.4, means an institution that:

1. Is organized or, in the case of a United States office of a foreign banking organization, is licensed, under the laws of the United States or any state thereof;

2. Is regulated, supervised, and examined by the United States federal or state authorities having regulatory authority over banks and trust companies; and

3. Has been determined by either the Commission or the Securities Valuation Office of the NAIC to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the Commission.

"Qualified United States financial institution" means, for purposes of those provisions of this article specifying those institutions that are eligible to act as a fiduciary of a trust, an institution that:

1. Is organized or, in the case of a United States branch or agency office of a foreign banking organization, is licensed, under the laws of the United States or any state thereof and has been granted authority to operate with fiduciary powers; and

2. Is regulated, supervised and examined by federal or state authorities having regulatory authority over banks and trust companies.

"Reciprocal jurisdiction" means (i) a non-United States jurisdiction that is subject to an in-force covered agreement with the United States, each within its legal authority, or, in the case of a covered agreement between the United States and the European Union, is a member state of the European Union; (ii) a United States jurisdiction that meets the requirements for accreditation under the NAIC financial standards and accreditation program; or (iii) a qualified jurisdiction, as determined by the Commission pursuant to subdivision D 3 of § 38.2-1316.2, that is not otherwise described in clause (i) or (ii) and that meets certain additional requirements, consistent with the terms and conditions of in-force covered agreements, as specified by the Commission in regulation.

1991, c. 264; 2012, c. 539; 2017, c. 477; 2020, c. 208.

§ 38.2-1316.2. Credit allowed a domestic ceding insurer.

A. Credit for reinsurance shall be allowed a domestic ceding insurer as either an asset or a reduction from liability on account of reinsurance ceded only when the reinsurer meets the requirements of subsection C, D, or E or § 38.2-1316.4, provided that the Commission may adopt by regulation pursuant to subsection B of § 38.2-1316.7 specific additional requirements relating to or setting forth any one or more of the following: (i) the valuation of assets or reserve credits, (ii) the amount and forms of security supporting reinsurance arrangements described in subsection B of § 38.2-1316.7, and (iii) the circumstances pursuant to which credit will be reduced or eliminated.

B. Credit shall be allowed under subdivisions C 1, 2, and 3 only as respects cessions of those kinds or classes of business that the assuming insurer is licensed or otherwise permitted to write or assume in its state of domicile or, in the case of a U.S. branch of an alien assuming insurer, in the state through which it is entered and licensed to transact insurance or reinsurance. Credit shall be allowed under subdivision C 3 or 4 only if the applicable requirements of subsection B of 14VAC5-300-150 of the Virginia Administrative Code have been satisfied.

C. Credit shall be allowed a domestic ceding insurer for reinsurance ceded only when the assuming insurer meets one of the following criteria:

1. Credit shall be allowed when the assuming insurer is licensed to transact insurance in the Commonwealth.

2. Credit shall be allowed when the assuming insurer is accredited as a reinsurer in the Commonwealth. An accredited reinsurer is one which:

a. Files with the Commission evidence of its submission to the Commission's jurisdiction;

b. Submits to the Commission's authority to examine its books and records;

c. Is licensed to transact insurance or reinsurance in at least one state or, in the case of a United States branch of an alien assuming insurer, is entered through and licensed to transact insurance or reinsurance in at least one state;

d. Files annually with the Commission a copy of its annual statement filed with the insurance department of its state of domicile or entry and a copy of its most recent audited financial statement; and

e. Demonstrates to the satisfaction of the Commission that it has adequate financial capacity to meet its reinsurance obligations and is otherwise qualified to assume reinsurance from domestic insurers. An assuming insurer is deemed to meet this requirement as of the time of its application if it maintains a surplus as regards policyholders in an amount not less than $20 million and its accreditation has not been denied by the Commission within 90 days of its initial submission.

3. Credit shall be allowed when the assuming insurer is domiciled and licensed in or, in the case of a United States branch of an alien insurer, is entered through, a state which employs standards regarding credit for reinsurance substantially similar to those applicable under this statute and the assuming insurer or United States branch of an alien assuming insurer:

a. Submits to the authority of the Commission to examine its books and records; and

b. Maintains a surplus as regards policyholders in an amount not less than $20 million. However, unless specifically required by the Commission, this surplus requirement shall be deemed waived when reinsurance is ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system.

4. Credit shall be allowed when the assuming insurer maintains a trust fund in a qualified United States financial institution for the payment of the valid claims of its United States policyholders and ceding insurers, their assigns and successors in interest. The assuming insurer shall report annually to the Commission information substantially the same as that required to be reported on the NAIC Annual Statement form by licensed insurers to enable the Commission to determine the sufficiency of the trust fund.

a. In the case of a single assuming insurer, the trust shall consist of a trusteed account representing the assuming insurer's liabilities attributable to business written in the United States, and in addition, the assuming insurer shall maintain a trusteed surplus amount not less than $20 million, except as provided in subdivision 4 b.

b. At any time after the assuming insurer has permanently discontinued underwriting new business secured by the trust for at least three full years, the commissioner with principal regulatory oversight of the trust may authorize a reduction in the required trusteed surplus, but only after a finding, based on an assessment of the risk, that the new required surplus level is adequate for the protection of United States ceding insurers, policyholders, and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flows, and shall consider all material risk factors, including when applicable the lines of business involved, the stability of the incurred loss estimates and the effect of the surplus requirements on the assuming insurer's liquidity or solvency. The minimum required trusteed surplus may not be reduced to an amount less than 30 percent of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers covered by the trust.

c. In the case of an association, including incorporated and individual unincorporated underwriters, the trust shall consist of a trusteed account representing the association's liabilities attributable to business written in the United States and in addition, the association shall maintain a trusteed surplus of which $100 million shall be held jointly for the benefit of United States ceding insurers of any member of the association, the incorporated members of which shall not be engaged in any business other than underwriting as a member of the association and shall be subject to the same level of solvency regulation and control by the association's domiciliary regulator as are the unincorporated members; and the association shall make available to the Commission an annual certification of the solvency of each underwriter by the association's domiciliary regulator and its independent public accountants.

d. In the case of an association of incorporated underwriters under common administration that complies with the filing requirements contained in subdivision 4 c, and that has continuously transacted an insurance business outside the United States for at least three years, and submits to the Commission's authority to examine its books and records and bears the expense of the examination, and which has aggregate policyholders' surplus of $10 billion; the trust shall be in an amount equal to the association's several liabilities attributable to business ceded by United States ceding insurers to any member of the association pursuant to reinsurance contracts issued in the name of such association. In addition, the association shall maintain a joint trusteed surplus of which $100 million shall be held jointly for the benefit of United States ceding insurers of any member of the association as additional security for any such liabilities, and each member of the association shall make available to the Commission an annual certification of the member's solvency by the member's domiciliary regulator and its independent public accountant.

D. Credit shall be allowed when the reinsurance is ceded to an assuming insurer that has been certified by the Commission as a reinsurer in the Commonwealth and secures its obligations in accordance with the following:

1. In order to be eligible for certification, the assuming insurer shall:

a. Be domiciled and licensed to transact insurance or reinsurance in a qualified jurisdiction, as determined by the Commission pursuant to subdivision 3;

b. Maintain minimum capital and surplus, or its equivalent, in an amount to be determined by the Commission pursuant to regulation;

c. Maintain financial strength ratings from two or more rating agencies deemed acceptable by the Commission pursuant to regulation;

d. Agree to submit to the jurisdiction of the Commonwealth, appoint the Commission as its agent for service of process in the Commonwealth, and agree to provide security for 100 percent of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers if it resists enforcement of a final United States judgment;

e. Agree to meet applicable information filing requirements as determined by the Commission, both with respect to an initial application for certification and on an ongoing basis; and

f. Satisfy other requirements for certification deemed relevant by the Commission.

2. In order to be eligible for certification as a certified reinsurer, an association including incorporated and individual unincorporated underwriters, in addition to satisfying requirements of subdivision 1, shall satisfy the following requirements:

a. The association shall satisfy its minimum capital and surplus requirements through the capital and surplus equivalents, net of liabilities, of the association and its members, which shall include a joint central fund that may be applied to any unsatisfied obligation of the association or any of its members, in an amount determined by the Commission to provide adequate protection;

b. The incorporated members of the association shall not be engaged in any business other than underwriting as a member of the association and shall be subject to the same level of regulation and solvency control by the association's domiciliary regulator as are the unincorporated members; and

c. Within 90 days after its financial statements are due to be filed with the association's domiciliary regulator, the association shall provide to the Commission an annual certification by the association's domiciliary regulator of the solvency of each underwriter member; or if a certification is unavailable, financial statements prepared by independent public accountants, of each underwriter member of the association.

3. The Commission shall create and publish a list of qualified jurisdictions, under which an assuming insurer licensed and domiciled in such jurisdiction is eligible to be considered for certification by the Commission as a certified reinsurer. With regard to determinations of qualified jurisdictions:

a. In order to determine whether the domiciliary jurisdiction of a non-United States assuming insurer is eligible to be recognized as a qualified jurisdiction, the Commission shall evaluate the appropriateness and effectiveness of the reinsurance supervisory system of the jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits, and the extent of reciprocal recognition

afforded by the non-United States jurisdiction to reinsurers licensed and domiciled in the United States. A qualified jurisdiction must agree to share information and cooperate with the Commission with respect to all certified reinsurers domiciled within that jurisdiction. A jurisdiction may not be recognized as a qualified jurisdiction if the Commission has determined that the jurisdiction does not adequately and promptly enforce final United States judgments and arbitration awards. Additional factors may be considered in the discretion of the Commission;

b. A list of qualified jurisdictions shall be published through the NAIC Committee Process. The Commission shall consider this list in determining qualified jurisdictions. If the Commission approves a jurisdiction as qualified that does not appear on the list of qualified jurisdictions, the Commission shall provide thoroughly documented justification in accordance with criteria to be developed under regulations;

c. United States jurisdictions that meet the requirement for accreditation under the NAIC financial standards and accreditation program shall be recognized as qualified jurisdictions; and

d. If a certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction, the Commission has the discretion to suspend the reinsurer's certification indefinitely, in lieu of revocation.

4. The Commission shall assign a rating to each certified reinsurer, giving due consideration to the financial strength ratings that have been assigned by rating agencies deemed acceptable to the Commission pursuant to regulation. The Commission shall publish a list of all certified reinsurers and their ratings.

5. A certified reinsurer shall secure obligations assumed from United States ceding insurers under this subsection at a level consistent with its rating, as specified in regulations promulgated by the Commission. With regard to securing obligations:

a. In order for a domestic ceding insurer to qualify for full financial statement credit for reinsurance ceded to a certified reinsurer, the certified reinsurer shall maintain security in a form acceptable to the Commission and consistent with the provisions of § 38.2-1316.4, or in a multibeneficiary trust in accordance with subdivision C 4, except as otherwise provided in this subsection;

b. If a certified reinsurer maintains a trust to fully secure its obligations subject to subdivision C 4, and chooses to secure its obligations incurred as a certified reinsurer in the form of a multibeneficiary trust, the certified reinsurer shall maintain separate trust accounts for its obligations incurred under reinsurance agreements issued or renewed as a certified reinsurer with reduced security as permitted by this subsection or comparable laws of other United States jurisdictions and for its obligations subject to subdivision C 4. It shall be a condition to the grant of certification under this section that the certified reinsurer shall have bound itself, by the language of the trust and agreement with the Commissioner with principal regulatory oversight of each such trust account, to fund, upon termination of any such trust account, out of the remaining surplus of such trust any deficiency of any other such trust account;

c. The minimum trusteed surplus requirements provided in subdivision C 4 are not applicable with respect to a multibeneficiary trust maintained by a certified reinsurer for the purpose of securing obligations incurred under this subsection, except that such trust shall maintain a minimum trusteed surplus of $10 million;

d. With respect to obligations incurred by a certified reinsurer under this subsection, if the security is insufficient, the Commission shall reduce the allowable credit by an amount proportionate to the deficiency and has the discretion to impose further reductions in allowable credit upon finding that there is a material risk that the certified reinsurer's obligations will not be paid in full when due; and

e. For purposes of this subsection, a certified reinsurer whose certification has been terminated for any reason shall be treated as a certified reinsurer required to secure 100 percent of its obligations. As used in this subsection, the term "terminated" means revocation, suspension, voluntary surrender, and inactive status. If the Commission continues to assign a higher rating as permitted by other provisions of this section, this requirement does not apply to a certified reinsurer in inactive status or to a reinsurer whose certification has been suspended.

6. If an applicant for certification has been certified as a reinsurer in an NAIC accredited jurisdiction, the Commission has the discretion to defer to that jurisdiction's certification and has the discretion to defer to the rating assigned by that jurisdiction, and such assuming insurer shall be considered to be a certified reinsurer in the Commonwealth.

7. A certified reinsurer that ceases to assume new business in the Commonwealth may request to maintain its certification in inactive status in order to continue to qualify for a reduction in security for its in-force business. An inactive certified reinsurer shall continue to comply with all applicable requirements of this subsection, and the Commission shall assign a rating that takes into account, if relevant, the reasons why the reinsurer is not assuming new business.

E. Credit shall be allowed when the reinsurance is ceded to an assuming insurer in accordance with the following:

1. The assuming insurer shall:

a. Be domiciled in, or its head office shall be located in, as applicable, a reciprocal jurisdiction identified by the Commission pursuant to this subsection and shall be licensed in such reciprocal jurisdiction;

b. Maintain minimum capital and surplus, or its equivalent, calculated according to the methodology of its domiciliary jurisdiction, in an amount to be determined by the Commission in regulation. If the assuming insurer is an association, including incorporated and individual unincorporated underwriters, it shall maintain minimum capital and surplus equivalents, net of liabilities, calculated according to the methodology applicable in its domiciliary jurisdiction, and a central fund containing a balance in amounts to be determined by the Commission in regulation;

c. Maintain a minimum solvency or capital ratio, as applicable, which will be determined by the Commission in regulation. If the assuming insurer is an association, including incorporated and individual unincorporated underwriters, it shall maintain a minimum solvency or capital ratio in the reciprocal jurisdiction where the assuming insurer is domiciled or its head office is located, as applicable, and is licensed;

d. Agree and provide adequate assurance to the Commission, in a form specified by the Commission pursuant to regulation, as follows:

(1) Provide prompt written notice and explanation to the Commission if it falls below the minimum requirements set forth in subdivision b or c, or if any regulatory action is taken against it for serious noncompliance with applicable law;

(2) Consent in writing to the jurisdiction of the courts of the Commonwealth and to the appointment of the Commission as an agent for service of process. The Commission may require that consent for service of process be provided to the Commission and included in each reinsurance agreement. Nothing in this subdivision shall limit, or in any way alter, the capacity of parties to a reinsurance agreement to agree to alternative dispute resolution mechanisms, except to the extent such agreements are unenforceable under applicable insolvency or delinquency laws;

(3) Consent in writing to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer or its legal successor, that have been declared enforceable in the jurisdiction where the judgment was obtained;

(4) Include, in each reinsurance agreement, a provision requiring the assuming insurer to provide security in an amount equal to 100 percent of the assuming insurer's liabilities attributable to reinsurance ceded pursuant to that agreement if the assuming insurer resists enforcement of a final judgment that is enforceable under the law of the jurisdiction in which it was obtained or a properly enforceable arbitration award, whether obtained by the ceding insurer or by its legal successor on behalf of its resolution estate; and

(5) Confirm that it is not presently participating in any solvent scheme of arrangement that involves the Commonwealth's ceding insurers, and agree to notify the ceding insurer and the Commission and to provide security in an amount equal to 100 percent of the assuming insurer's liabilities to the ceding insurer, should the assuming insurer enter into such a solvent scheme of arrangement. Such security shall be in a form consistent with the provisions of subsection D of this section and subdivision 2 of § 38.2-1316.4 and as determined by the Commission in regulation;

e. Provide, or its legal successor shall provide, if requested by the Commission, on behalf of itself and any legal predecessors, certain documentation to the Commission, as specified by the Commission in regulation; and

f. Maintain a practice of prompt payment of claims under reinsurance agreements, pursuant to criteria set forth by regulation.

Nothing in this subdivision 1 precludes an assuming insurer from providing the Commission with information on a voluntary basis.

2. The assuming insurer's supervisory authority shall confirm to the Commission on an annual basis as of the preceding December 31, or at the annual date otherwise statutorily reported to the reciprocal jurisdiction, that the assuming insurer complies with the requirements set forth in subdivisions 1 b and c.

3. The Commission shall create and publish a list of reciprocal jurisdictions. With regard to determinations of reciprocal jurisdictions, the Commission:

a. Shall include (i) any non-United States jurisdiction that is subject to an in-force covered agreement with the United States, each within its legal authority, or, in the case of a covered agreement between the United States and the European Union, is a member state of the European Union; (ii) any United States jurisdiction that meets the requirements for accreditation under the NAIC financial standards and accreditation program; or (iii) any qualified jurisdiction, as determined by the Commission pursuant to subdivision D 3 of § 38.2-1316.2, that is not otherwise described in clause (i) or (ii) and that meets certain additional requirements, consistent with the terms and conditions of in-force covered agreements, as specified by the Commission in regulation;

b. Shall consider including any other reciprocal jurisdiction included on the NAIC list published through the NAIC Committee Process. The Commission may approve a jurisdiction that does not appear on the NAIC list of reciprocal jurisdictions in accordance with criteria to be developed under regulations issued by the Commission; and

c. May remove a jurisdiction from the list of reciprocal jurisdictions upon a determination that the jurisdiction no longer meets the requirements of a reciprocal jurisdiction, in accordance with a process set forth in regulations issued by the Commission, except that the Commission shall not remove from the list a reciprocal jurisdiction described in clause (i) or (ii) of subdivision a. Upon removal of a reciprocal jurisdiction from this list, credit for reinsurance ceded to an assuming insurer that is domiciled or has its home office in that jurisdiction shall be allowed, if otherwise allowed pursuant to this section.

4. The Commission shall create and publish a list of assuming insurers that have satisfied the conditions set forth in this subsection and to which cessions shall be granted credit in accordance with this subsection. The Commission may add an assuming insurer to such list if an NAIC-accredited jurisdiction has added such assuming insurer to a list of such assuming insurers or if, upon initial eligibility, the assuming insurer submits the information to the Commission as required under subdivision 1 d and complies with any additional requirements that the Commission may impose by regulation, except to the extent that they conflict with an applicable covered agreement.

5. If the Commission determines that an assuming insurer no longer meets one or more of the requirements under this subsection, the Commission may revoke or suspend the eligibility of the assuming insurer for recognition under this subsection in accordance with procedures set forth in regulation.

a. While an assuming insurer's eligibility is suspended, no reinsurance agreement issued, amended, or renewed after the effective date of the suspension qualifies for credit except to the extent that the assuming insurer's obligations under the contract are secured in accordance with subdivision 2 of § 38.2-1316.4.

b. If an assuming insurer's eligibility is revoked, no credit for reinsurance may be granted after the effective date of the revocation with respect to any reinsurance agreements entered into by the assuming insurer, including reinsurance agreements entered into prior to the date of revocation, except to the extent that the assuming insurer's obligations under the contract are secured in a form acceptable to the Commission and consistent with the provisions of subdivision 2 of § 38.2-1316.4.

6. If subject to a legal process of rehabilitation, liquidation, or conservation, as applicable, the ceding insurer, or its representative, may seek and, if determined appropriate by the court in which the proceedings are pending, may obtain an order requiring that the assuming insurer post security for all outstanding ceded liabilities.

7. Nothing in this subsection shall limit or in any way alter the capacity of parties to a reinsurance agreement to agree on requirements for security or other terms in that reinsurance agreement, except as expressly prohibited by this article or other applicable law or regulation.

8. Credit may be taken under this subsection only for reinsurance agreements entered into, amended, or renewed on or after July 1, 2020, and only with respect to losses incurred and reserves reported on or after the later of (i) the date on which the assuming insurer has met all eligibility requirements pursuant to subdivision 1 and (ii) the effective date of the new reinsurance agreement, amendment, or renewal. This subdivision does not alter or impair a ceding insurer's right to take credit for reinsurance, to the extent that credit is not available under this subsection, as long as the reinsurance qualifies for credit under any other applicable provision of this article.

9. Nothing in this subsection shall authorize an assuming insurer to withdraw or reduce the security provided under any reinsurance agreement except as permitted by the terms of the agreement.

10. Nothing in this subsection shall limit, or in any way alter, the capacity of parties to any reinsurance agreement to renegotiate the agreement.

F. If an accredited or certified reinsurer ceases to meet the requirements for accreditation or certification, the Commission may suspend or revoke the reinsurer's accreditation or certification in accordance with the following:

1. The Commission shall give the reinsurer notice and opportunity for hearing. The suspension or revocation may not take effect until after the Commission's order on hearing, unless:

a. The reinsurer waives its right to hearing;

b. The Commission's order is based on regulatory action by the reinsurer's domiciliary jurisdiction or the voluntary surrender or termination of the reinsurer's eligibility to transact insurance or reinsurance

business in its domiciliary jurisdiction or in the primary certifying state of the reinsurer under subdivision D 6; or

c. The Commission finds that an emergency requires immediate action and a court of competent jurisdiction has not stayed the Commission's action.

2. While a reinsurer's accreditation or certification is suspended, no reinsurance contract issued or renewed after the effective date of the suspension qualifies for credit except to the extent that the reinsurer's obligations under the contract are secured in accordance with § 38.2-1316.4. If a reinsurer's accreditation or certification is revoked, no credit for reinsurance may be granted after the effective date of the revocation except to the extent that the reinsurer's obligations under the contract are secured in accordance with subdivision D 5 or § 38.2-1316.4.

G. A ceding insurer shall take steps to manage its concentration risk and diversify its reinsurance program in the following manner:

1. A ceding insurer shall take steps to manage its reinsurance recoverables proportionate to its own book of business. A domestic ceding insurer shall notify the Commission within 30 days after reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers, exceeds 50 percent of the domestic ceding insurer's last reported surplus to policyholders, or after it is determined that reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers, is likely to exceed this limit. The notification shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

2. A ceding insurer shall take steps to diversify its reinsurance program. A domestic ceding insurer shall notify the Commission within 30 days after ceding to any single assuming insurer, or group of affiliated assuming insurers, more than 20 percent of the ceding insurer's gross written premium in the prior calendar year, or after it has determined that the reinsurance ceded to any single assuming insurer, or group of affiliated assuming insurers, is likely to exceed this limit. The notification shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

H. The trusts described in subdivision C 4 shall be established in a form acceptable to the Commission.

1. The trust instrument shall provide that contested claims shall be valid and enforceable upon the final order of any court of competent jurisdiction in the United States.

2. The trust shall vest legal title to its assets in the trustees of the trust for its United States policyholders and ceding insurers, their assigns and successors in interest.

3. The trust and the assuming insurer shall be subject to examination as determined by the Commission.

4. The trust described herein must remain in effect for as long as the assuming insurer shall have outstanding obligations due under the reinsurance agreements subject to the trust.

5. No later than February 28 of each year the trustees of the trust shall report to the Commission in writing setting forth the balance of the trust and listing the trust's investments at the preceding year end and shall certify the date of termination of the trust, if so planned, or certify that the trust shall not expire prior to the next following December 31.

1991, c. 264; 1994, c. 647; 2012, c. 539; 2017, c. 477; 2020, c. 208.

§ 38.2-1316.3. Repealed.

Repealed by Acts 2012, c. 539, cl. 2.

§ 38.2-1316.4. Credit allowed any ceding insurer.

Credit shall be allowed any ceding insurer under the following conditions:

1. Credit shall be allowed when reinsurance is ceded to an assuming insurer not meeting the requirements of § 38.2-1316.2 but only with respect to the insurance of risks located in jurisdictions where such reinsurance is required by applicable law or regulation of that jurisdiction.

2. Credit, in the form of a reduction from liability for reinsurance ceded to an assuming insurer not meeting the requirements of § 38.2-1316.2, shall be allowed in an amount not exceeding the liabilities carried by the ceding insurer and attributable to the reinsurance, provided that the Commission may adopt by regulation pursuant to subsection B of § 38.2-1316.7 specific additional requirements relating to or setting forth any one or more of the following: (i) the valuation of assets or reserve credits, (ii) the amount and forms of security supporting reinsurance arrangements described in subsection B of § 38.2-1316.7, and (iii) the circumstances pursuant to which credit will be reduced or eliminated. Additionally, such reduction shall not exceed the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with such assuming insurer as security for the payment of obligations thereunder, if such security is (a) held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer or (b) in the case of a trust, held in a qualified United States financial institution. The required security may be in the form of:

a. Cash.

b. Securities listed by the Securities Valuation Office of the NAIC, including those deemed exempt from filing as defined by the Purposes and Procedures Manual of the Investment Analysis Office, and qualifying as admitted assets with adequate liquidity and readily determinable market value.

c. Clean, irrevocable, unconditional letters of credit issued or confirmed by a qualified United States financial institution, as defined in this article, no later than December 31 in respect of the year for which filing is being made, and in the possession of the ceding insurer on or before the filing date of its annual statement. Letters of credit meeting applicable standards of insurer acceptability as of the dates of their issuance (or confirmation) shall, notwithstanding the issuing (or confirming) institution's subsequent failure to meet applicable standards of insurer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification or amendment, whichever first occurs.

d. Any other form of security acceptable to the Commission.

1991, c. 264; 2012, c. 539; 2017, c. 477; 2020, c. 208.

§§ 38.2-1316.5, 38.2-1316.6. Repealed.

Repealed by Acts 2012, c. 539, cl. 2.

§ 38.2-1316.7. Rules and regulations.

A. The Commission may adopt rules and regulations implementing the provisions of this article.

B. The Commission is further authorized to adopt rules and regulations applicable to reinsurance arrangements described in subdivision 1. A regulation adopted pursuant to:

1. This subsection shall apply only to reinsurance relating to:

a. Life insurance policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits;

b. Universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period;

c. Variable annuities with guaranteed death or living benefits;

d. Long-term care insurance policies; or

e. Such other life and health insurance and annuity products as to which the NAIC adopts model regulatory requirements with respect to credit for reinsurance.

2. Subdivision 1 a or 1 b shall apply to any treaty containing (i) policies issued on or after January 1, 2015, and (ii) policies issued prior to January 1, 2015, if risk pertaining to such pre-2015 policies is ceded in connection with the treaty, in whole or in part, on or after January 1, 2015.

3. This subsection may require the ceding insurer, in calculating the amounts or forms of security required to be held under regulations promulgated under this authority, to use the Valuation Manual adopted by the NAIC under subdivision B 1 of § 38.2-1379, including all amendments adopted by the NAIC and in effect on the date as of which the calculation is made, to the extent applicable.

4. This subsection shall not apply to cessions to an assuming insurer that:

a. Is certified in the Commonwealth;

b. Meets the conditions set forth in subsection E of § 38.2-1316.2; or

c. Maintains at least $250 million in capital and surplus when determined in accordance with the NAIC Accounting Practices and Procedures Manual, including all amendments thereto adopted by the NAIC, excluding the impact of any permitted or prescribed practices, and is (i) licensed in at least 26 states or (ii) licensed in at least 10 states and licensed or accredited in a total of at least 35 states.

C. The authority to adopt regulations pursuant to subsection B does not limit the Commission's general authority to adopt regulations pursuant to subsection A.

1991, c. 264; 2017, c. 477; 2020, c. 208.

§ 38.2-1316.8. Reinsurance agreements affected.

The provisions of this article shall apply to all cessions after the effective date of this article under reinsurance agreements which have had an inception, anniversary or renewal date not less than six months after July 1, 2012.

1991, c. 264; 2012, c. 539.

Article 4 - EXAMINATIONS

§ 38.2-1317. Examinations; when authorized or required.

A. Whenever the Commission considers it expedient for the protection of the interests of the people of this Commonwealth, it may make or direct to be made an examination into the affairs of any person licensed to transact any insurance business in this Commonwealth or any other person subject to the jurisdiction of the Commission pursuant to provisions of this title. The Commission may also make or direct to be made, whenever necessary or advisable an examination into the affairs of:

1. Any person having a contract under which he has the exclusive or dominant right to manage or control any licensed insurer,

2. Any person holding the shares of capital stock or policyholder proxies of any domestic insurer amounting to control as defined in § 38.2-1322 either as voting trustee or otherwise,

3. Any person engaged or assisting in, or proposing or claiming to engage or assist in the promotion or formation of a domestic insurer, or

4. Any person seeking a license to transact any insurance business in this Commonwealth.

B. The Commission shall examine or cause to be examined every domestic insurer at least once in every five years; however, on or after January 1, 1993, the Commission shall examine every insurer licensed in this Commonwealth at least once in every five years.

C. The examination of any foreign or alien insurer or any other foreign or alien person subject to examination shall be made to the extent practicable in cooperation with the insurance departments of other states.

D. Instead of making its own examination, the Commission may accept a full report of the examination of a foreign or alien person, duly authenticated by the insurance supervisory official of the state of domicile or of entry until January 1, 1994. Thereafter, such reports may only be accepted if:

1. The insurance department was at the time of the examination accredited under the National Association of Insurance Commissioners' (NAIC) Financial Regulation Standards and Accreditation Program;

2. The examination is performed under the supervision of such an accredited insurance department or with the participation of one or more examiners who are employed by an accredited insurance department and who, after a review of the examination work papers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their insurance department; or

3. The Commission determines, in its sole discretion, that the examination was performed in a manner consistent with standards and procedures employed by the Commission in the examination of domestic insurers, and the report of examination is duly authenticated by the insurance supervisory official of the insurer's state of domicile or entry.

Code 1950, §§ 38-125, 38-126, 38-216, 38-253.40, 38-253.86, 38-516; 1952, c. 317, § 38.1-174; 1972, c. 836; 1973, c. 504; 1977, c. 321; 1986, c. 562; 1992, c. 588; 1996, c. 47.

§ 38.2-1317.1. Examinations; nature and scope.

A. In scheduling and determining the nature, scope and frequency of examinations, the Commission shall consider such matters as the conduct of business in the marketplace, results of financial statement analyses and ratios, results of market analyses, changes in management or ownership, actuarial opinions, reports of independent certified public accountants and other criteria as set forth in any Examiners' Handbook, or any successor publications, adopted by the NAIC and in effect when the Commission exercises discretion under this article.

Procedures for examinations concerning the conduct of business in the marketplace shall be exclusively subject to the provisions of §§ 38.2-218 through 38.2-222 and §§ 38.2-1318, 38.2-1319, 38.2-1320.5, and 38.2-1321.1.

B. For purposes of completing an examination of any company under this article, the Commission may examine or investigate any person, or the business of any person, in so far as such examination or investigation is, in the sole discretion of the Commission, necessary or material to the examination of the company.

C. The examination of any alien insurer or person shall be limited to its insurance transactions in the United States unless the Commission considers a complete examination of the alien insurer or person to be necessary.

D. As used in this article:

"Company" means any person engaging in or proposing or attempting to engage in any transaction or kind of insurance or surety business and any person or group of persons who, pursuant to the provisions of this title, Title 58.1, or any rule or regulation promulgated by the Commission, may otherwise be subject to the administrative or regulatory authority of the Commission as set forth in the provisions of this title.

"Insurance department" means the supervising regulatory officials of a given state who are responsible for administering the insurance laws of said state.

"Insurer" means an insurance institution as defined by § 38.2-602.

"NAIC" means the National Association of Insurance Commissioners.

"Person" means any association, aggregate of individuals, business, company, corporation, individual, joint-stock company, Lloyds type of organization, organization, partnership, receiver, reciprocal or interinsurance exchange, trustee or society, or any affiliate thereof.

1992, c. 588; 2008, c. 249.

§ 38.2-1317.2. Market analyses confidential.

A. All market analyses concerning companies or insurance transactions that are obtained by the Commission from the NAIC, including information generated by any NAIC databases developed for use by regulators, and all market analyses generated by the Commission based on documents or information submitted to the Commission by a company or person, including its officers, directors, and agents, shall receive confidential treatment by the Commission, shall not be subject to subpoena, and are not public records. All working papers, recorded information, documents and copies thereof produced by, obtained by, or disclosed to the Commission or any other person in the course of a market analysis or market conduct action shall receive confidential treatment by the Commission, shall not be subject to subpoena, and are not public records. Any such disclosure to the Commission shall not constitute a waiver of confidentiality of any such documents or information.

B. Notwithstanding other provisions to the contrary, nothing shall prevent or be construed as prohibiting the Commission from disclosing otherwise confidential information, administrative or judicial orders, or the content of any analysis or any matter related thereto, at any time to (i) a regulatory official of any state or country; (ii) the NAIC, its affiliate or its subsidiary; or (iii) a law-enforcement authority of any state or country, provided that those officials are required under their law to maintain its confidentiality. Any such disclosure by the Commission shall not constitute a waiver of confidentiality of any such documents or information.

C. Documents or information received in the course of a market analysis or market conduct action from the NAIC, a law-enforcement official of any state or country, or regulatory officials of any state or country that are confidential in those jurisdictions shall receive confidential treatment by the Commission, shall not be subject to subpoena, and are not public records.

D. Nothing in this section shall prohibit the Commission from releasing a report containing aggregated findings.

2008, c. 249.

§ 38.2-1318. Examinations; how conducted.

A. Whenever the Commission examines the affairs of any person, as set forth in § 38.2-1317, it may appoint as examiners one or more competent persons.

1. To the extent practicable, the examiners shall be regular employees of the Commission.

2. No examiner may be appointed by the Commission if such examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any per-

son subject to examination under this article; however, this section shall not be construed to automatically preclude an examiner from being:

a. A policyholder or claimant under an insurance policy;

b. A grantor of a mortgage or similar instrument on the examiner's residence to a regulated entity if done under customary terms and in the ordinary course of business;

c. An investment owner in shares of regulated diversified investment companies; or

d. A settlor or beneficiary of a "blind trust" into which any otherwise impermissible holdings have been placed.

3. Notwithstanding the requirements of this subsection, the Commission may retain from time to time, on an individual basis, qualified actuaries, certified public accountants, or other similar individuals or firms who are independently practicing their professions, even though said persons may from time to time be similarly employed or retained by persons subject to examination under this article.

B. The examiners shall be instructed as to the scope of the examination, and, in conducting the examination, the examiner shall observe, to the extent practicable, those guidelines and procedures set forth in the Examiners' Handbook, or any successor publications, adopted by the NAIC and such other guidelines or procedures as the Commission may deem appropriate.

C. Every company or person from whom information is sought, its officers, directors, and agents shall provide the examiners convenient access at all reasonable hours to its books, records, files, securities, accounts, papers, documents, and any or all computer or other recordings relating to the property, assets, business and affairs of the company being examined or those of any person, including any affiliates or subsidiaries of the person examined, that are relevant to the examination.

1. The officers, directors, employees and agents of the company or person shall facilitate the examination and aid in the examination so far as it is in their power to do so.

2. The refusal of any company, by its officers, directors, employees or agents, to submit to examination or to comply with any reasonable written request of the examiners shall be grounds for suspension or refusal of, or nonrenewal of, any license or authority held by the company to engage in an insurance or other business subject to the Commission's jurisdiction. Any such proceedings for suspension, revocation or refusal of any license or authority shall be conducted pursuant to § 38.2-1040.

D. For the purpose of any investigation or proceeding under this article, the Commission or any individual designated by it may administer oaths and affirmations, subpoena witnesses, compel their attendance, take evidence and require the production of any books, papers, correspondence, memoranda, agreements or other documents or records which the Commission determines are relevant to the examination.

E. In connection with any examination, the Commission may retain attorneys, appraisers, independent actuaries, independent certified public accountants, security analysts or other professionals and

specialists as examiners; the cost of which shall be borne by the company which is the subject of the examination.

F. Nothing contained in this article shall be construed to limit the Commission's authority to terminate or suspend any examination in order to pursue other legal or regulatory action pursuant to the provisions of this title.

G. Nothing contained in this article shall be construed to limit the Commission's authority to use and, if appropriate, to make public any final or preliminary examination report, any examiner or company workpapers or other documents, or any other information discovered or developed during the course of any examination in the furtherance of any legal or regulatory action which the Commission may deem appropriate.

H. Whenever the Commission examines the affairs of any person providing benefits pursuant to Title XIX or Title XXI of the Social Security Act, as amended, as set forth in § 38.2-1317, nothing contained in this article shall be construed to limit the Commission's authority to consult with the Department of Medical Assistance Services about such person before taking any action as a result of services the person provides pursuant to Title XIX or Title XXI of the Social Security Act, as amended.

Code 1950, §§ 38-69, 38-125; 1952, c. 317, § 38.1-175; 1986, c. 562; 1992, c. 588; 2006, c. 866.

§ 38.2-1319. Expense of examination.

A. Any person examined shall be liable for the necessary traveling and other expenses reasonably attributable to the examiners or incurred by the Commission on account of its examination. The Commission may require the person to pay either a reasonable living expense allowance or the actual living expenses of an examiner, whichever the Commission determines to be more appropriate. Where the examiner is other than a full-time employee of the Commission, the person may, in addition, be required to pay to the Commission's examiners, upon presentation of an itemized statement, consulting fees or a per diem compensation at a reasonable rate approved by the Commission.

B. Where the examination concerns a person domiciled or having its home office in this Commonwealth, the Commission may, at its discretion and for good cause, waive payment of expenses.

C. If the Commission finds the accounts to be inadequate, or inadequately kept or posted, it may employ experts to rewrite, post or balance them at the expense of the person examined if that person has failed to complete or correct the accounts after notice and reasonable opportunity has been given by the Commission.

Code 1950, §§ 38-70, 38-125; 1952, c. 317, § 38.1-176; 1986, c. 562; 1992, c. 588.

§ 38.2-1320. Examination reports; general description.

The Commission's examiners shall make a true report of every examination. The report shall include only facts appearing upon the books, records or other documents of the person examined or as ascertained from the sworn testimony of its directors, officers, employees, agents or other persons examined concerning its affairs and any conclusions and recommendations reasonably warranted

from such facts. Findings of fact and conclusions made pursuant to any examination, and reported in any filed examination report for which the period for appeal has expired, shall be prima facie evidence in any subsequent legal or regulatory action.

Code 1950, §§ 38-127, 38-216; 1952, c. 317, § 38.1-177; 1986, c. 562; 1992, c. 588.

§ 38.2-1320.1. Submission of examination report.

No later than ninety days following completion of any examination, the Commission shall furnish two copies of the report to the person examined and shall notify the person that he may, within thirty days, make a written submission with respect to any facts, conclusions or recommendations contained in the examination report.

1. If the report contains any recommendation for corrective action by or on behalf of the person examined, the person shall make a written submission explaining what procedures have been implemented or are anticipated with respect to each recommendation of corrective action.

2. Any person seeking to take issue with any matter contained in the examination report shall do so by including in its written submission a request for a hearing before the Commission.

1992, c. 588; 1994, c. 308.

§ 38.2-1320.2. Filing of report on examination.

Within thirty days of the end of the period allowed for the receipt of written submissions, the Commission shall fully consider and review the report, together with any written submissions and any relevant portions of the examiner's workpapers and act upon the report by:

1. Certifying that the examination report as initially provided to the person examined, or with modifications or corrections, is the Commission's true examination report and filing such report in the offices of the Commission;

2. Rejecting the examination report with notice to the person examined that the Commission's examiners are being directed to reopen the examination for purposes of obtaining additional data, documentation or information, and resubmission pursuant to § 38.2-1320.1; or

3. Calling for an investigatory hearing before the Commission with no less than ten days' notice to the company for purposes of obtaining additional documentation, data, information and testimony.

1992, c. 588.

§ 38.2-1320.3. Examination reports; orders and procedures.

A. A certified copy of the examination report filed pursuant to subdivision 1 of § 38.2-1320.2 shall be served upon the company by certified mail. Within thirty days of the filing of the report, the company shall file affidavits executed by each of its directors stating under oath that they have received a copy of the filed report and any related orders.

B. If the examination report reveals that the company is operating in violation of any law, regulation or prior order of the Commission, the Commission may order the company to take any action the Commission considers necessary and appropriate to cure such violation.

C. Any hearing conducted by the Commission under subdivision 2 of § 38.2-1320.1 or subdivision 3 of § 38.2-1320.2 shall be conducted as a nonadversarial confidential investigatory proceeding as necessary for the resolution of any inconsistencies, discrepancies or disputed issues apparent upon the face of the examination report or raised by or as a result of the Commission's review of relevant workpapers or by the written submission of the company.

1992, c. 588.

§ 38.2-1320.4. Publication and use of examination reports.

A. Upon the filing of the examination report under subdivision 1 of § 38.2-1320.2, the Commission shall continue to hold the content of the examination report as private and confidential information for a period of ten days except to the extent provided in § 38.2-1320.3. Thereafter, the Commission may open the report for public inspection so long as no court of competent jurisdiction has stayed its publication.

B. Nothing contained in this Code shall prevent or be construed as prohibiting the Commission from disclosing the content of an examination report, preliminary examination report or results, or any matter relating thereto, at any time to (i) a regulatory official of any state or country; (ii) the NAIC, its affiliate or its subsidiary; or (iii) a law-enforcement authority of any state or country, so long as such agency, authority or office receiving the report or matters relating thereto agrees in writing to hold it confidential and in a manner consistent with this article. Any such disclosure by the Commission shall not constitute a waiver of confidentiality of any such reports or any matter relating thereto.

C. In the event the Commission determines that regulatory action is appropriate as a result of any examination, it may initiate any proceedings or actions as provided by law.

1992, c. 588; 2001, c. 519.

§ 38.2-1320.5. Confidentiality of ancillary information.

All working papers, recorded information, documents and copies thereof produced by, obtained by or disclosed to the Commission or any other person in the course of an examination made under this article shall be given confidential treatment, are not subject to subpoena, and may not be made public by the Commission or any other person, except to the extent provided in § 38.2-1320.4. Access may also be granted to (i) a regulatory official of any state or country; (ii) the NAIC, its affiliate or its subsidiary; or (iii) a law-enforcement authority of any state or country, provided that those officials are required under their law to maintain its confidentiality. Any such disclosure by the Commission shall not constitute a waiver of confidentiality of such papers, recorded information, documents or copies thereof. Any parties receiving such papers must agree in writing prior to receiving the information to provide to it the same confidential treatment as required by this section, unless the prior written consent of the company to which it pertains has been obtained.

1992, c. 588; 2001, c. 519; 2007, c. 488.

§ 38.2-1321. Records of examination preserved.

The Commission shall keep and preserve in permanent form the reports of all its official examinations, including all records, orders, exhibits or schedules filed in connection with these reports.

Code 1950, § 38-124; 1952, c. 317, § 38.1-178; 1986, c. 562; 1992, c. 588.

§ 38.2-1321.1. Immunity from liability.

A. No cause of action shall arise nor shall any liability be imposed against the Commission, the Commission's authorized representatives or any examiner appointed by the Commission for any statements made or conduct performed in good faith while carrying out the provisions of this article.

B. No cause of action shall arise, nor shall any liability be imposed against any person for the act of communicating or delivering information or data to the Commission or the Commission's authorized representative or examiner pursuant to an examination made under this article, if such act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive.

C. This section does not abrogate or modify in any way any common law or statutory privilege or immunity heretofore enjoyed by any person identified in subsection A of this section.

1992, c. 588.

Article 5 - Insurance Holding Companies

§ 38.2-1322. Definitions.

As used in this article:

"Acquiring person" means any person by whom or on whose behalf acquisition of control of any domestic insurer is to be effected.

"Affiliate" of a specific person or a person "affiliated" with a specific person means a person that directly or indirectly through one or more intermediaries, controls, is controlled by or is under common control with the person specified.

"Control," including the terms "controlling," "controlled by" and "under common control with," means direct or indirect possession of the power to direct or cause the direction of the management and policies of a person, through (i) the ownership of voting securities, (ii) by contract other than a commercial contract for goods or nonmanagement services, or (iii) otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person directly or indirectly owns, controls, holds with the power to vote, or holds proxies representing collectively 10 percent or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided by subsection K of § 38.2-1329 that control does not exist. After giving all interested persons notice and opportunity to be heard and making

specific findings to support its determination, the Commission may determine that control exists, notwithstanding the absence of a presumption to that effect.

"Enterprise risk" means any activity, circumstance, event, or series of events involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer or its insurance holding company system as a whole, including, but not limited to, anything that would cause the insurer's risk-based capital to fall into company action level as set forth in § 38.2-5503 or would cause the insurer to be in hazardous financial condition pursuant to 14VAC5-290-30 and 14VAC5-290-40 of the Virginia Administrative Code.

"Group-wide supervisor" means the regulatory official authorized to engage in conducting and coordinating group-wide supervision activities who is determined or acknowledged by the Commission under § 38.2-1332.2 to have sufficient significant contacts with the internationally active insurance group.

"Insurance holding company system" means two or more affiliated persons, one or more of which is an insurer.

"Insurer" means an insurance company as defined in § 38.2-100.

"Internationally active insurance group" means an insurance holding company system that includes an insurer registered under § 38.2-1329 and that meets the following criteria: (i) premiums written in at least three countries; (ii) the percentage of gross premiums written outside the United States is at least 10 percent of the insurance holding company system's total gross written premiums; and (iii) based on a three year rolling average, (a) the total assets of the insurance holding company system are at least $50 billion or (b) the total gross written premiums of the insurance holding company system are at least $10 billion.

"Lead state commissioner" means the insurance commissioner, director, or superintendent of the lead state of the insurance holding company system as determined by the Financial Analysis Handbook adopted by the NAIC.

"Material transaction" means (i) any sale, purchase, exchange, loan or extension of credit, or investment; (ii) any dividend or distribution; (iii) any reinsurance treaty or risk-sharing arrangement; (iv) any management contract, service contract or cost-sharing arrangement; (v) any merger with or acquisition of control of any corporation; or (vi) any other transaction or agreement that the Commission by order, rule or regulation determines to be material. Any series of transactions occurring within a 12-month period that are sufficiently similar in nature as to be reasonably construed as a single transaction and that in the aggregate exceed any minimum limits shall be deemed a material transaction.

"NAIC" means the National Association of Insurance Commissioners.

"NAIC Group Capital Calculation Instructions" means the group capital calculation instructions as adopted by the NAIC and as amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

"NAIC Liquidity Stress Test Framework" or "Framework" means an NAIC publication that includes a history of the NAIC's development of regulatory liquidity stress testing, the scope criteria applicable for a specific data year, and the liquidity stress test instructions and reporting templates for a specific data year, as adopted by the NAIC and amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

"Scope criteria" means the designated exposure bases along with minimum magnitudes thereof for the specified data year, used to establish a preliminary list of insurers considered scoped into the NAIC Liquidity Stress Test Framework for that data year.

"SEC" means the U.S. Securities and Exchange Commission.

"Subsidiary" of a specified person means an affiliate directly or indirectly controlled by that person through one or more intermediaries.

"Ultimate controlling person" means the person that is not controlled by any other person.

"Voting security" means any security that enables the owner to vote for the election of directors. "Voting security" includes any security convertible into or evidencing a right to acquire a voting security.

1973, c. 505, § 38.1-178.1; 1977, c. 414, § 38.1-178.1:2; 1986, c. 562; 1992, c. 588; 1993, c. 158; 1998, c. 42; 2014, c. 309; 2019, c. 692; 2022, c. 113.

§ 38.2-1323. Acquisition of control of insurers.

A. No person other than the issuer shall make a tender offer or a request or invitation for tenders of, or enter into any agreement to exchange securities for, seek to acquire, or acquire, in the open market or otherwise, any voting security of a domestic insurer if, after the consummation thereof, such person would, directly or indirectly (or by conversion or by exercise of any right to acquire) be in control of the insurer. No person shall enter into an agreement to merge with or otherwise to acquire control of a domestic insurer or any person controlling a domestic insurer unless, at the time the offer, request, or invitation is made or the agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, such person has filed with the Commission and has sent to the insurer a statement containing the information required by this section and the offer, request, invitation, agreement, or acquisition has been approved by the Commission pursuant to this article.

B. If the merger or acquisition of an insurer not covered by subsection A causes or tends to cause a substantial lessening of competition in any line of insurance and such lessening of competition is detrimental to policyholders or the public in general, then the Commission may suspend such insurer's license after giving the insurer 10 days' notice and the opportunity to be heard.

C. Any notice issued pursuant to the provisions of subsection B shall be accompanied by a request for such information as required by § 38.2-1324. Any hearing held pursuant to the provisions of this section shall begin, unless waived by the insurer, within 40 days of the receipt by the Commission of all material required by this subsection.

D. For purposes of this section, any controlling person of a domestic insurer seeking to divest its controlling interest in the domestic insurer, in any manner, shall file with the Commission, with a copy to the insurer, confidential notice of its proposed divestiture at least 30 days prior to the cessation of control. The Commission shall determine those instances in which the party or parties seeking to divest or to acquire a controlling interest in an insurer will be required to file for and obtain approval of the transaction. The information shall remain confidential until the conclusion of the transaction unless the Commission, in its discretion, determines that confidential treatment will interfere with enforcement of this section. If the statement referred to in subsection A is otherwise filed, this subsection shall not apply.

E. With respect to a transaction subject to this section, the acquiring person may also be required to file a pre-acquisition notification as established by the Commission.

F. For purposes of this section:

"Domestic insurer" includes any person controlling a domestic insurer unless the person, as determined by the Commission, is either directly or through its affiliates primarily engaged in business other than the business of insurance.

"Person" does not include any securities broker holding, in the usual and customary broker's function, less than 20 percent of the voting securities of an insurance company or of any person that controls an insurance company.

1977, c. 414, § 38.1-178.1:1; 1986, c. 562; 1992, c. 588; 1993, c. 158; 2014, c. 309.

§ 38.2-1324. Contents of application.

A. The application filed with the Commission under § 38.2-1323 shall be made under oath or affirmation and shall contain the following information:

1. The name and address of each acquiring person including:

a. If the acquiring person is a natural person, his principal occupation, all offices and positions held during the past five years, and any conviction of crimes other than minor traffic violations during the past 10 years; and

b. If the acquiring person is not a natural person, (i) a report of the nature of its business operations during the existence of the acquiring person and any of its predecessors, not to exceed five years; (ii) an informative description of the business intended to be done by the person and the person's subsidiaries; and (iii) a list of all individuals who are or who have been selected to become directors or executive officers of the person or who perform or will perform functions appropriate to those positions. The report shall include the information required by subdivision 1 a.

2. The source, nature, and amount of the consideration used or to be used in effecting the acquisition of control, a description of any transaction in which funds were or are to be obtained for that purpose, and the identity of persons furnishing the consideration. However, where a source of the consideration

is a loan made in the lender's ordinary course of business, the identity of the lender shall remain confidential if requested by the person filing the application;

3. Fully audited financial information regarding the earnings and financial condition of each acquiring person during the existence of the acquiring person or the predecessors, not to exceed five years, and similar unaudited information as of a date not earlier than 90 days prior to the filing of the application;

4. Any plans or proposals that each acquiring person may have to liquidate the insurer, to sell its assets or merge or consolidate it with any person, or to make any other material change in its business or corporate structure or management;

5. The number of shares of any security of the insurer that each acquiring person proposes to acquire and the terms of the acquisition;

6. The amount of each class of any such security that each acquiring person beneficially owns or has a right to acquire beneficial ownership of;

7. A full description of any contracts, arrangements, or understandings with respect to any security in which an acquiring person is involved, including but not limited to transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. The description shall identify the persons with whom the contracts, arrangements, or understandings have been made;

8. A description of any acquiring person's purchase of any such security during the 12 calendar months preceding the filing of the application, including the dates of purchases, names of the purchasers, and consideration paid or agreed to be paid for the security;

9. A description of any recommendations to purchase any such security made by any acquiring person or by any person based upon interviews or at the suggestion of any acquiring person during the 12 calendar months preceding the filing of the application;

10. Copies of all tender offers, requests or invitations for tenders of exchange offers and agreements to acquire or exchange any such security and of additional related soliciting material which has been distributed;

11. The terms of any agreement, contract, or understanding made with any broker-dealer as to solicitation of these securities for tender and the amount of any associated fees, commissions, or other compensation to be paid to broker-dealers;

12. An agreement by the person required to file the statement referred to in subsection A of § 38.2-1323 that it will provide the annual enterprise risk report specified in subsection L of § 38.2-1329, for so long as control exists;

13. An acknowledgment by the person required to file the statement referred to in subsection A of § 38.2-1323 that the person and all subsidiaries within its control in the insurance holding company

system will provide information to the Commission upon request as necessary to evaluate enterprise risk to the insurer; and

14. Any additional information the Commission may prescribe as necessary or appropriate for the protection of the policyholders or the public.

B. If the person required to file the application referred to in § 38.2-1323 is a partnership, limited partnership, syndicate, or other group, the Commission may require that the information called for by subsection A be given with respect to (i) each partner of the partnership or limited partnership, (ii) each member of the syndicate or group, and (iii) each person who controls any partner or member. If any partner, member, or person is a corporation, or if the person required to file the application referred to in § 38.2-1323 is a corporation, the Commission may require that information be given for the corporation, each officer and director of the corporation, and each person who is directly or indirectly the beneficial owner of more than 10 percent of the outstanding voting securities of the corporation as required by subsection A.

C. If any material change occurs in the facts set forth in the application filed with the Commission and sent to an insurer pursuant to § 38.2-1323, an amendment setting forth the change, together with copies of all documents and other material relevant to the change, shall be filed with the Commission and sent to the insurer within two business days after the person filing the application learns of the change.

1977, c. 414, § 38.1-178.1:2; 1986, c. 562; 2014, c. 309.

§ 38.2-1325. Alternate filing materials.

If any acquisition referred to in § 38.2-1323 is proposed to be made by means of a registration statement under the Securities Act of 1933 or in circumstances requiring the disclosure of similar information under the Securities Exchange Act of 1934, the person required by § 38.2-1323 to file an application may use these documents in furnishing the required information.

1977, c. 414, § 38.1-178.1:3; 1986, c. 562; 2014, c. 309.

§ 38.2-1326. Approval by Commission.

The Commission shall approve the application required by § 38.2-1323 unless, after giving notice and opportunity to be heard, it determines that:

1. After the change of control, the insurer would not be able to satisfy the requirements for the issuance of a license to write the classes of insurance for which it is presently licensed;

2. The acquisition of control would lessen competition substantially or tend to create a monopoly in insurance in this Commonwealth;

3. The financial condition of any acquiring person might jeopardize the financial stability of the insurer, or prejudice the interest of its policyholders;

4. Any plans or proposals of the acquiring party to liquidate the insurer, sell its assets or consolidate or merge it with any person, or to make any other material change in its business or corporate structure

or management, are unfair and unreasonable to policyholders of the insurer and not in the public interest;

5. The competence, experience, and integrity of those persons who would control the operation of the insurer are such that it would not be in the interest of policyholders of the insurer and of the public to permit the acquisition of control;

6. After the change of control, the insurer's surplus as regards policyholders would not be reasonable in relation to its outstanding liabilities or adequate to its financial needs; or

7. The acquisition is likely to be hazardous or prejudicial to the insurance-buying public.

1977, c. 414, § 38.1-178.1:4; 1986, c. 562; 2014, c. 309.

§ 38.2-1327. Time for hearing; order of Commission.

A. Any hearing held pursuant to § 38.2-1326 shall begin within 40 days of the date the application is filed with the Commission. In approving any application filed pursuant to § 38.2-1323, the Commission may include in its order any conditions, stipulations, or provisions that the Commission determines to be necessary to protect the interests of the policyholders of the insurer and the public.

B. The Commission may retain at the acquiring person's expense any attorneys, actuaries, accountants, and other experts not otherwise a part of the Commission's staff as may be reasonably necessary to assist the Commission in reviewing the proposed acquisition of control.

1977, c. 414, § 38.1-178.1:6; 1986, c. 562; 2014, c. 309.

§ 38.2-1328. Exemption.

The provisions of §§ 38.2-1323 through 38.2-1327 shall not apply to any acquisition that the Commission, by order, exempts from those sections. Acquisitions granted exemption shall include those which (i) have not been made or entered into for the purpose of and do not have the effect of changing or influencing the control of a domestic insurer, or (ii) otherwise are not comprehended within these sections.

1977, c. 414, § 38.1-178.1:7; 1986, c. 562.

§ 38.2-1329. Registration of insurers that are members of holding company system.

A. Each insurer licensed to do business in the Commonwealth that is a member of an insurance holding company system shall register with the Commission.

B. 1. This section shall not apply to any foreign insurer subject to disclosure requirements and standards adopted by statute or regulation in the jurisdiction of its domicile that are substantially similar to those contained in this section, subsection A of § 38.2-1330, subsection D of § 38.2-1330, § 38.2-1330.1, and either (i) a provision substantially similar to subsection B of § 38.2-1330 or (ii) a provision such as the following: "Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions within 15 days after the end of the month in which it learns of each change or addition."

2. Any insurer that is subject to registration under this section shall register within 15 days after it becomes subject to registration, and annually thereafter by April 30 of each year for the previous calendar year, unless the Commission for good cause shown extends the time for registration, and then within the extended time.

3. Any licensed insurer that is a member of an insurance holding company system but not subject to registration under this section may be required by the Commission to furnish a copy of the registration statement, or other information filed by the insurer, with the insurance regulatory authority of its domiciliary jurisdiction.

C. Each insurer subject to registration under this section shall file a registration statement on a form provided by the Commission. Such statement shall contain current information on:

1. The capital structure, general financial condition, ownership, and management of the insurer and any person controlling the insurer;

2. The identity of every member of the insurance holding company system;

3. The following agreements in force, continuing relationships and transactions currently outstanding between the insurer and its affiliates:

a. Loans, other investments, or purchases, sales or exchanges of securities of the affiliates by the insurer or of the insurer by its affiliates;

b. Purchases, sales, or exchanges of assets;

c. Transactions not in the ordinary course of business;

d. Guarantees or undertakings for the benefit of an affiliate that result in an actual contingent exposure of the insurer's assets to liability, other than insurance contracts entered into in the ordinary course of the insurer's business;

e. All management and service contracts and all cost-sharing arrangements;

f. Reinsurance agreements or other risk-sharing arrangements;

g. Dividends and other distributions to shareholders; and

h. Consolidated tax allocation agreements;

4. Any pledge of the insurer's stock, including stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system;

5. If requested by the Commission, financial statements of or within an insurance holding company system, including all affiliates. Financial statements may include but are not limited to annual audited financial statements filed with the SEC pursuant to the Securities Act of 1933, as amended, or the Securities Exchange Act of 1934, as amended. An insurer required to file financial statements pursuant to this subdivision may satisfy the request by providing the Commission with the most recently filed parent corporation financial statements that have been filed with the SEC;

6. Other matters relating to transactions between registered insurers and any affiliates which may be included from time to time in any registration forms adopted or approved by the Commission;

7. Statements that the corporate governance and internal controls are managed under the direction of the insurer's board of directors in a manner consistent with § 13.1-673 or § 13.1-853 as applicable, and that the insurer's officers or senior management have approved, implemented, and continue to maintain and monitor corporate governance and internal control procedures; and

8. Any other information required by the Commission by rule or regulation.

D. All registration statements shall contain a summary outlining all items in the current registration statement representing changes from the prior registration statement.

E. If information is not material for the purposes of this section, it need not be disclosed on the registration statement filed pursuant to subsection C. Unless the Commission prescribes otherwise and except for the purposes of subsections M and N, sales, purchases, exchanges, loans or extensions of credit, investments, or guarantees involving one-half of one percent or less of an insurer's admitted assets as of the immediately preceding December 31 shall not be deemed material for purposes of this section.

F. Each registered insurer shall report all additional material transactions with affiliates and any material changes in previously reported material transactions with affiliates on amendment forms provided by the Commission. Each insurer shall make its report within 15 days after the end of the month in which it learns of each additional material transaction or material change in material transaction. Subject to § 38.2-1330.1, each insurer shall report to the Commission all dividends and other distributions to shareholders within five business days following their declaration, and such declaration shall confer no rights upon shareholders until:

1. The Commission has approved the payment of such dividend or distribution; or

2. Thirty days after the Commission has received written notice of the declaration thereof and has not within such period disapproved such payment.

Each registered insurer shall also keep current the information required by subsection C by filing an amendment to its registration statement within 120 days after the end of each fiscal year of the ultimate controlling person of the insurance holding company system.

G. The Commission shall terminate the registration of any insurer that demonstrates it no longer is a member of an insurance holding company system.

H. The Commission may require or allow two or more affiliated insurers subject to registration under this section to file a consolidated registration statement or consolidated reports amending their consolidated registration statement or their individual registration statements.

I. The Commission may allow an insurer that is authorized to do business in this Commonwealth and that is part of an insurance holding company system to register on behalf of any affiliated insurer

required to register under subsection A and to file all information and material required to be filed under this section.

J. The provisions of this section shall not apply to any insurer, information, or transaction if and to the extent that the Commission by rule, regulation, or order shall exempt the same from the provisions of this section.

K. Any person may file with the Commission a disclaimer of affiliation with any authorized insurer. The disclaimer shall fully disclose all material relationships and bases for affiliation between the person and the insurer as well as the basis for disclaiming the affiliation. A disclaimer of affiliation shall be deemed to have been granted unless the Commission, within 30 days following receipt of a complete disclaimer, notifies the filing party the disclaimer is disallowed. In the event of disallowance, the disclaiming party may request a hearing. The disclaiming party shall be relieved of its duty to register under this section if approval of the disclaimer has been granted by the Commission or if the disclaimer is deemed to have been approved.

L. The ultimate controlling person of every insurer subject to registration shall also file an annual enterprise risk report. The report shall be appropriate to the nature, scale, and complexity of the operations of the insurance holding company system, and shall, to the best of the ultimate controlling person's knowledge and belief, identify the material risks within the insurance holding company system that could pose enterprise risk to the insurer. The report shall be filed with the lead state commissioner.

M. Except as provided below, the ultimate controlling person of every insurer subject to registration shall concurrently file with the registration an annual group capital calculation as directed by the lead state commissioner. The report shall be completed in accordance with the NAIC Group Capital Calculation Instructions, which may permit the lead state commissioner to allow a controlling person that is not the ultimate controlling person to file the group capital calculation. The report shall be filled with the lead state commissioner of the insurance holding company system. The following insurance holding company systems are exempt from filing the group capital calculation:

1. An insurance holding company system that has only one insurer within its holding company structure, that only writes business and is only licensed in its domestic state, and that assumes no business from any other insurer.

2. Any insurance holding company system that is required to perform a group capital calculation specified by the Federal Reserve Board. The lead state commissioner shall request the calculation from the Federal Reserve Board under the terms of information sharing agreements in effect. However, if the Federal Reserve Board cannot share the calculation with the lead state commissioner, the insurance holding company shall not be exempt from filing the group capital calculation.

3. An insurance holding company system whose non-U.S. group-wide supervisor is located within a reciprocal jurisdiction as described in subsection E of § 38.2-1316.2 that recognizes the U.S. state regulatory approach to group supervision and group capital.

4. An insurance holding system:

a. That provides information to the lead state that meets the requirements for accreditation under the NAIC financial standards and accreditation program, either directly or indirectly through the group-wide supervisor, who has determined such information is satisfactory to allow the lead state to comply with the NAIC group supervision approach, as detailed in the NAIC Financial Analysis Handbook; and

b. Whose non-U.S. group-wide supervisor that is not located in a reciprocal jurisdiction recognizes and accepts, as specified by the Commission in regulation, the group capital calculation as the world-wide group capital assessment for the U.S. insurance groups that operate in that jurisdiction.

Notwithstanding the exemptions provided for in subdivisions 3 and 4, a lead state commissioner shall require the group capital calculation for U.S. operations of any non-U.S.-based insurance holding company system where, after any necessary consultation with other supervisors or officials, it is deemed appropriate by the lead state commissioner for prudential oversight and solvency monitoring purposes or for ensuring the competitiveness of the insurance market.

Notwithstanding the exemptions provided for in subdivisions 1 through 4, the lead state commissioner has the discretion to exempt the ultimate controlling person from filing the annual group capital calculation or to accept a limited group capital filing or report in accordance with criteria as specified by the Commission in regulation.

If the lead state commissioner determines that an insurance holding company system no longer meets one or more of the requirements for an exemption specified in subdivisions 1 through 4, the insurance holding company system shall file the group capital calculation at the next annual filing date unless given an extension by the lead state commissioner based on reasonable grounds shown.

N. The ultimate controlling person of every insurer subject to registration and scoped into the NAIC Liquidity Stress Test Framework shall file the results of a specific year's liquidity stress test. The filing shall be made to the lead state commissioner of the insurance holding company system.

1. Any change to the NAIC Liquidity Stress Test Framework or to the data year for which the scope criteria are to be measured shall be effective on January 1 of the year following the calendar year when such changes are adopted. Insurers meeting at least one threshold of the scope criteria are considered scoped in the Framework for the specified data year unless the lead state commissioner, in consultation with the NAIC Financial Stability Task Force or its successor, determines the insurer should not be scoped into the Framework for that data year. Insurers that do not trigger at least one threshold of the scope criteria shall be considered scoped out of the Framework for the specified data year, unless the lead state commissioner, in consultation with the NAIC Financial Stability Task Force or its successor, determines the insurer should be scoped into the Framework for that data year.

2. The performance of and filing of the results from a specific year's liquidity stress test shall comply with Framework's instructions and reporting templates for that year and any lead state commissioner determinations, in consultation with the NAIC Financial Stability Task Force or its successor, provided within the Framework.

O. The failure to file a registration statement or any summary of the registration statement or enterprise risk filing required by this section within the time specified for filing shall be a violation of this section.

1973, c. 505, § 38.1-178.2; 1977, c. 414; 1986, c. 562; 1992, c. 588; 2000, c. 46; 2006, c. 577; 2009, c. 717; 2014, c. 309; 2022, c. 113.

§ 38.2-1330. Standards for transactions within an insurance holding company system; adequacy of surplus.

A. Transactions within an insurance holding company system to which an insurer subject to registration is a party shall be subject to the following standards:

1. The terms shall be fair and reasonable;

2. Agreements for cost-sharing services and management shall include such provisions as required by rule or regulation promulgated by the Commission;

3. Charges or fees for services performed shall be reasonable;

4. Expenses incurred and payments received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied;

5. The books, accounts, and records of each party shall disclose clearly and accurately the precise nature and details of the transactions, including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties;

6. The insurer's surplus as regards policyholders following any dividends or distributions to shareholder affiliates shall be reasonable in relation to the insurer's outstanding liabilities and adequate to meet its financial needs;

7. If an insurer subject to this article is deemed by the Commission to be in a hazardous financial condition as defined by 14VAC5-290 or a condition that would be grounds for supervision, conservation, or a delinquency proceeding, then the Commission may require the insurer to secure and maintain either a deposit held by the Commission or a bond as determined by the insurer at the insurer's discretion, for the protection of the insurer for the duration of the contract, agreement, or existence of the condition for which the Commission required deposit or bond.

In determining if a deposit or bond is required, the Commission shall consider whether concerns exist with respect to the affiliated person's ability to fulfill the contract or agreement if the insurer were to be put into liquidation. Once the insurer is deemed to be in a hazardous financial condition or a condition that would be grounds for supervision, conservation, or a delinquency proceeding, and a deposit or bond is necessary, the Commission has the discretion to determine the amount of the deposit or bond, not to exceed the value of the contract or agreement in any one year, and whether such deposit or bond shall be required for a single contract, multiple contracts, or a contract only with a specific person;

8. All records and data of the insurer held by an affiliate are and remain the property of the insurer, are subject to the control of the insurer, are identifiable, and are segregated or readily capable of segregation at no additional cost to the insurer from all other persons' records and data. This includes all records and data that are otherwise the property of the insurer, in whatever form maintained, including claims and claim files, policyholder lists, application files, litigation files, premium records, rate books, underwriting manuals, personnel records, financial records, or similar records within the possession, custody, or control of the affiliate. At the request of the insurer, the affiliate shall provide that the receiver may (i) obtain a complete set of all records of any type that pertain to the insurer's business, (ii) obtain access to the operating systems on which the data is maintained, (iii) obtain the software that runs those systems either through assumption of licensing agreements or otherwise, and (iv) restrict the use of the data by the affiliate if it is not operating the insurer's business. The affiliate shall provide a waiver of any landlord lien or other encumbrance to give the insurer access to all records and data in the event of the affiliate's default under a lease or other agreement; and

9. Premiums or other funds belonging to the insurer that are collected by or held by an affiliate are the exclusive property of the insurer and subject to the control of the insurer. Any right of offset in the event that an insurer is placed into receivership shall be subject to Chapter 15 (§ 38.2-1500 et seq.).

B. Transactions described in subdivisions 1 through 7 that involve a domestic insurer and any person in its insurance holding company system, including amendments or modifications of affiliate agreements previously filed pursuant to this section, that are subject to materiality standards contained in such subdivisions may not be entered into unless the insurer has notified the Commission in writing of its intention to enter into the transaction at least 30 days prior thereto, or such shorter period as the Commission may permit, and the Commission has not disapproved it within that period. The notice for amendments or modifications shall include the reasons for the change and the financial impact on the domestic insurer. Informal notice shall be reported, within 30 days after a termination of a previously filed agreement, to the Commission for determination of the type of filing required, if any. Transactions to which this subsection applies, with their materiality standards, are:

1. Sales, purchases, exchanges, loans, extensions of credit, or investments, provided the transactions are equal to or exceed:

a. With respect to nonlife insurers, the lesser of three percent of the insurer's admitted assets or 25 percent of surplus as regards policyholders as of the immediately preceding December 31; or

b. With respect to life insurers, three percent of the insurer's admitted assets as of the immediately preceding December 31;

2. Loans or extensions of credit to any person who is not an affiliate, where the insurer makes loans or extensions of credit with the agreement or understanding that the proceeds of the transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of, or to make investments in, any affiliate of the insurer making the loans or extensions of credit, provided the transactions are equal to or exceed:

a. With respect to nonlife insurers, the lesser of three percent of the insurer's admitted assets or 25 percent of surplus as regards policyholders as of the immediately preceding December 31; or

b. With respect to life insurers, three percent of the insurer's admitted assets as of the immediately preceding December 31;

3. Reinsurance agreements or modifications thereto, including:

a. All reinsurance pooling agreements; and

b. Agreements in which the reinsurance premium or a change in the insurer's liabilities, or the projected reinsurance premium or a change in the insurer's liabilities in any of the next three years, equals or exceeds five percent of the insurer's surplus as regards policyholders, as of the immediately preceding December 31, including those agreements that may require as consideration the transfer of assets from an insurer to a nonaffiliate, if an agreement or understanding exists between the insurer and nonaffiliate that any portion of the assets will be transferred to one or more affiliates of the insurer;

4. All management agreements, service contracts, tax allocation agreements, guarantees, and cost-sharing arrangements;

5. Guarantees when made by a domestic insurer, provided, however, that a guarantee that is quantifiable as to amount is not subject to the notice requirements of this subdivision unless it exceeds the lesser of one-half of one percent of the insurer's admitted assets or 10 percent of surplus as regards policyholders as of the immediately preceding December 31. Further, all guarantees that are not quantifiable as to amount are subject to the notice requirements of this subdivision;

6. Direct or indirect acquisitions or investments in a person that controls the insurer or in an affiliate of the insurer in an amount that, together with its present holdings in such investments, exceeds two and one-half percent of the insurer's surplus to policyholders. The Commission may exempt such a transaction by regulation; and

7. Any material transactions that the Commission determines may adversely affect the interests of the insurer's policyholders.

Nothing in this subsection shall be deemed to authorize or permit any transactions that, in the case of an insurer not a member of the same insurance holding company system, would be otherwise contrary to law.

C. In addition:

1. Notwithstanding the control of a domestic insurer by any person, the officers and directors of the insurer shall not thereby be relieved of any obligation or liability to which they would otherwise be subject by law, and the insurer shall be managed so as to assure its separate operating identity consistent with this article;

2. Nothing in this section shall preclude a domestic insurer from having or sharing a common management or cooperative or joint use of personnel, property, or services with one or more other persons under arrangements meeting the standards of subsection A;

3. Not less than one-third of the directors of a domestic insurer, and not less than one-third of the members of each committee of the board of directors of any domestic insurer, shall be persons who are not officers or employees of the insurer or of any entity controlling, controlled by, or under common control with the insurer and who are not beneficial owners of a controlling interest in the voting stock of the insurer or entity. At least one such person shall be included in any quorum for the transaction of business at any meeting of the board of directors or any committee thereof;

4. The board of directors of a domestic insurer shall establish one or more committees composed solely of directors who are not officers or employees of the insurer or of any entity controlling, controlled by, or under common control with the insurer and who are not beneficial owners of a controlling interest in the voting stock of the insurer or any such entity. The committee or committees shall have responsibility for nominating candidates for director for election by shareholders or policyholders, evaluating the performance of officers deemed to be principal officers of the insurer, and recommending to the board of directors the selection and compensation of the principal officers;

5. The provisions of subdivisions 3 and 4 shall not apply to a domestic insurer if the person controlling the insurer, such as an insurer, a mutual insurance holding company, or a publicly held corporation, has a board of directors and committees thereof that meet the requirements of subdivisions 3 and 4 with respect to such controlling entity; and

6. An insurer may make application to the Commission for a waiver from the requirements of this subsection if the insurer's annual direct written and assumed premium, excluding premiums reinsured with the Federal Crop Insurance Corporation and National Flood Insurance Program, is less than $300 million. An insurer may also make application to the Commission for a waiver from the requirements of this subsection based upon unique circumstances. The Commission may consider various factors including the type of business entity, volume of business written, availability of qualified board members, or ownership or organizational structure of the entity.

D. For purposes of this article, in determining whether an insurer's surplus as regards policyholders is reasonable in relation to the insurer's outstanding liabilities and adequate to meet its financial needs, the following factors, among others, shall be considered:

1. The size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force, and other appropriate criteria;

2. The extent to which the insurer's business is diversified among different lines of insurance;

3. The number and size of risks insured in each line of business;

4. The extent of the geographical dispersion of the insurer's insured risk;

5. The nature and extent of the insurer's reinsurance program;

6. The quality, diversification, and liquidity of the insurer's investment portfolio;

7. The recent past and projected future trend in the size of the insurer's surplus to policyholders;

8. The recent past and projected future trend in the size of the insurer's investment portfolio;

9. The surplus as regards policyholders maintained by other comparable insurers;

10. The adequacy of the insurer's reserves;

11. The quality of the insurer's earnings and the extent to which the reported earnings of the insurer include extraordinary items; and

12. The quality and liquidity of investments in affiliates. The Commission in its judgment may classify any investment as a nonadmitted asset for the purpose of determining the adequacy of surplus as regards policyholders.

E. No domestic insurer shall enter into transactions that are part of a plan or series of like transactions with persons within the insurance holding company system if the purpose of those separate transactions is to avoid the statutory threshold amount and thus avoid the review that otherwise would be required. If the Commission determines that separate transactions were entered into over any 12-month period for that purpose, the Commission may exercise its authority under § 38.2-1334.2:2.

F. The Commission, in reviewing transactions pursuant to subsection B, shall consider whether the transactions comply with the standards set forth in subsection A and whether they may adversely affect the interests of policyholders.

G. The Commission shall be notified in writing within 30 days of any investment of the domestic insurer in any one corporation if the total investment in such corporation by the insurance holding company system exceeds 10 percent of such corporation's voting securities.

H. Any affiliate that is party to a contract or agreement described in subdivision B 4 with a domestic insurer shall be subject to the jurisdiction of any supervision, seizure, conservatorship, or receivership proceedings against the insurer and to the authority of any supervisor, conservator, rehabilitator, or liquidator for the insurer appointed pursuant to Chapter 15 (§ 38.2-1500 et seq.) for the purpose of interpreting, enforcing, and overseeing the affiliate's obligations under the agreement or contract to perform services for the insurer that are (i) an integral part of the insurer's operation, including management, administrative, accounting, data processing, marketing, underwriting, claims handling, investment, or any other similar functions or (ii) essential to the insurer's ability to fulfill its obligations under insurance policies. The Commission may require that an agreement or contract described in subdivision B 4 for the provision of services described in clause (i) or (ii) specify that the affiliate consents to the jurisdiction as set forth in this subsection.

1973, c. 505, § 38.1-178.3; 1986, c. 562; 1987, c. 417; 1992, c. 588; 2006, c. 577; 2014, c. 309; 2022, c. 113.

§ 38.2-1330.1. Dividends and other distributions.

A. Except as otherwise provided by law, a domestic insurer shall not declare or pay a dividend or other distribution from any source other than earned surplus without the Commission's prior written approval. For purposes of this section, "earned surplus" means an amount equal to the unassigned funds (surplus) of an insurer as set forth in the most recent annual statement of the insurer filed with the Commission including all or part of the surplus arising from unrealized capital gains or revaluation of assets. No domestic insurer shall pay an extraordinary dividend or make any other extraordinary distribution to its shareholders until the earlier of:

1. Thirty days after the Commission has received written notice of the declaration thereof and has not within such period disapproved such payment; or

2. The Commission's approval of such payment.

B. For purposes of this section, an extraordinary dividend or distribution includes any dividend or distribution of cash or other property whose fair market value together with that of other dividends or distributions made within the preceding 12 months exceeds the greater of (i) 10 percent of such insurer's surplus as regards policyholders as of the immediately preceding December 31 or (ii) the net gain from operations of such insurer, if such insurer is a life insurer, or the net income, if such insurer is not a life insurer, not including realized capital gains, for the 12-month period ending the immediately preceding December 31, but shall not include pro rata distributions of any class of the insurer's own securities.

C. In determining whether a dividend or distribution is extraordinary, an insurer other than a life insurer may carry forward net income from the previous two calendar years that has not already been paid out as dividends. This carry-forward shall be computed by taking the net income from the second and third preceding calendar years, not including realized capital gains, less dividends paid in the second and immediate preceding calendar years.

D. Notwithstanding any other provision of law, an insurer may declare an extraordinary dividend or distribution that is conditional upon the Commission's approval thereof, and such declaration shall confer no rights upon shareholders until:

1. The Commission has approved the payment of such dividend or distribution; or

2. The Commission has not disapproved such payment within the 30-day period described in subsection A.

E. The Commission may limit or disallow the payment of ordinary dividends by a domestic insurer if the insurer is presently or potentially financially distressed or troubled. The Commission shall set forth the specific reasons for limiting or disallowing the payment of any ordinary dividends.

2006, c. 577; 2014, c. 309.

§ 38.2-1331. Repealed.

Repealed by Acts 2014, c. 309, cl. 2. For applicability, see Editor's note.

§ 38.2-1332. Examinations.

A. In addition to the powers the Commission has under Article 4 (§ 38.2-1317 et seq.), the Commission shall have the power to examine any insurer registered under § 38.2-1329 and its affiliates to ascertain the financial condition of the insurer, including the enterprise risk to the insurer by the ultimate controlling party, or by any entity or combination of entities within the insurance holding company system, or by the insurance holding company system on a consolidated basis.

B. The Commission may order any insurer registered under § 38.2-1329 to produce such records, books, or other information papers in the possession of the insurer or its affiliates as are reasonably necessary to determine compliance with this article.

C. To determine compliance with this article, the Commission may order any insurer registered under § 38.2-1329 to produce information not in the possession of the insurer if the insurer can obtain access to such information pursuant to contractual relationships, statutory obligations, or other method. In the event the insurer cannot obtain the information requested by the Commission, the insurer shall provide the Commission a detailed explanation of the reason that the insurer cannot obtain the information and the identity of the holder of such information. Whenever it appears to the Commission that the detailed explanation is without merit, the Commission may require, after notice and hearing, the insurer to pay a penalty pursuant to § 38.2-218 for each day's delay or may suspend or revoke the insurer's license.

D. The Commission may retain at the registered insurer's expense any attorneys, actuaries, accountants and other experts reasonably necessary to assist in the conduct of the examination under subsection A. Any persons so retained shall be under the direction and control of the Commission and shall act in a purely advisory capacity.

E. Each insurer producing books and papers for examination records pursuant to subsection B shall be liable for and shall pay the expense of the examination in accordance with the provisions of Article 4 (§ 38.2-1317 et seq.).

F. In the event the insurer fails to comply with an order, the Commission shall have the power to examine the affiliates to obtain the information.

1973, c. 505, § 38.1-178.4; 1986, c. 562; 1992, c. 588; 2014, c. 309.

§ 38.2-1332.1. Supervisory colleges.

A. With respect to any insurer registered under § 38.2-1329, and in accordance with subsection C, the Commission shall also have the power to participate in a supervisory college for any domestic insurer that is part of an insurance holding company system with international operations in order to determine compliance by the insurer with this article. The powers of the Commission with respect to supervisory colleges include the following:

1. Initiating the establishment of a supervisory college;

2. Clarifying the membership and participation of other supervisors in the supervisory college;

3. Clarifying the functions of the supervisory college and the role of other regulators, including the establishment of a group-wide supervisor;

4. Coordinating the ongoing activities of the supervisory college, including planning meetings, supervisory activities, and processes for information sharing; and

5. Establishing a crisis management plan.

B. Each registered insurer subject to this section shall be liable for and shall pay the necessary traveling and other expenses reasonably attributable to other regulators or incurred by the Commission for its participation in a supervisory college in accordance with subsection C. For purposes of this section, a supervisory college may be convened as either a temporary or permanent forum for communication and cooperation between the regulators charged with the supervision of the insurer or its affiliates, and the Commission may establish a regular assessment to the insurer for the payment of these expenses. If an assessment is required by this subsection, it shall be collected by the Commission and paid directly into the state treasury and credited to the "Bureau of Insurance Special Fund -- State Corporation Commission" for the maintenance of the Bureau of Insurance as provided in subsection B of § 38.2-400.

C. In order to assess the business strategy, financial position, legal and regulatory position, risk exposure, risk management, and governance processes, and as part of the examination of individual insurers in accordance with § 38.2-1332, the Commission may participate in a supervisory college with other regulators charged with supervision of the insurer or its affiliates, including other state, federal, and international regulatory agencies. The Commission may enter into agreements in accordance with subsection C of § 38.2-1333 providing the basis for cooperation between the Commission and the other regulatory agencies and the activities of the supervisory college. Nothing in this section shall delegate to the supervisory college the authority of the Commission to regulate or supervise the insurer or its affiliates within its jurisdiction.

2014, c. 309.

§ 38.2-1332.2. Group-wide supervision of internationally active insurance groups.

A. The Commission is authorized to act as the group-wide supervisor for any internationally active insurance group in accordance with the provisions of this section. However, the Commission may otherwise acknowledge another regulatory official as the group-wide supervisor where the internationally active insurance group:

1. Does not have substantial insurance operations in the United States;

2. Has substantial insurance operations in the United States but not in the Commonwealth; or

3. Has substantial insurance operations in the United States and the Commonwealth, but the Commission has determined pursuant to the factors set forth in subsections B and F that the other regulatory official is the appropriate group-wide supervisor.

An insurance holding company system that does not otherwise qualify as an internationally active insurance group may request that the Commission make a determination or acknowledgment as to a group-wide supervisor pursuant to this section.

B. In cooperation with other state, federal, and international regulatory agencies, the Commission shall identify a single group-wide supervisor for an internationally active insurance group. The Commission may determine that the Commission is the appropriate group-wide supervisor for an internationally active insurance group that conducts substantial insurance operations concentrated in the Commonwealth. However, the Commission may acknowledge that a regulatory official from another jurisdiction is the appropriate group-wide supervisor for the internationally active insurance group. The Commission shall consider the following factors when making a determination or acknowledgment under this subsection:

1. The place of domicile of the insurers within the internationally active insurance group that holds the largest share of the internationally active insurance group's written premiums, assets, or liabilities;

2. The place of domicile of the top-tiered insurer or insurers in the insurance holding company system of the internationally active insurance group;

3. The location of the executive offices or largest operational offices of the internationally active insurance group;

4. Whether another regulatory official is acting or is seeking to act as the group-wide supervisor under a regulatory system that the Commission determines to be:

a. Substantially similar to the system of regulation provided under the laws of the Commonwealth; or

b. Otherwise sufficient in terms of providing for group-wide supervision, enterprise risk analysis, and cooperation with other regulatory officials; and

5. Whether another regulatory official acting or seeking to act as the group-wide supervisor provides the Commission with reasonably reciprocal recognition and cooperation.

However, a regulatory official identified under this section as the group-wide supervisor may determine that it is appropriate to acknowledge another supervisor to serve as the group-wide supervisor. The acknowledgment of the group-wide supervisor shall be made after consideration of the factors listed in subdivisions 1 through 5, and shall be made in cooperation with and subject to the acknowledgment of other regulatory officials involved with supervision of members of the internationally active insurance group and in consultation with the internationally active insurance group.

C. Notwithstanding any other provision of this section, the Commission's regulatory authority under this section shall not be impaired. To the extent that the Commission acknowledges a regulatory official from another jurisdiction as a group-wide supervisor and in the event of a material change in the internationally active insurance group that results in (i) the internationally active insurance group's insurers domiciled in the Commonwealth holding the largest share of the group's premiums, assets, or liabilities or (ii) the Commonwealth being the place of domicile of the top-tiered insurer or insurers in

the insurance holding company system of the internationally active insurance group, the Commission may make a determination or acknowledgment as to the appropriate group-wide supervisor for such an internationally active insurance group pursuant to subsection B.

D. Pursuant to § 38.2-1332, the Commission is authorized to collect from any insurer registered pursuant to § 38.2-1329 all information necessary to determine whether the Commission may act as the group-wide supervisor of an internationally active insurance group or if the Commission may acknowledge another regulatory official to act as the group-wide supervisor. Prior to issuing a determination that an internationally active insurance group is subject to group-wide supervision by the Commission, the Commission shall notify the insurer registered pursuant to § 38.2-1329 and the ultimate controlling person within the internationally active insurance group. The internationally active insurance group shall have not less than 30 days to provide the Commission with additional information pertinent to the pending determination. The Commission shall publish in any manner it considers appropriate and on its website the identity of internationally active insurance groups that the Commission has determined are subject to group-wide supervision by the Commission.

E. If the Commission is the group-wide supervisor for an internationally active insurance group, the Commission is authorized to engage in any of the following group-wide supervision activities:

1. Assess the enterprise risks within the internationally active insurance group to ensure that:

a. The material financial condition and liquidity risks to the members of the internationally active insurance group that are engaged in the business of insurance are identified by management; and

b. Reasonable and effective mitigation measures are in place;

2. Request, from any member of an internationally active insurance group subject to the Commission's supervision, information necessary and appropriate to assess enterprise risk, including information about the members of the internationally active insurance group regarding:

a. Governance, risk assessment, and management;

b. Capital adequacy; and

c. Material intercompany transactions;

3. Coordinate and, through the authority of the regulatory officials of the jurisdictions where members of the internationally active insurance group are domiciled, compel development and implementation of reasonable measures designed to ensure that the internationally active insurance group is able to timely recognize and mitigate enterprise risks to members of such internationally active insurance group that are engaged in the business of insurance;

4. Communicate with other state, federal, and international regulatory agencies for members within the internationally active insurance group and share relevant information, subject to the confidentiality provisions of § 38.2-1333, through supervisory colleges as set forth in § 38.2-1332.1 or otherwise;

5. Enter into agreements with or obtain documentation from any insurer registered under § 38.2-1329, any member of the internationally active insurance group, and any other state, federal, or international regulatory agencies for members of the internationally active insurance group, providing the basis for or otherwise clarifying the Commission's role as group-wide supervisor, including provisions for resolving disputes with other regulatory officials. Such agreements or documentation shall not serve as evidence in any proceeding that any insurer or person within an insurance holding company system not domiciled or incorporated in the Commonwealth is doing business in the Commonwealth or is otherwise subject to jurisdiction in the Commonwealth; and

6. Engage in other group-wide supervision activities, consistent with the authorities and purposes enumerated above, as considered necessary by the Commission.

F. If the Commission acknowledges that another regulatory official from a jurisdiction that is not accredited by the NAIC is the group-wide supervisor, the Commission is authorized to reasonably cooperate, through supervisory colleges or otherwise, with group-wide supervision undertaken by the group-wide supervisor, provided that:

1. The Commission's cooperation is in compliance with the laws of the Commonwealth; and

2. The regulatory official acknowledged as the group-wide supervisor also recognizes and cooperates with the Commission's activities as a group-wide supervisor for other internationally active insurance groups where applicable. Where such recognition and cooperation is not reasonably reciprocal, the Commission is authorized to refuse recognition and cooperation.

G. The Commission is authorized to enter into agreements with or obtain documentation from any insurer registered under § 38.2-1329, any affiliate of the insurer, and other state, federal, or international regulatory agencies for members of the internationally active insurance group that provide the basis for or otherwise clarify a regulatory official's role as group-wide supervisor.

H. Each registered insurer subject to this section shall be liable for and shall pay the necessary traveling and other expenses incurred by the Commission for its participation in the administration of this section. The Commission may retain at the registered insurer's expense any attorneys, actuaries, accountants, and other experts reasonably necessary to assist in the administration of this section. Any persons so retained shall be under the direction and control of the Commission and shall act in a purely advisory capacity. The Commission may establish a regular assessment to the insurer for the payment of these expenses. If an assessment is required by this subsection, it shall be collected by the Commission and paid directly into the state treasury and credited to the "Bureau of Insurance Special Fund – State Corporation Commission" for the maintenance of the Bureau of Insurance as provided in subsection B of § 38.2-400.

2019, c. 692.

§ 38.2-1333. Confidential treatment of information and documents.

A. All documents, materials, or other information obtained by or disclosed to the Commission or any other person in the course of an examination or investigation made pursuant to § 38.2-1332, and all information reported or provided to the Commission pursuant to subdivisions A 12 and 13 of § 38.2-1324 and §§ 38.2-1329, 38.2-1330, 38.2-1330.1, and 38.2-1332.2 is declared to be proprietary and to contain trade secrets and shall be confidential by law and privileged, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the Commission is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the Commission's official duties. The Commission shall not otherwise make the documents, materials, or other information public without the prior written consent of the insurer to which they pertain. After an insurer and its affiliates have been given notice and opportunity to be heard, the Commission may publish all or any part of the documents, materials, or other information referred to in this section in any manner it considers appropriate if it determines that the interests of policyholders or the public will be served by the publication.

1. For the purposes of the information reported to the Commission pursuant to subsection M of § 38.2-1329, the Commission shall maintain the confidentiality of the group capital calculation and group capital ratio produced within the calculation and any group capital information received from an insurance holding company system supervised by the Federal Reserve Board or U.S. group-wide supervisor.

2. For the purposes of the information reported to the Commission pursuant to subsection N of § 38.2-1329, the Commission shall maintain the confidentiality of the liquidity stress test results and supporting disclosures and any liquidity stress test information received from an insurance holding company system supervised by the Federal Reserve Board and non-U.S. group-wide supervisor.

B. Neither the Commission nor any person who received documents, materials, or other information while acting under the authority of the Commission or with whom such documents, materials, or other information are shared pursuant to this article shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection A.

C. In order to assist in the performance of the Commission's duties, the Commission:

1. May share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to subsection A, including proprietary and trade secret documents and materials, with other state, federal, and international regulatory agencies; with the NAIC; with any third-party consultants designated by the Commission; and with state, federal, and international law-enforcement authorities, including members of any supervisory college described in § 38.2-1332.1, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the document, material, or other information and has verified in writing the legal authority to maintain confidentiality;

2. May, notwithstanding subdivision 1, only share confidential and privileged documents, materials, or information reported pursuant to subsection L of § 38.2-1329 with insurance commissioners in any

states that have statutes or regulations substantially similar to subsection A and that have agreed in writing not to disclose such information;

3. May receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information, including proprietary and trade secret information from the NAIC and its affiliates and subsidiaries and from regulatory and law-enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any documents, materials, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information; and

4. Shall enter into written agreements with the NAIC and any third-party consultant designated by the Commission governing sharing and use of information provided pursuant to this article consistent with this subsection that shall:

a. Specify procedures and protocols regarding the confidentiality and security of information shared with the NAIC or a third-party consultant designated by the Commission pursuant to this article, including procedures and protocols for sharing by the NAIC with other state, federal, or international regulators. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the documents, materials, or other information and has verified in writing the legal authority to maintain such confidentiality;

b. Specify that ownership of information shared with the NAIC or a third-party consultant designated by the Commission pursuant to this article remains with the Commission and that the NAIC's or third party consultant's use of the information is subject to the direction of the Commission;

c. Except for documents, material, or information reported pursuant to subsection N of § 38.2-1329, prohibit the NAIC or third-party consultant designated by the Commission from storing the information shared pursuant to this article in a permanent database after the underlying analysis is completed;

d. Require prompt notice to be given to an insurer whose confidential information in the possession of the NAIC or a third-party consultant designated by the Commission pursuant to this article is subject to a request or subpoena to the NAIC or a third-party consultant designated by the Commission for disclosure or production;

e. Require the NAIC or a third-party consultant designated by the Commission to consent to intervention by an insurer in any judicial or administrative action in which the NAIC and its affiliates and subsidiaries may be required to disclose confidential information about the insurer shared with the NAIC or a third-party consultant designated by the Commission pursuant to this article; and

f. For documents, materials, and information reported pursuant to subsection N of § 38.2-1329, in the case of an agreement involving a third-party consultant, provide for notification of the identity of the consultant to the applicable insurers.

D. The sharing of information by the Commission pursuant to this article shall not constitute a delegation of regulatory authority or rulemaking, and the Commission is solely responsible for the administration, execution, and enforcement of the provisions of this article.

E. No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the Commission under this section or as a result of sharing as authorized in subsection C.

F. Documents, materials, or other information in the possession or control of the NAIC or a third-party consultant designated by the Commission pursuant to this article shall be confidential by law and privileged, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

G. Except as otherwise provided by the provisions of this article, the making, publishing, disseminating, circulating, or placing before the public, or causing directly or indirectly to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station or any electronic means of communication available to the public, or in any other way as an advertisement, announcement, or statement containing a representation or statement with regard to the group capital calculation, group capital ratio, liquidity stress test results, or supporting disclosures for the liquidity stress test, of any insurer or any insurer group, or of any component derived in the calculation by an insurer, broker, or other person engaged in any manner in the insurance business, shall be prohibited. However, if any materially false statement with respect to the group capital calculation, the resulting group capital ratio, an inappropriate comparison of any amount to an insurer's or insurance group's group capital calculation or resulting group capital ratio, the liquidity stress test result, or supporting disclosures is published in any written publication, and the insurer is able to demonstrate to the Commission with substantial proof the falsity or the inappropriateness of such statement, as the case may be, then the insurer may publish announcements in a written publication if the sole purpose of the announcement is to rebut the materially false or inappropriate statement.

1973, c. 505, § 38.1-178.5; 1986, c. 562; 2001, c. 519; 2014, c. 309; 2019, c. 692; 2022, c. 113.

§ 38.2-1334. Revocation, suspension, or nonrenewal of insurer's license.

Whenever it appears to the Commission that any person has committed a violation of this article that makes the continued operation of an insurer contrary to the interests of policyholders or the public, the Commission after giving notice and an opportunity to be heard, may suspend, revoke or refuse to renew the insurer's license to transact business in this Commonwealth for whatever period it finds is required for the protection of policyholders or the public. Any such action shall be supported by specific findings of fact and conclusions of law.

1973, c. 505, § 38.1-178.9; 1986, c. 562.

§ 38.2-1334.1. Voting of securities, injunctions, and sequestration of voting securities.

A. No security that is the subject of any agreement or arrangement regarding acquisition, or that is acquired or to be acquired, in contravention of the provisions of this article or of any rule, regulation, or order issued by the Commission hereunder, may be voted at any shareholders' meeting, or may be counted for quorum purposes, and any action of shareholders requiring the affirmative vote of a percentage of shares may be taken as though such securities were not issued and outstanding. However, no action taken at any such meeting shall be invalidated by the voting of such securities, unless the action would materially affect control of an insurer subject to any provision of this article or unless the Commission or other court of the Commonwealth has so ordered. If the insurer or Commissioner of Insurance has reason to believe that any security of the insurer has been or is about to be acquired in contravention of the provisions of this article or of any rule, regulation or order issued by the Commission hereunder, the insurer or Commissioner of Insurance may apply to the Commission to enter an order (i) enjoining any offer, request, invitation, agreement, or acquisition made in contravention of § 38.2-1323; (ii) enforcing any rule, regulation, or order issued by the Commission under the foregoing sections to enjoin the voting of any security so acquired; or (iii) voiding any vote of such security already cast at any meeting of shareholders or providing for such other equitable relief as the nature of the case and the interest of the insurer's policyholders, creditors, and shareholders or the public may require.

B. Whenever it appears to the Commission that any person has committed or is about to commit a violation of this article, the Commission may enter an order enjoining such person from violating or continuing to violate this article or any such rule or order, and for such other equitable relief as the nature of the case and the interests of the domestic insurer's policyholders or the public may require.

C. In any case where a person has acquired or is proposing to acquire any voting securities in violation of this article or any rule, regulation, or order issued by the Commission hereunder, the Commission may, after reasonable notice, upon application of the insurer or application of the Commissioner of Insurance, seize or sequester any voting securities of the insurer owned directly or indirectly by the person, and issue the order with respect thereto as may be appropriate to effectuate the provisions of this article.

Notwithstanding any other provisions of law, for the purposes of this article, the situs of the ownership of the securities of domestic insurers shall be deemed to be in the Commonwealth.

D. The actions authorized by this section are in addition to any remedies provided for by other sections of this title and may be imposed, in addition to or in lieu of any other penalties or actions provided for by law, whenever such actions involve a person that is neither domiciled nor licensed in this Commonwealth.

1993, c. 158; 2014, c. 309.

§ 38.2-1334.2. Recovery.

A. If an order for liquidation or rehabilitation of a domestic insurer has been entered, the receiver appointed under such order shall have a right to recover on behalf of the insurer (i) from any parent

corporation or holding company or person or affiliate who otherwise controlled the insurer, the amount of distributions (other than distributions of shares of the same class of stock) paid by the insurer on its capital stock or (ii) any payment in the form of a bonus, termination settlement or extraordinary lump sum salary adjustment made by the insurer or its subsidiary or subsidiaries to a director, officer or employee, where the distribution or payment pursuant to (i) or (ii) is made at any time during the one year preceding the petition for liquidation, conservation or rehabilitation, as the case may be, subject to the limitations of subsections B, C and D of this section.

B. No such distribution shall be recoverable if the parent or affiliate shows that, when paid, such distribution was lawful and reasonable and that the insurer did not know and could not reasonably have known that such distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

C. Any person who was a parent corporation or holding company or a person who otherwise controlled the insurer or affiliate at the time such distributions were paid shall be liable up to the amount of distributions or payments under subsection A of this section. Any person who otherwise controlled the insurer at the time such distributions were declared shall be liable up to the amount of distributions he would have received if they had been paid immediately. If two or more persons are liable with respect to the same distributions, they shall be jointly and severally liable.

D. The maximum amount recoverable under this section shall be the amount needed in excess of all other available assets of the impaired or insolvent insurer to pay its obligations and to reimburse any guaranty funds.

E. To the extent that any person liable under subsection C of this section is insolvent or otherwise fails to pay claims due from it pursuant to such subsection, its parent corporation, holding company, or person who otherwise controlled it at the time the distribution was paid shall be jointly and severally liable for any resulting deficiency in the amount recovered from such parent corporation, holding company, or person who otherwise controlled it.

1993, c. 158.

§ 38.2-1334.2:1. Rules and regulations.

The Commission may adopt rules and regulations implementing the provisions of this article.

2014, c. 309.

§ 38.2-1334.2:2. Sanctions.

Whenever it appears to the Commission that any person has committed a violation of §§ 38.2-1323 through 38.2-1328 and the violation prevents the full understanding of the enterprise risk to the insurer by affiliates or by the insurance holding company system, the violation may serve as an independent basis for disapproving dividends or distributions and for instituting delinquency proceedings pursuant to § 38.2-1503.

2014, c. 309.

§ 38.2-1334.2:3. Statutory construction and relationship to other laws.

Provisions of this title, insofar as they are not inconsistent with this article, shall be applicable to any insurer subject to registration under this article.

2014, c. 309.

Article 5.1 - RISK MANAGEMENT FRAMEWORK; OWN RISK AND SOLVENCY ASSESSMENTS

§ 38.2-1334.3. Definitions.

As used in this article, unless the context requires a different meaning:

"Insurance group" means those insurers and affiliates included within an insurance holding company system as defined in § 38.2-1322.

"Insurer" means an insurance company as defined in § 38.2-100, except that "insurer" shall not include agencies, authorities, or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

"NAIC" means the National Association of Insurance Commissioners.

"ORSA Guidance Manual" means the current version of the NAIC Own Risk and Solvency Assessment (ORSA) Guidance Manual developed and adopted by the NAIC and as amended from time to time. A change in the ORSA Guidance Manual shall be effective on the January 1 following the calendar year in which the changes have been adopted by the NAIC.

"ORSA summary report" means a confidential high-level summary of an insurer or insurance group's ORSA.

"Own Risk and Solvency Assessment" or "ORSA" means a confidential internal assessment, appropriate to the nature, scale, and complexity of an insurer or insurance group, conducted by that insurer or insurance group, of the material and relevant risks associated with the insurer or insurance group's current business plan, and the sufficiency of capital resources to support those risks.

2014, c. 248.

§ 38.2-1334.4. Risk management framework.

An insurer shall maintain a risk management framework to assist the insurer with identifying, assessing, monitoring, managing, and reporting on its material and relevant risks. This requirement may be satisfied if the insurance group of which the insurer is a member maintains a risk management framework applicable to the operations of the insurer.

2014, c. 248.

§ 38.2-1334.5. ORSA requirement.

Subject to § 38.2-1334.7, an insurer, or the insurance group of which the insurer is a member, shall regularly conduct an ORSA consistent with a process comparable to the ORSA Guidance Manual. The ORSA shall be conducted no less than annually, but also at any time when there are significant changes to the risk profile of the insurer or the insurance group of which the insurer is a member.

2014, c. 248.

§ 38.2-1334.6. ORSA summary report.

A. Upon the Commission's request, and no more than once each year, an insurer shall submit to the Commission an ORSA summary report or any combination of reports that together contain the information described in the ORSA Guidance Manual, applicable to the insurer or the insurance group of which it is a member, or both. The first filing of an ORSA summary report shall be made in 2015. Notwithstanding any request from the Commission, if the insurer is a member of an insurance group, the insurer shall submit any report required by this subsection if the Commission is the lead state of the insurance group as determined by the procedures within the Financial Analysis Handbook adopted by the NAIC.

B. The report shall include a signature of the insurer or insurance group's chief risk officer or other executive having responsibility for the oversight of the insurer's enterprise risk management process attesting to the best of his belief and knowledge that the insurer has applied the enterprise risk management process described in the ORSA summary report and that a copy of the report has been provided to the insurer's board of directors or the appropriate committee thereof.

C. An insurer may comply with subsection A by providing the most recent and substantially similar report provided by the insurer or another member of an insurance group of which the insurer is a member to the commissioner of another state or to a supervisor or regulator of a foreign jurisdiction, if that report provides information that is comparable to the information described in the ORSA Guidance Manual. Any such report in a language other than English must be accompanied by a translation of that report into the English language.

2014, c. 248.

§ 38.2-1334.7. Scope of article; exemption.

A. The requirements of this article shall apply to all insurers domiciled in the Commonwealth unless exempt pursuant to this section.

B. An insurer shall be exempt from the requirements of this article if:

1. The insurer has annual direct written and unaffiliated assumed premium, including international direct and assumed premium but excluding premiums reinsured with the Federal Crop Insurance Corporation and National Flood Insurance Program, less than $500 million; and

2. The insurance group of which the insurer is a member has annual direct written and unaffiliated assumed premium, including international direct and assumed premium but excluding premiums rein-

sured with the Federal Crop Insurance Corporation and National Flood Insurance Program, less than $1 billion.

C. If an insurer qualifies for exemption pursuant to subdivision B 1, but the insurance group of which the insurer is a member does not qualify for exemption pursuant to subdivision B 2, then the ORSA summary report that may be required pursuant to § 38.2-1334.6 shall include every insurer within the insurance group. This requirement may be satisfied by the submission of more than one ORSA summary report for any combination of insurers, provided any combination of reports includes every insurer within the insurance group.

D. If an insurer does not qualify for exemption pursuant to subdivision B 1, but the insurance group of which it is a member qualifies for exemption pursuant to subdivision B 2, then the only ORSA summary report that may be required pursuant to § 38.2-1334.6 shall be the report applicable to that insurer.

E. An insurer that does not qualify for exemption pursuant to subsection B may apply to the Commission for a waiver from the requirements of this article based upon unique circumstances. In deciding whether to grant the insurer's request for waiver, the Commission may consider the type and volume of business written, ownership and organizational structure, and any other factor the Commission considers relevant to the insurer or insurance group of which the insurer is a member. If the insurer is part of an insurance group with insurers domiciled in more than one state, the Commission shall coordinate with the lead state commissioner and with the other domiciliary commissioners in considering whether to grant the insurer's request for a waiver.

F. Notwithstanding the exemptions stated in this section:

1. The Commission may require that an insurer maintain a risk management framework, conduct an ORSA, and file an ORSA summary report based on unique circumstances, including the type and volume of business written, ownership and organizational structure, federal agency requests, and international supervisor requests.

2. The Commission may require that an insurer maintain a risk management framework, conduct an ORSA, and file an ORSA summary report if the insurer has risk-based capital for company action level event as set forth in § 38.2-5503, meets one or more of the standards of an insurer deemed to be in hazardous financial condition as defined in 14VAC5-290-30 of the Virginia Administrative Code, or otherwise exhibits qualities of a troubled insurer as determined by the Commission.

G. If an insurer that qualifies for an exemption pursuant to subsection B subsequently no longer qualifies for that exemption due to changes in premium as reflected in the insurer's most recent annual statement or in the most recent annual statements of the insurers within the insurance group of which the insurer is a member, the insurer shall have one year following the year the threshold is exceeded to comply with the requirements of this article.

2014, c. 248.

§ 38.2-1334.8. Contents of ORSA summary report.

A. The ORSA summary report shall be prepared consistent with the ORSA Guidance Manual, subject to the requirements of subsection B. Documentation and supporting information shall be maintained and made available upon examination or upon request of the Commission.

B. The review of the ORSA summary report, and any additional requests for information, shall be made using similar procedures currently used in the analysis and examination of multistate or global insurers and insurance groups.

2014, c. 248.

§ 38.2-1334.9. Confidentiality.

A. The ORSA summary report is recognized by the Commonwealth as containing confidential and sensitive information related to an insurer or insurance group's identification of risks material and relevant to the insurer or insurance group filing the report. This information includes proprietary and trade secret information that has the potential for harm and competitive disadvantage to the insurer or insurance group if the information is made public. The ORSA summary report shall be a confidential document filed with the Commission, the report may be shared only as stated in this article and to assist the Commission in the performance of its duties, and in no event shall the report be subject to public disclosure.

B. Documents, materials, or other information, including the ORSA summary report, in the possession of or control of the Commission that is obtained by, created by, or disclosed to the Commission or any other person under this article is declared to be proprietary and to contain trade secrets. All such documents, materials, or other information shall be confidential by law and privileged, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the Commission is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the Commission's official duties. The Commission shall not otherwise make the documents, materials, or other information public without the prior written consent of the insurer.

C. Neither the Commission nor any person who received documents, materials, or other ORSA-related information, through examination or otherwise, while acting under the authority of the Commission or with whom such documents, materials, or other information is shared pursuant to this article shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsections A and B.

D. In order to assist in the performance of the Commission's regulatory duties, the Commission:

1. May, upon request, share documents, materials, or other ORSA-related information, including the confidential and privileged documents, materials, or information subject to subsection A, including proprietary and trade secret documents and materials, with other state, federal, and international financial regulatory agencies, including any forum for cooperation and communication between insurance supervisors, known as a supervisory college, that is established for the purpose of facilitating the

effectiveness of supervision of insurers, with the NAIC, and with any third-party consultants designated by the Commission, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the ORSA-related documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality;

2. May receive documents, materials, or other ORSA-related information, including otherwise confidential and privileged documents, materials, or information, including proprietary and trade-secret information or documents, from regulatory officials of other foreign or domestic jurisdictions, including members of any supervisory college, and from the NAIC and shall maintain as confidential or privileged any documents, materials, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information; and

3. Shall enter into a written agreement with the NAIC or a third-party consultant governing the sharing and use of information provided pursuant to this article, consistent with this subsection. The agreement shall:

a. Specify procedures and protocols regarding the confidentiality and security of information shared with the NAIC or a third-party consultant pursuant to this article, including procedures and protocols for sharing by the NAIC with other state regulators from states in which the insurance group has domiciled insurers. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the ORSA-related documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality;

b. Specify that ownership of information shared with the NAIC or a third-party consultant pursuant to this article remains with the Commission and that the use of information by the NAIC or a third-party consultant is subject to the direction of the Commission;

c. Prohibit the NAIC or third-party consultant from storing the information shared pursuant to this article in a permanent database after the underlying analysis is completed;

d. Require prompt notice to be given to an insurer whose confidential information in the possession of the NAIC or a third-party consultant pursuant to this article is subject to a request or subpoena to the NAIC or a third-party consultant for disclosure or production;

e. Require the NAIC or a third-party consultant to consent to intervention by an insurer in any judicial or administrative action in which the NAIC or a third-party consultant may be required to disclose confidential information about the insurer shared with the NAIC or a third-party consultant pursuant to this article; and

f. In the case of an agreement involving a third-party consultant, provide for the insurer's written consent.

E. The sharing of information and documents by the Commission pursuant to this article shall not constitute a delegation of regulatory authority or rulemaking, and the Commission is solely responsible for the administration, execution, and enforcement of the provisions of this article.

F. No waiver of any applicable privilege or claim of confidentiality in the documents, proprietary and trade-secret materials, or other ORSA-related information shall occur as a result of disclosure of such ORSA-related information or documents to the Commission under this section or as a result of sharing as authorized in this article.

G. Documents, materials, or other information in the possession or control of the NAIC or a third-party consultant pursuant to this article shall be confidential by law and privileged, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

2014, c. 248.

§ 38.2-1334.10. Sanctions.

Any insurer failing, without just cause, to timely file the ORSA summary report as required in this article shall be subject to the enforcement and penalty provisions set forth in Chapter 2 (§ 38.2-200 et seq.).

2014, c. 248.

Article 5.2 - CORPORATE GOVERNANCE ANNUAL DISCLOSURES

§ 38.2-1334.11. Definitions.

As used in this article, unless the context requires a different meaning:

"Commissioner" means the chief insurance regulatory official of a state, however designated.

"Corporate Governance Annual Disclosure" or "CGAD" means a confidential report filed by the insurer or insurance group made in accordance with the requirements of this article.

"Insurance group" means those insurers and affiliates included within an insurance holding company system as defined in § 38.2-1322.

"Insurer" means an insurance company as defined in § 38.2-100, except that "insurer" shall not include agencies, authorities, or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

"NAIC" means the National Association of Insurance Commissioners.

2017, c. 643.

§ 38.2-1334.12. Disclosure requirement.

A. The requirements of this article shall apply to all insurers domiciled in the Commonwealth. An insurer, or the insurance group of which the insurer is a member, shall, no later than June 1 of each calendar year, submit to the Commission a Corporate Governance Annual Disclosure that contains

the information described in subsection B of § 38.2-1334.13. Notwithstanding any request from the Commission made pursuant to subsection C, if the insurer is a member of an insurance group, the insurer shall submit the report required by this section to the Commissioner of the lead state for the insurance group, in accordance with the laws of the lead state, as determined by the procedures outlined in the most recent Financial Analysis Handbook adopted by the NAIC.

B. The CGAD shall include a signature of the insurer or insurance group's chief executive officer or corporate secretary attesting to the best of that individual's belief and knowledge that the insurer has implemented the corporate governance practices and that a copy of the disclosure has been provided to the insurer's board of directors or the appropriate committee thereof.

C. An insurer not required to submit a CGAD under this section shall do so upon the Commission's request.

D. For purposes of completing the CGAD, the insurer or insurance group may provide information regarding corporate governance at one or more of the ultimate controlling parent level, an intermediate holding company level, or the individual legal entity level, depending upon how the insurer or insurance group has structured its system of corporate governance. The insurer or insurance group is encouraged to make the CGAD disclosures at the level at which the insurer's or insurance group's risk appetite is determined, or at which the earnings, capital, liquidity, operations, and reputation of the insurer are overseen collectively and at which the supervision of those factors are coordinated and exercised, or the level at which legal liability for failure of general corporate governance duties would be placed. If the insurer or insurance group determines the level of reporting based on these criteria, it shall indicate which of the three criteria was used to determine the level of reporting and explain any subsequent changes in level of reporting.

E. The review of the CGAD and any additional requests for information shall be made through the lead state as determined by the procedures within the most recent Financial Analysis Handbook referenced in subsection A.

F. Insurers providing information substantially similar to the information required by this article in other documents provided to the Commission, including proxy statements filed in conjunction with the registration requirements pursuant to § 38.2-1329, or other state or federal filings provided to the Commission shall not be required to duplicate that information in the CGAD, but shall only be required to cross-reference the document in which the information is included.

G. Nothing in this article shall be construed to prescribe or impose corporate governance standards and internal procedures beyond that which is required under applicable state corporate law. Notwithstanding the foregoing, nothing in this article shall be construed to limit the Commission's authority, or the rights or obligations of third parties, under § 38.2-1318.

2017, c. 643.

§ 38.2-1334.13. Contents of Corporate Governance Annual Disclosure.

A. The insurer or insurance group shall have discretion over the responses to the CGAD inquiries, provided that the CGAD shall contain the material information necessary to permit the Commission to gain an understanding of the insurer's or insurance group's corporate governance structure, policies, and practices. The Commission may request additional information deemed material and necessary to provide the Commission with a clear understanding of the corporate governance policies, the reporting or information system, or the controls implementing those policies.

B. Notwithstanding subsection A, the CGAD shall be prepared consistent with the rules and regulations promulgated by the Commission to administer the requirements of this article. Documentation and supporting information shall be maintained and made available upon examination or upon request of the Commission.

2017, c. 643.

§ 38.2-1334.14. Confidentiality.

A. The CGAD is recognized by the Commonwealth as containing confidential and sensitive information related to an insurer or insurance group's internal operations. This information includes proprietary and trade secret information that has the potential for harm and competitive disadvantage to the insurer or insurance group if the information is made public. The CGAD shall be a confidential document filed with the Commission, the CGAD may be shared only as stated in this article and to assist the Commission in the performance of its duties, and in no event shall the CGAD be subject to public disclosure.

B. Documents, materials, or other information, including the CGAD, in the possession of or control of the Commission that is obtained by, created by, or disclosed to the Commission or any other person under this article is declared to be proprietary and to contain trade secrets. All such documents, materials, or other information shall be confidential by law and privileged, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the Commission is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the Commission's official duties. The Commission shall not otherwise make the documents, materials, or other information public without the prior written consent of the insurer. Nothing in this section shall be construed to require written consent of the insurer before the Commission may share or receive confidential documents, materials, or other CGAD-related information pursuant to subsection C to assist in the performance of the Commission's regular duties.

C. Neither the Commission nor any person who received documents, materials, or other CGAD-related information, through examination or otherwise, while acting under the authority of the Commission or with whom such documents, materials, or other information are shared pursuant to this article shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection A.

D. In order to assist in the performance of the Commission's regulatory duties, the Commission:

1. May, upon request, share documents, materials, or other CGAD-related information, including the confidential and privileged documents, materials, or information subject to subsection A, including proprietary and trade secret documents and materials, with other state, federal, and international financial regulatory agencies, including any forum for cooperation and communication between insurance supervisors, known as a supervisory college, that is established for the purpose of facilitating the effectiveness of supervision of insurers, with the NAIC, and with third-party consultants pursuant to § 38.2-1334.15, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the CGAD-related documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality; and

2. May receive documents, materials, or other CGAD-related information, including otherwise confidential and privileged documents, materials, or information, including proprietary and trade-secret information or documents, from regulatory officials of other foreign or domestic jurisdictions, including members of any supervisory college, and from the NAIC and shall maintain as confidential or privileged any documents, materials, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information.

E. The sharing of information and documents by the Commission pursuant to this article shall not constitute a delegation of regulatory authority or rulemaking, and the Commission is solely responsible for the administration, execution, and enforcement of the provisions of this article.

F. No waiver of any applicable privilege or claim of confidentiality in the documents, proprietary and trade-secret materials, or other CGAD-related information shall occur as a result of disclosure of such CGAD-related information or documents to the Commission under this section or as a result of sharing as authorized in this article.

2017, c. 643.

§ 38.2-1334.15. NAIC and third-party consultants.

A. The Commission may retain, at the insurer's expense, third-party consultants, including attorneys, actuaries, accountants, and other experts not otherwise a part of the Commission's staff as may be reasonably necessary to assist the Commission in reviewing the CGAD and related information or the insurer's compliance with this article.

B. Any persons retained under subsection A shall be under the direction and control of the Commission and shall act in a purely advisory capacity.

C. The NAIC and third-party consultants shall be subject to the same confidentiality standards and requirements as the Commission.

D. As part of the retention process, a third-party consultant shall verify to the Commission, with notice to the insurer, that it is free of a conflict of interest and that it has internal procedures in place to mon-

itor compliance with a conflict and to comply with the confidentiality standards and requirements of this article.

E. A written agreement with the NAIC or a third-party consultant, or both, governing sharing and use of information provided pursuant to this article shall contain the following provisions and expressly require the written consent of the insurer prior to making public information provided under this article:

1. Specific procedures and protocols for maintaining the confidentiality and security of CGAD-related information shared with the NAIC or a third-party consultant pursuant to this article;

2. Procedures and protocols for sharing by the NAIC only with other state regulators from states in which the insurance group has domiciled insurers. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the CGAD-related documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality;

3. A provision specifying that ownership of the CGAD-related information shared with the NAIC or a third-party consultant remains with the Commission and the NAIC's or third-party consultant's use of the information is subject to the direction of the Commission;

4. A provision that prohibits the NAIC or a third-party consultant from storing the information shared pursuant to this article in a permanent database after the underlying analysis is completed;

5. A provision requiring the NAIC or third-party consultant to provide prompt notice to the Commission and to the insurer or insurance group regarding any subpoena, request for disclosure, or request for production of the insurer's CGAD-related information; and

6. A requirement that the NAIC or a third-party consultant consent to intervention by an insurer in any judicial or administrative action in which the NAIC or a third-party consultant may be required to disclose confidential information about the insurer shared with the NAIC or a third-party consultant pursuant to this article.

2017, c. 643.

§ 38.2-1334.16. Rules and regulations.

The Commission may adopt rules and regulations implementing the provisions of this article.

2017, c. 643.

§ 38.2-1334.17. Sanctions.

Any insurer failing, without just cause, to timely file the CGAD as required in this article shall be subject to the enforcement and penalty provisions set forth in Chapter 2 (§ 38.2-200 et seq.).

2017, c. 643.

Article 6 - SUBSIDIARIES OF INSURANCE COMPANIES

§ 38.2-1335. Definitions.

The terms defined in § 38.2-1322 shall have the same meaning in this article.

1977, c. 414, § 38.1-178.11; 1986, c. 562.

§ 38.2-1336. Subsidiaries of insurers.

Notwithstanding the provisions of any other law, a domestic insurer shall not organize, acquire, or obtain control of any subsidiary, either by itself or in cooperation with one or more persons, unless the subsidiary is engaged in the following kinds of business:

1. Transacting any kind of insurance business authorized by the jurisdiction in which the subsidiary is incorporated;

2. Acting as an insurance broker or as an insurance agent for its parent or for any of its parent's insurer subsidiaries;

3. Investing, reinvesting or trading in securities for its own account, that of its parent, any subsidiary of its parent, or any affiliate or subsidiary;

4. Managing any investment company subject to or registered pursuant to the Investment Company Act of 1940, as amended, including related sales and services;

5. Acting as a broker-dealer subject to or registered pursuant to the Securities Exchange Act of 1934, as amended;

6. Rendering investment advice to governments, governmental agencies, corporations or other organizations or groups;

7. Rendering other services related to the operations of an insurance business including, but not limited to, actuarial, loss prevention, safety engineering, data processing, accounting, claims, appraisal and collection services;

8. Owning and managing assets that the domestic insurer could itself own or manage;

9. Acting as administrative agent for a governmental instrumentality that is performing an insurance function;

10. Financing of insurance premiums or agents;

11. Engaging in any other business activity the Commission determines to be reasonably ancillary to an insurance business; or

12. Owning a corporation or corporations engaged or organized to engage exclusively in one or more of the businesses specified in this section.

1977, c. 414, § 38.1-178.12; 1986, c. 562.

§ 38.2-1337. Disclaimer of control.

1. A domestic insurer may acquire voting securities of any company in an amount sufficient to presume control without the company's being considered a subsidiary if the domestic insurer files a disclaimer of affiliation with the Commission. The disclaimer shall disclose fully (i) the nature and purpose of the investment, (ii) all material transactions and relationships between the domestic insurer

and the company, and (iii) the basis for the disclaimer. The Commission may disallow the disclaimer only after giving the domestic insurer and the company notice and an opportunity to be heard. Any disallowance shall be supported by specific findings of fact.

2. If the Commission disallows the disclaimer, the domestic insurer shall immediately take action sufficient to satisfy the Commission that the domestic insurer does not control the company.

1977, c. 414, § 38.1-178.13; 1986, c. 562.

§ 38.2-1338. Applicability.

This article shall not apply to any investment or subsidiary relationship that was in effect prior to June 1, 1977, between a domestic insurer and another company. However, no domestic insurer may increase its investment or ownership of voting securities or otherwise materially increase its control over the affairs of the company without prior approval of the Commission.

1977, c. 414, § 38.1-178.14; 1986, c. 562.

§ 38.2-1339. Exemptions.

Nothing in this article shall exempt any domestic insurer from the provisions of Article 5 (§ 38.2-1322 et seq.), Article 5.1 (§ 38.2-1334.3 et seq.), or Article 5.2 (§ 38.2-1334.11 et seq.).

1977, c. 414, § 38.1-178.15; 1986, c. 562; 2014, c. 248; 2017, c. 643.

§ 38.2-1340. Revocation, suspension, or nonrenewal of insurer's license.

Whenever it appears to the Commission that any person has committed a violation of this article that makes the continued operation of a domestic insurer contrary to the interests of policyholders or the public, the Commission may, after giving notice and an opportunity to be heard, suspend, revoke or refuse to renew the insurer's license to do business in this Commonwealth for whatever period it finds is required for the protection of policyholders or the public. Any such action shall be supported by specific findings of fact and conclusions of law.

1977, c. 414, § 38.1-178.19; 1986, c. 562.

Article 7 - BUSINESS TRANSACTED WITH PRODUCER-CONTROLLED PROPERTY AND CASUALTY INSURER ACT

§ 38.2-1341. Definitions.

As used in this article:

"Accredited state" means a state in which the insurance department or regulatory agency responsible for administering the insurance laws of said state has qualified as meeting the minimum financial regulatory standards promulgated and established from time to time by the National Association of Insurance Commissioners' (NAIC) Financial Regulation Standards and Accreditation Program.

"Control" or "controlled" has the meaning ascribed in § 38.2-1322.

"Controlled insurer" means a licensed insurer which is controlled, directly or indirectly, by a producer.

"Controlling producer" means a producer who, directly or indirectly, controls an insurer.

"Foreign insurer" means any foreign or alien insurer licensed to transact the business of insurance in this Commonwealth pursuant to § 38.2-1024.

"Licensed insurer," "insurer" or "property and casualty insurer" means any person, firm, association or corporation duly licensed under this title to write policies or agreements providing any form of insurance as defined in §§ 38.2-110 through 38.2-134. The following, inter alia, are not licensed insurers for the purposes of this article:

1. All risk retention groups as defined in the Superfund Amendments Reauthorization Act of 1986, Pub. L. No. 99-499, 100 Stat. 1613 (1986) and the Risk Retention Act, 15 U.S.C. § 3901 et seq. and § 38.2-5101 of this title;

2. All residual market pools and joint underwriting authorities or associations; and

3. Any insurer licensed as a captive insurer under Chapter 11 (§ 38.2-1100 et seq.) and any foreign insurer which is either (i) an association captive or (ii) a pure captive. An "association captive" is an insurer whose exclusive purpose is transacting the business of insurance and reinsurance only on risks, hazards and liabilities of the members of an insurance association comprised of any group of individuals, corporations, partnerships, associations, or governmental units or agencies whose members collectively own, control, or hold with power to vote, all of the outstanding voting securities of the association insurer. A "pure captive" is an insurer whose exclusive purpose is transacting the business of insurance and reinsurance only on risks, hazards, and liabilities of its parent, subsidiary companies of its parent, and associated and affiliated companies.

"Producer" means:

1. Any insurance agent subject to licensure pursuant to the provisions of Chapter 18 (§ 38.2-1800 et seq.) of this title, or any managing general agent or reinsurance intermediary subject to licensure pursuant to the provisions of this chapter; or

2. Any person subject to substantially similar licensure provisions of another state when, for any compensation, commission or other thing of value, such agent, intermediary or person acts on behalf of an insured other than the agent, intermediary or person, or aids in any manner, in selling, soliciting, or negotiating the making of any contract of insurance in which the insured, owner and beneficiary are other than the agent, intermediary or person.

1993, c. 158; 2001, c. 706.

§ 38.2-1342. Applicability.

A. All provisions of this article shall apply to domestic insurers.

B. Effective January 1, 1994, any foreign insurer not domiciled and licensed in an accredited state shall confirm, at least once every five years, as a condition of licensing and licensing renewal, its compliance with the provisions of this article or those of a substantially similar law enacted by an

accredited state in which the insurer is licensed. The method of confirmation shall be determined by the Commission and may include examination of such foreign insurer and its controlling producer pursuant to Article 4 (§ 38.2-1317 et seq.) of Chapter 13. Any foreign insurer that is unable to confirm substantial compliance in a manner satisfactory to the Commission shall be subject to all of the provisions of this title.

C. All provisions of Article 5 (§ 38.2-1322 et seq.), Article 5.1 (§ 38.2-1334.3 et seq.), and Article 5.2 (§ 38.2-1334.11 et seq.) of this chapter and Article 2 (§ 38.2-4230 et seq.) of Chapter 42, to the extent they are not superseded by the provisions of this article, shall continue to apply to all parties within holding company systems subject to this article.

1993, c. 158; 2014, c. 248; 2017, c. 643.

§ 38.2-1343. Minimum standards.

A. The provisions of this section shall apply if, in any calendar year, the aggregate amount of gross written premium on business placed with a controlled insurer by a controlling producer is equal to or greater than five percent of the admitted assets of the controlled insurer, as reported in the controlled insurer's quarterly statement filed as of September 30 of the prior year.

B. Notwithstanding the provisions of subsection A of this section, the provisions of subsections A, C, D and E of this section shall not apply if:

1. The controlling producer (i) places insurance only with the controlled insurer, or only with the controlled insurer and a member or members of the controlled insurer's holding company system, or the controlled insurer's parent, affiliate or subsidiary and receives no compensation based upon the amount of premiums written in connection with such insurance and (ii) accepts insurance placements only from nonaffiliated subproducers and not directly from insureds; and

2. The controlled insurer, except for insurance business written through a residual market facility such as the Virginia Automobile Insurance Plan, as set forth in § 38.2-2015, or the Virginia Property Insurance Association, as set forth in Chapter 27 (§ 38.2-2700 et seq.), accepts insurance business only from a controlling producer, a producer controlled by the controlled insurer, or a producer that is a subsidiary of the controlled insurer.

C. A controlled insurer shall not accept business from a controlling producer and a controlling producer shall not place business with a controlled insurer unless there is a written contract between them specifying the responsibilities of each party, which contract has been approved by the board of directors of the insurer and contains the following minimum provisions:

1. The controlled insurer may terminate the contract for cause, upon written notice to the controlling producer. The controlled insurer shall suspend the authority of the controlling producer to write business during the pendency of any dispute regarding the cause for the termination;

2. The controlling producer shall render accounts to the controlled insurer detailing all material transactions, including information necessary to support all commissions, charges and other fees received by, or owing to, the controlling producer;

3. The controlling producer shall remit all funds due under the terms of the contract to the controlled insurer on at least a monthly basis. The due date shall be fixed so that premiums or installments thereof collected shall be remitted no later than ninety days after the effective date of any policy placed with the controlled insurer under this contract;

4. All funds collected for the controlled insurer's account shall be held by the controlling producer in a fiduciary capacity, in one or more appropriately identified bank accounts in banks that are members of the Federal Reserve System, in accordance with the provisions of the insurance law as applicable. However, funds of a controlling producer not required to be licensed in this Commonwealth shall be maintained in compliance with the requirements of the controlling producer's domiciliary jurisdiction;

5. The controlling producer shall maintain separately identifiable records of business written for the controlled insurer;

6. The contract shall not be assigned in whole or in part by the controlling producer;

7. The controlled insurer shall provide the controlling producer with its underwriting standards, rules and procedures, manuals setting forth the rates to be charged, and the conditions for the acceptance or rejection of risks. The controlling producer shall adhere to the standards, rules, procedures, rates and conditions. The standards, rules, procedures, rates and conditions shall be the same as those applicable to comparable business placed with the controlled insurer by a producer other than the controlling producer;

8. The rates and terms of the controlling producer's commissions, charges or other fees and the purposes for those charges or fees shall be specified. The rates of the commissions, charges and other fees shall be no greater than those applicable to comparable business placed with the controlled insurer by producers other than controlling producers. For purposes of this subdivision and subdivision 7 of this subsection, examples of "comparable business" include the same lines of insurance, same kinds of insurance, same kinds of risks, similar policy limits, and similar quality of business;

9. If the contract provides that the controlling producer, on insurance business placed with the insurer, is to be compensated contingent upon the insurer's profits on that business, then such compensation shall not be determined and paid until at least five years after the premiums on liability insurance are earned and at least one year after the premiums are earned on any other insurance. In no event shall the commissions be paid until the adequacy of the controlled insurer's reserves on remaining claims has been independently verified pursuant to subdivision 1 of subsection E of this section;

10. The contract shall place a limit on the controlling producer's writings in relation to the controlled insurer's surplus and total writings. The insurer may establish a different limit for each line or sub-line of business. The controlled insurer shall notify the controlling producer when the applicable limit is

approached and shall not accept business from the controlling producer if the limit is reached. The controlling producer shall not place business with the controlled insurer if it has been notified by the controlled insurer that the limit has been reached; and

11. The controlling producer may negotiate but shall not bind reinsurance on behalf of the controlled insurer on business the controlling producer places with the controlled insurer, except that the controlling producer may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the controlled insurer contains underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with which such automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured and commission schedules.

D. Every controlled insurer shall have an Audit Committee of the Board of Directors composed of independent directors. The Audit Committee shall annually meet with management, the insurer's independent certified public accountants, and an independent casualty actuary or other independent loss reserve specialist acceptable to the Commission to review the adequacy of the insurer's loss reserves.

E. The controlled insurer shall obtain annually prior to March 1 of each year the following data and reports:

1. In addition to any other required loss reserve certification, an opinion of an independent casualty actuary reporting loss ratios for each line of business written and attesting to the adequacy of loss reserves established for losses incurred and outstanding as of year's end (including incurred but not reported) on business placed by the producer; and

2. The controlled insurer shall annually report to the Commission the amount of commissions paid to the producer during the preceding calendar year, the percentage such amount represents of the net premiums written and comparable amounts and percentage paid to noncontrolling producers for placements of the same kinds of insurance.

The data and reports required by this subsection shall be retained by the insurer for a period of not less than five years and shall be filed with the Commission upon request.

1993, c. 158.

§ 38.2-1344. Disclosure.

The producer, prior to the effective date of the policy, shall deliver written notice to the prospective insured disclosing the relationship between the producer and the controlled insurer. However, if the business is placed through a subproducer who is not a controlling producer, the controlling producer shall retain in his records a signed commitment from the subproducer that the subproducer is aware of the relationship between the insurer and the producer and that the subproducer has or will notify the insured.

1993, c. 158.

§ 38.2-1345. Penalties.

A. If the Commission finds, after providing an opportunity to be heard, that the controlling producer or any other person has not materially complied with the provisions of this article, or any regulation or order promulgated hereunder, the Commission may order the controlling producer to cease placing business with the controlled insurer.

B. If it is found that because of such material noncompliance that the controlled insurer or any policyholder thereof has suffered any loss or damage, the Commission may order the controlling producer or any other party licensed under this title to make restitution to the controlled insurer or its statutory successor, including any rehabilitator, liquidator or receiver of the insurer, for the net losses or damages incurred by the insurer or its policyholders.

C. Nothing contained in this section shall affect the right of the Commission to impose any other penalties provided for in this title.

D. Nothing contained in this section is intended to or shall in any manner alter or affect the rights of policyholders, claimants, creditors or other third parties.

1993, c. 158.

§ 38.2-1346. Licensure.

A. No person shall act in this Commonwealth as a producer, and no resident of this Commonwealth shall act as a producer, unless such person or resident is licensed as an insurance agent pursuant to the provisions of Chapter 18 (§ 38.2-1800 et seq.) of this title, or as a reinsurance intermediary or managing general agent pursuant to the provisions of this chapter.

B. As used in this section, the terms "resident" and "insurance agent" have the meanings prescribed in § 38.2-1800, and the terms "managing general agent," and "reinsurance intermediary" have the meanings set forth in §§ 38.2-1347 and 38.2-1358.

1993, c. 158; 2001, c. 706.

Article 8 - LICENSING OF REINSURANCE INTERMEDIARIES

§ 38.2-1347. Definitions.

As used in this article:

"Actuary" means a person who is a member in good standing of the American Academy of Actuaries.

"Business entity" means a partnership, limited partnership, limited liability company, corporation, or other legal entity that is entitled to hold property in its own name and which is not a sole proprietorship.

"Controlling" shall have the same meaning as set forth in § 38.2-1322.

"Insurer" means any person duly licensed in this Commonwealth pursuant to Chapters 10 (§ 38.2-1000 et seq.), 11 (§ 38.2-1100 et seq.), 12 (§ 38.2-1200 et seq.), 25 (§ 38.2-2500 et seq.), 26 (§ 38.2-2600 et seq.), 38 (§ 38.2-3800 et seq.) through 46 (§ 38.2-4600 et seq.), or 51 (§ 38.2-5100 et seq.) of this title.

"Licensed reinsurance intermediary" means an agent, broker or reinsurance intermediary licensed to act as a reinsurance intermediary pursuant to the applicable provision of this article.

"Qualified United States financial institution" means an institution that:

1. Is organized or (in the case of a United States office of a foreign banking organization) licensed under the laws of the United States or any state thereof;

2. Is regulated, supervised and examined by federal or state authorities having regulatory authority over banks and trust companies; and

3. Has been determined by either the Commission, or the Securities Valuation Office of the National Association of Insurance Commissioners, to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the Commission.

"Reinsurance intermediary" means a reinsurance intermediary broker or a reinsurance intermediary manager as these terms are defined in this article.

"Reinsurance intermediary broker" means any person, other than an officer or employee of the ceding insurer, who, without the power to bind the ceding insurer, solicits, negotiates or places reinsurance cessions or retrocessions on behalf of a ceding insurer or otherwise negotiates with a ceding insurer concerning reinsurance cessions or retrocessions.

"Reinsurance intermediary manager" means any person who (i) has authority to bind reinsurance risks or (ii) manages all or part of the assumed reinsurance business of a reinsurer, including the management of a separate division, department or underwriting office, and acts as an agent for such reinsurer whether known as a reinsurance intermediary manager or other similar term. Notwithstanding the foregoing, the following persons shall not be considered a reinsurance intermediary manager for the purposes of this article, provided such person is acting in the capacity of employee or agent, as described herein, and properly discharging the duties of such employment or agency:

1. An employee of the reinsurer;

2. A United States manager of the United States branch of an alien reinsurer;

3. An underwriting manager who, pursuant to contract, manages all or part of the reinsurance operations of the reinsurer, is under common control with the reinsurer, subject to Article 5 (§ 38.2-1322 et seq.) of this chapter or Article 2 (§ 38.2-4230 et seq.) of Chapter 42 of this title, and whose compensation is not based on the volume of premiums written;

4. The manager of a group, association, pool or organization of insurers that engages in joint underwriting or joint reinsurance and that is subject to examination by the supervising insurance official of the state, as defined in § 38.2-100, in which the manager's principal business office is located; or

5. A licensed managing general agent who binds facultative reinsurance contracts by placing individual risks pursuant to obligatory facultative agreements and subdivision 10 of § 38.2-1360.

"Reinsurer" means any insurer licensed in this Commonwealth with the authority to cede or accept from any insurer reinsurance pursuant to § 38.2-136.

2001, c. 706.

§ 38.2-1348. License requirements.

A. No insurer shall permit a person to act, and no person shall act, as a reinsurance intermediary broker in this Commonwealth if the reinsurance intermediary broker maintains an office either directly or as a member or employee of a firm or association, or an officer, director or employee of a corporation:

1. In this Commonwealth, unless such reinsurance intermediary broker is a licensed reinsurance intermediary in this Commonwealth; or

2. In another state, unless such reinsurance intermediary broker is a licensed reinsurance intermediary in this Commonwealth or in another state having a law substantially similar to this law.

B. No insurer shall permit a person to act, and no person shall act, as a reinsurance intermediary manager:

1. For a reinsurer domiciled in this Commonwealth, unless such reinsurance intermediary manager is a licensed reinsurance intermediary in this Commonwealth;

2. In this Commonwealth, if the reinsurance intermediary manager maintains an office either directly or as a member or employee of a firm or association, or an officer, director or employee of a corporation in this Commonwealth, unless such reinsurance intermediary manager is a licensed reinsurance intermediary in this Commonwealth; or

3. In another state for an insurer not domiciled in this Commonwealth, unless such reinsurance intermediary manager is a licensed reinsurance intermediary in this Commonwealth or in another state having a law substantially similar to this law.

C. The Commission may require a reinsurance intermediary manager to:

1. Be bonded in a manner acceptable to the Commission for the protection of the reinsurer and to provide a certification or attestation that such bond is in effect as a prerequisite to license issuance or renewal; and

2. Maintain an errors and omissions policy that is acceptable to the Commission and to provide a certification or attestation that such policy is in effect as a prerequisite to license issuance or renewal.

D. The Commission may issue a reinsurance intermediary license to any individual or business entity who has complied with the requirements of this article. Any such license issued to a business entity will authorize all the members of such business entity and any designated officers, directors or employees to act as reinsurance intermediaries under the license, and all such persons shall be named in the application and any supplements thereto.

E. Except where prohibited by state or federal law, by submitting an application for license, the applicant shall be deemed to have appointed the clerk of the Commission as the agent for service of process on the applicant in any action or proceeding arising in this Commonwealth out of or in connection with the exercise of the license. Such appointment of the clerk of the Commission as agent for service of process shall be irrevocable during the period within which a cause of action against the applicant may arise out of transactions with respect to subjects of insurance in this Commonwealth. Service of process on the clerk of the Commission shall conform to the provisions of Chapter 8 (§ 38.2-800 et seq.) of this title. An applicant for a reinsurance intermediary license also shall furnish the clerk of the Commission with the name and address of a resident of this Commonwealth upon whom notices or orders of the Commission or process affecting such reinsurance intermediary may be served. Such licensee shall promptly notify the clerk of the Commission in writing of every change in its designated agent for service of process, and such change shall not become effective until acknowledged by the Commission.

F. The Commission may refuse to issue a reinsurance intermediary license, subject to the right of the applicant to demand a hearing on the application, if the Commission believes the applicant, any person named on the application, or any member, principal, officer or director of the applicant, is not trustworthy; that any controlling person of such applicant is not trustworthy to act as a reinsurance intermediary; or that any of the foregoing has given cause for revocation or suspension of such license or has failed to comply with any prerequisite for the issuance of such license.

G. Residents of Virginia who are members of the Virginia State Bar when acting in their professional capacity as such shall be exempt from the requirements of this section.

H. Any person seeking to be licensed as a reinsurance intermediary in this Commonwealth shall apply for such license in a form acceptable to the Commission, and shall pay to the Commission a nonrefundable application fee in an amount prescribed by the Commission. Such fee shall be not less than $500 and not more than $1,000. Every licensed reinsurance intermediary shall pay to the Commission a nonrefundable biennial renewal fee in an amount prescribed by the Commission. Such fee shall be not less than $500 and not more than $1,000. Between May 1 and June 1 of the renewal year, each licensed reinsurance intermediary shall submit to the Commission a renewal application and fee in the manner and form prescribed by the Commission. All fees shall be collected by the Commission and paid into the state treasury and placed to the credit of the fund for the maintenance of the Bureau of Insurance as provided in subsection B of § 38.2-400. Each license and renewed license shall expire on June 30 of the appropriate year.

I. Any person seeking to be licensed as a reinsurance intermediary in this Commonwealth shall observe and abide by the laws of this Commonwealth and submit with its license application the following:

1. A statement identifying its principal place of business, organizational structure, and other such information as the Commission may require to verify that the reinsurance intermediary is qualified under the definition of this article;

2. A copy of its plan of operations;

3. A copy of its current financial statement, which shall be certified by an independent public accountant and in a form acceptable to the Commission; and

4. Such information or reports as may be required to verify its continuing qualification as a reinsurance intermediary.

2001, c. 706.

§ 38.2-1349. Required contract provisions; reinsurance intermediary brokers.

Transactions between a reinsurance intermediary broker and the insurer it represents in such capacity shall only be entered into pursuant to a written authorization, specifying the responsibilities of each party. The authorization shall, at a minimum, provide that:

1. The insurer may terminate the reinsurance intermediary broker's authority at any time;

2. The reinsurance intermediary broker will render accounts to the insurer accurately detailing all material transactions, including information necessary to support all commissions, charges and other fees received by, or owing to, the reinsurance intermediary broker, and remit all funds due to the insurer within thirty calendar days of receipt;

3. All funds collected for the insurer's account will be held by the reinsurance intermediary broker in a fiduciary capacity in a bank that is a qualified United States financial institution as defined in § 38.2-1347;

4. The reinsurance intermediary broker will comply with § 38.2-1350;

5. The reinsurance intermediary broker will comply with the written standards established by the insurer for the cession or retrocession of all risks; and

6. The reinsurance intermediary broker will disclose to the insurer any relationship with any reinsurer to which business will be ceded or retroceded.

2001, c. 706.

§ 38.2-1350. Books and records; reinsurance intermediary brokers.

A. For at least ten years after expiration of each contract of reinsurance transacted by the reinsurance intermediary broker, the reinsurance intermediary broker will keep a complete record for each transaction showing:

1. The type of contract, limits, underwriting restrictions, classes or risks and territory;

2. Period of coverage, including effective and expiration dates, cancellation provisions and notice required of cancellation;

3. Reporting and settlement requirements of balances;

4. Rate used to compute the reinsurance premium;

5. Names and addresses of assuming reinsurers;

6. Rates of all reinsurance commissions, including the commissions on any retrocessions handled by the reinsurance intermediary broker;

7. Related correspondence and memoranda;

8. Proof of placement;

9. Details regarding retrocessions handled by the reinsurance intermediary broker including the identity of retrocessionaires and percentage of each contract assumed or ceded;

10. Financial records, including but not limited to, premium and loss accounts; and

11. When the reinsurance intermediary broker procures a reinsurance contract on behalf of a licensed ceding insurer:

a. Directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or

b. If placed through a representative of the assuming reinsurer, other than an employee, written evidence that such reinsurer has delegated binding authority to the representative.

B. The insurer will have reasonable access to and the right to copy and audit all accounts and records maintained by the reinsurance intermediary broker related to its business in a form usable by the Commission.

2001, c. 706.

§ 38.2-1351. Duties of insurers utilizing the services of a reinsurance intermediary broker.

A. An insurer shall not engage the services of any individual or business entity to act as a reinsurance intermediary broker on its behalf unless such person is licensed as required by § 38.2-1348.

B. An insurer may not employ an individual who is employed by a reinsurance intermediary broker with which it transacts business, unless such reinsurance intermediary broker is under common control with the insurer and subject to Article 5 (§ 38.2-1322 et seq.) of this chapter or Article 2 (§ 38.2-4230 et seq.) of Chapter 42 of this title.

C. The insurer shall annually obtain a copy of the current financial statement of each reinsurance intermediary broker with which it transacts business. Such statement shall be certified by an independent public accountant and in a form acceptable to the Commission.

2001, c. 706.

§ 38.2-1352. Required contract provisions; reinsurance intermediary managers.

Transactions between a reinsurance intermediary manager and the reinsurer it represents in such capacity shall only be entered into pursuant to a written contract, specifying the responsibilities of

each party, which shall be approved by the reinsurer's board of directors. At least thirty calendar days before such reinsurer assumes or cedes business through such reinsurance intermediary manager, a true copy of the approved contract shall be filed with the Commission for approval. The contract shall, at a minimum, provide that:

1. The reinsurer may terminate the contract for cause upon written notice to the reinsurance intermediary manager. The reinsurer may immediately suspend the authority of the reinsurance intermediary manager to assume or cede business during the pendency of any dispute regarding the cause for termination.

2. The reinsurance intermediary manager will render timely accounts to the reinsurer accurately detailing all material transactions, including information necessary to support all commissions, charges and other fees received by, or owing to the reinsurance intermediary manager, and remit all funds due under the contract to the reinsurer on not less than a monthly basis.

3. All funds collected for the reinsurer's account will be held by the reinsurance intermediary manager in a fiduciary capacity in a bank that is a qualified United States financial institution as defined in § 38.2-1347. The reinsurance intermediary manager may retain no more than three months' estimated claims payments and allocated loss adjustment expenses. The reinsurance intermediary manager shall maintain a separate bank account for each reinsurer that it represents.

4. For at least ten years after expiration of each contract of reinsurance transacted by the reinsurance intermediary manager, the reinsurance intermediary manager will keep a complete record for each transaction showing:

a. The type of contract, limits, underwriting restrictions, classes or risks and territory;

b. Period of coverage, including effective and expiration dates, cancellation provisions and notice required of cancellation, and disposition of outstanding reserves on covered risks;

c. Reporting and settlement requirements of balances;

d. Rate used to compute the reinsurance premium;

e. Names and addresses of assuming reinsurers;

f. Rates of all reinsurance commissions, including the commissions on any retrocessions handled by the reinsurance manager;

g. Related correspondence and memoranda;

h. Proof of placement;

i. Details regarding retrocessions handled by the reinsurance intermediary manager, as permitted by subsection D of § 38.2-1354, including the identity of retrocessionaires and percentage of each contract assumed or ceded;

j. Financial records, including but not limited to, premium and loss accounts; and

k. When the reinsurance intermediary manager places a reinsurance contract on behalf of a ceding insurer:

(1) Directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or

(2) If placed through a representative of the assuming reinsurer, other than an employee, written evidence that such reinsurer has delegated binding authority to the representative.

5. The reinsurer will have reasonable access to and the right to copy all accounts and records maintained by the reinsurance intermediary manager related to its business in a form usable by the reinsurer.

6. The contract cannot be assigned in whole or in part by the reinsurance intermediary manager.

7. The reinsurance intermediary manager will comply with the written underwriting and rating standards established by the insurer for the acceptance, rejection or cession of all risks.

8. Sets forth the rates, terms and purposes of commissions, charges and other fees that the reinsurance intermediary manager may levy against the reinsurer.

9. If the contract permits the reinsurance intermediary manager to settle claims on behalf of the reinsurer:

a. All claims will be reported to the reinsurer in a timely manner;

b. A copy of the claim file will be sent to the reinsurer at its request or as soon as it becomes known that the claim:

(1) Has the potential to exceed one percent of the insurer's surplus to policyholders as of December 31 of the last completed calendar year, an amount set by the reinsurer, or any other amount deemed appropriate by the Commission, whichever is less;

(2) Involves a coverage dispute;

(3) May exceed the reinsurance intermediary manager's claims settlement authority;

(4) Is open for more than six months; or

(5) Is closed by payment of an amount exceeding one percent of the insurer's surplus to policyholders as of December 31 of the last completed calendar year, an amount set by the reinsurer, or any other amount deemed appropriate by the Commission, whichever is less;

c. All claim files will be the joint property of the reinsurer and reinsurance intermediary manager. However, upon entry of order of liquidation or the appointment of a receiver for the liquidation of the reinsurer, such files shall become the sole property of the reinsurer or its estate; the reinsurance intermediary manager shall have reasonable access to and the right to copy the files on a timely basis;

d. Any settlement authority granted to the reinsurance intermediary manager may be terminated for cause upon the reinsurer's written notice to the reinsurance intermediary manager or upon the

termination of the contract. The reinsurer may suspend the settlement authority during the pendency of the dispute regarding the cause of termination.

10. Where electronic claims files are in existence, the contract must address the timely transmission of the data.

11. If the contract provides for a sharing of interim profits by the reinsurance intermediary manager, such interim profits will not be paid until one year after the end of each underwriting period for property business and five years after the end of each underwriting period for casualty business, or a later period set by the Commission for specified lines of insurance, and not until the adequacy of reserves on remaining claims has been verified pursuant to subsection C of § 38.2-1354.

12. The reinsurance intermediary manager will annually provide the reinsurer with a current financial statement prepared by an independent certified accountant in a form acceptable to the Commission.

13. The reinsurer shall, at least semiannually, conduct an on-site review of the underwriting and claims processing operations of the reinsurance intermediary manager.

14. The reinsurance intermediary manager will disclose to the reinsurer any relationship it has with any insurer prior to negotiating any business with such insurer pursuant to this contract.

15. Within the scope of its actual or apparent authority, the acts of the reinsurance intermediary manager shall be deemed to be the acts of the reinsurer on whose behalf it is acting.

2001, c. 706.

§ 38.2-1353. Prohibited acts.

No insurer shall authorize its reinsurance intermediary manager to, and no reinsurance intermediary manager shall:

1. Cede retrocessions on behalf of the reinsurer, except that the reinsurance intermediary manager may cede facultative retrocessions pursuant to obligatory facultative agreements if the contract between the reinsurance intermediary manager and the reinsurer contains reinsurance underwriting guidelines for such retrocessions. Such guidelines shall include a list of reinsurers with which such automatic agreements are in effect, and for each such reinsurer, the coverages and amounts or percentages that may be reinsured, and commission schedules.

2. Commit the reinsurer to participate in reinsurance syndicates.

3. Permit any agent or reinsurance intermediary to represent the reinsurer without assuring that the agent or reinsurance intermediary is lawfully licensed.

4. Without prior approval of the reinsurer, pay or commit the reinsurer to pay a claim, net of retrocessions, that exceeds the lesser of an amount specified by the reinsurer or one percent of the reinsurer's surplus to policyholders as of December 31 of the last completed calendar year.

5. Collect any payment from a retrocessionaire or commit the reinsurer to any claim settlement with a retrocessionaire without prior approval of the reinsurer. If prior approval is given, a report must be promptly forwarded to the reinsurer.

6. Jointly employ an individual who is employed by the reinsurer unless such reinsurance manager is under common control with the reinsurer subject to Article 5 (§ 38.2-1322 et seq.) of this chapter or Article 2 (§ 38.2-4230 et seq.) of Chapter 42 of this title.

7. Appoint a sub-reinsurance intermediary manager.

2001, c. 706.

§ 38.2-1354. Duties of reinsurers utilizing the services of a reinsurance intermediary manager.

A. A reinsurer shall not engage the services of any individual or business entity to act as a reinsurance intermediary manager on its behalf unless such individual or business entity is licensed as required by § 38.2-1348.

B. The reinsurer shall annually obtain a copy of the current financial statement of each reinsurance intermediary manager that such reinsurer has engaged. Such statements shall be prepared by an independent certified accountant in a form acceptable to the Commission.

C. If a reinsurance intermediary manager establishes loss reserves, the reinsurer shall annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the reinsurance intermediary manager. This opinion shall be in addition to any other required loss reserve certification.

D. Binding authority for all retrocessional contracts or participation in reinsurance syndicates shall rest with an officer of the reinsurer who shall not be affiliated with the reinsurance intermediary manager.

E. Within thirty calendar days of termination of a contract with a reinsurance intermediary manager, the reinsurer shall provide written notification of such termination in a form acceptable to the Commission.

F. A reinsurer shall not appoint to its board of directors, any officer, director, employee, controlling shareholder or subproducer of its reinsurance intermediary manager. This subsection shall not apply to relationships governed by Article 5 (§ 38.2-1322 et seq.) of this chapter or Article 2 (§ 38.2-4230 et seq.) of Chapter 42 of this title.

G. An insurer shall not delegate to any person, other than one of its officers, the authority to enter into or bind any reinsurance agreement by which the insurer agrees to cede or retrocede any risk to a reinsurer, except that an insurer may delegate the specific authority to bind facultative reinsurance contracts by placing individual risks pursuant to the provisions of subdivision 1 of § 38.2-1353 or subdivision 10 of § 38.2-1360.

1. The officer shall be a regular salaried employee of such insurer and shall not be affiliated with the reinsurance intermediary.

2. The insurer is not prohibited by the provisions of this subsection from delegating the authority to enter into or bind an agreement to assume a risk to a licensed reinsurance intermediary manager pursuant to the provisions of this article, provided the authority to cede and assume a given risk is not simultaneously vested in the same intermediary.

2001, c. 706.

§ 38.2-1355. Examination authority.

A. A reinsurance intermediary shall be subject to examination by the Commission. The Commission shall have reasonable access to all books, bank accounts and records of the reinsurance intermediary in a form usable to the Commission.

B. A reinsurance intermediary manager may be examined, pursuant to Article 4 (§ 38.2-1317 et seq.) of this chapter, as if it were the reinsurer. In addition, the reinsurance intermediary shall be subject to examination pursuant to § 38.2-1809 if it or any of its officers, directors, agents, or employees is licensed as a producer under Chapter 18 (§ 38.2-1800 et seq.) of this title.

2001, c. 706.

§ 38.2-1356. Penalties and liabilities; grounds for placing on probation, refusal to issue or renew, revocation, or suspension of license.

A. If the Commission finds, after providing an opportunity to be heard, that any person has violated any provisions of this article, the Commission may, in addition to any other remedies authorized by this title, order the reinsurance intermediary to make restitution to the insurer, reinsurer, rehabilitator or liquidator or receiver of the insurer or reinsurer for the net losses incurred by the insurer or reinsurer attributable to such violation.

B. The Commission may, in addition to or in lieu of a penalty under § 38.2-218, place on probation, suspend, revoke, or refuse to issue or renew a reinsurance intermediary's license for any one or more of the following causes:

1. Providing materially incorrect, misleading, incomplete, or untrue information in the license application or any other document filed with the Commission;

2. Violating any insurance or reinsurance laws or violating any regulation, subpoena or order of the Commission or of another state's insurance regulatory authority;

3. Obtaining or attempting to obtain a license through misrepresentation or fraud;

4. Improperly withholding, misappropriating or converting any moneys or properties received in the course of doing business;

5. Intentionally misrepresenting the terms of an actual or proposed insurance or reinsurance contract;

6. Having been convicted of a felony;

7. Having admitted or been found to have committed any insurance unfair trade practice or fraud;

8. Using fraudulent, coercive, or dishonest practices, or demonstrating incompetence, or untrustworthiness in the conduct of business in this Commonwealth or elsewhere, or demonstrating financial irresponsibility in the handling of applicant, policyholder, agency, or insurance company funds;

9. Having an insurance producer license, or its equivalent, denied, suspended or revoked in any other state, province, or territory;

10. Forging another's name to an application for insurance or reinsurance, or to any document related to an insurance or reinsurance transaction;

11. Knowingly accepting insurance business from an individual who is not licensed;

12. Failing to comply with an administrative or court order imposing a child support obligation;

13. Failing to pay state income tax or comply with any administrative or court order directing payment of state income tax; or

14. If the reinsurance intermediary is a business entity, having its corporate existence terminated, its certificate of organization, trust, limited liability company, or limited partnership canceled, or its certificate of authority or registration to transact business in the Commonwealth revoked or canceled, as the case may be.

C. If the Commission believes that any applicant for licensing pursuant to this article is not of good character or does not have a good reputation for honesty, it may refuse to issue the license, subject to the right of the applicant to demand a hearing on the application. The Commission shall not revoke or suspend an existing license until the licensee is given an opportunity to be heard before the Commission. If the Commission refuses to issue a new license or proposes to revoke or suspend an existing license, it shall give the applicant or licensee at least 10 calendar days' notice in writing of the time and place of the hearing, if a hearing is requested. The notice shall contain a statement of the objections to the issuance of the license, or the reason for its proposed revocation or suspension as the case may be. The notice may be given to the applicant or licensee by registered or certified mail, sent to the last known address of record pursuant to § 38.2-1357, or the last known business address if the address of record is incorrect, or in any other lawful manner the Commission prescribes. The Commission may summon witnesses to testify with respect to the applicant or licensee, and the applicant or licensee may introduce evidence in his or its behalf. No applicant to whom a license is refused after a hearing, nor any licensee whose license is revoked, shall again apply for a license until the expiration of a period of five years from the date of the Commission's order, or such other period of time as the Commission prescribes in its order.

D. Nothing contained in this article is intended to or shall in any manner limit or restrict the rights of policyholders, claimants, creditors or other third parties or confer any rights to such persons.

E. If an order of rehabilitation or liquidation of the insurer has been entered pursuant to Chapter 15 (§ 38.2-1500 et seq.) of this title or the rehabilitation and liquidation statutes of a reciprocal state, and the receiver appointed under that order determines that the reinsurance intermediary or any other person

has not materially complied with the provisions of this article, or any rule, regulation or order promulgated thereunder, and the insurer suffered any loss or damage therefrom, the receiver may maintain a civil action for recovery of damages or other appropriate sanctions for the benefit of the insurer.

2001, c. 706; 2006, c. 762.

§ 38.2-1357. Requirement to report to Commission.

A. Each licensed reinsurance intermediary shall report any change in business or residence address or name within thirty calendar days to the Commission and to any contracted insurer.

B. In addition to the requirements of §§ 59.1-69 and 59.1-70, any individual or business entity licensed as a reinsurance intermediary in this Commonwealth and operating under an assumed or fictitious name shall notify the Commission, at the earlier of the time the application for a reinsurance intermediary license is filed or within thirty calendar days from the date the assumed or fictitious name is adopted, setting forth the name under which the reinsurance intermediary intends to operate in Virginia. The Commission shall also be notified within thirty calendar days from the date of cessation of the use of such assumed or fictitious name.

C. Each licensed reinsurance intermediary convicted of a felony shall report within thirty calendar days to the Commission the facts and circumstances regarding the criminal conviction.

2001, c. 706.

Article 9 - LICENSING OF MANAGING GENERAL AGENTS

§ 38.2-1358. Definitions.

As used in this article:

"Actuary" means a person who is a member in good standing of the American Academy of Actuaries.

"Business entity" means a partnership, limited partnership, limited liability company, corporation, or other legal entity that is entitled to hold property in its own name and which is not a sole proprietorship.

"Insurer" means any person, duly licensed in the Commonwealth pursuant to Chapters 10 (§ 38.2-1000 et seq.), 11 (§ 38.2-1100 et seq.), 12 (§ 38.2-1200 et seq.), 25 (§ 38.2-2500 et seq.), 26 (§ 38.2-2600 et seq.), 38 (§ 38.2-3800 et seq.) through 46 (§ 38.2-4600 et seq.), or 51 (§ 38.2-5100 et seq.) of this title.

"Managing general agent" means any person who manages all or part of the insurance business of an insurer, including the management of a separate division, department or underwriting office; and who acts as an agent for such insurer whether known as a managing general agent, manager or other similar term, who, with or without the authority, either separately or together with affiliates, produces, directly or indirectly, and underwrites an amount of gross direct written premium equal to or exceeding five percent of the surplus to policyholders of the insurer as reported in the last annual statement of the insurer in any one quarter or year together with one or more of the following: (i) adjusts or pays claims

in excess of an amount determined by the Commission or (ii) negotiates reinsurance on behalf of the insurer.

Notwithstanding the above, the following persons shall not be considered as managing general agents for the purposes of this article:

1. An employee of the insurer;

2. A United States manager of the United States branch of an alien insurer;

3. An underwriting manager who, pursuant to contract, manages all or part of the insurance operations of the insurer, is under common control with the insurer, subject to Article 5 (§ 38.2-1322 et seq.) of this chapter or Article 2 (§ 38.2-4230 et seq.) of Chapter 42 of this title, and whose compensation is not based on the volume of premiums written; or

4. The attorney-in-fact authorized by and acting for the subscribers of a reciprocal insurer.

"Qualified United States financial institution" means an institution that:

1. Is organized or, in the case of a United States office of a foreign banking organization, licensed, under the laws of the United States or any state thereof;

2. Is regulated, supervised and examined by United States federal or state authorities having regulatory authority over banks and trust companies; and

3. Has been determined by either the Commission, or the Securities Valuation Office of the National Association of Insurance Commissioners, to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the Commission.

"Underwrite" means the authority to accept or reject risk on behalf of the insurer.

2001, c. 706.

§ 38.2-1359. Licensure.

A. No domestic insurer shall permit a person to act, and no person shall act, in the capacity of a managing general agent for an insurer domiciled in this Commonwealth unless such person is licensed in this Commonwealth to act as a managing general agent.

B. No foreign or alien insurer shall permit a person to act, and no person shall act, in the capacity of a managing general agent representing such an insurer unless such person is licensed (i) in this Commonwealth to act as a managing general agent or (ii) in another state under laws that are substantially similar to the provisions of this article.

C. The Commission may license as a managing general agent any individual or business entity that has complied with the requirements of this article and any regulations concerning licensure that may be promulgated by the Commission. The Commission may refuse to issue a license, subject to the right of the applicant to demand a hearing on the application, if the Commission believes the

applicant, any person named on the application, or any member, principal, officer or director of the applicant is not trustworthy to act as a managing general agent, or that any of the foregoing has given cause for revocation or suspension of such license, or has failed to comply with any prerequisite for issuance of such license.

D. Any person seeking a license pursuant to subsection A or clause (i) of subsection B of this section shall apply for such license in a form acceptable to the Commission, and shall pay to the Commission a nonrefundable application fee in an amount prescribed by the Commission. Such fee shall be not less than $500 and not more than $1,000. Every licensed managing general agent shall pay to the Commission a nonrefundable biennial renewal fee in an amount prescribed by the Commission. Such fee shall be not less than $500 and not more than $1,000. Between May 1 and June 1 of the renewal year, each licensed managing general agent shall submit to the Commission a renewal application form and fee in the manner and form prescribed by the Commission. All fees shall be collected by the Commission, paid into the state treasury, and placed to the credit of the fund for maintenance of the Bureau of Insurance as provided in subsection B of § 38.2-400. Each license and renewed license shall expire on June 30 of the appropriate year.

E. The Commission may require that the managing general agent be bonded in a manner acceptable to the Commission for the protection of the insurer, and shall require, as a prerequisite to licensure or license renewal, a certification or attestation from the applicant that such bond is in effect.

F. The Commission may require a managing general agent to maintain an errors and omissions policy that is acceptable to the Commission, and shall require, as a prerequisite to licensure or license renewal, a certification or attestation from the applicant that such policy is in effect.

G. Except where prohibited by state or federal law, by submitting an application for license, the applicant shall be deemed to have appointed the clerk of the Commission as the agent for service of process on the applicant in any action or proceeding arising in this Commonwealth out of or in connection with the exercise of the license. Such appointment of the clerk of the Commission as agent for service of process shall be irrevocable during the period within which a cause of action against the applicant may arise out of transactions with respect to subjects of insurance in this Commonwealth. Service of process on the clerk of the Commission shall conform to the provisions of Chapter 8 (§ 38.2-800 et seq.) of this title.

H. A person seeking licensure shall provide evidence, in a form acceptable to the Commission, of its appointments or contracts as a managing general agent. The Commission may refuse to renew the license of a person that has not been appointed by, or otherwise authorized to act for, an insurer as a managing general agent.

2001, c. 706.

§ 38.2-1360. Required contract provisions.

No insurer shall retain or act through a managing general agent unless there is in force a written contract between said insurer and its managing general agent that sets forth the responsibilities of each

party and where both parties share responsibility for a particular function, specifies the division of such responsibilities, and that contains the following minimum provisions:

1. The insurer may terminate the contract for cause upon written notice to the managing general agent. The insurer may suspend the underwriting authority of the managing general agent during the pendency of any dispute regarding the cause for termination.

2. The managing general agent will render accounts to the insurer detailing all transactions and remit all funds due under the contract to the insurer on not less than a monthly basis.

3. All funds collected for the account of an insurer will be held by the managing general agent in a fiduciary capacity in a bank that is a qualified United States financial institution. This account shall be used for all payments on behalf of the insurer. The managing general agent may retain no more than three months' estimated claims payments and allocated loss adjustment expenses. The managing general agent shall maintain a separate bank account for each insurer it represents.

4. Separate records of business written by the managing general agent will be maintained. The insurer shall have reasonable access to and the right to copy all accounts and records related to its business in a form usable by the insurer, and the Commission shall have access to all books, bank accounts and records of the managing general agent in a form usable by the Commission. Such records shall be retained in order to accomplish the purpose of subdivision 9 of this section but in no case for a period of less than five years.

5. The contract may not be assigned in whole or part by the managing general agent.

6. Appropriate underwriting guidelines including:

a. The maximum annual premium volume;

b. The basis of the rates to be charged;

c. The types of risks that may be written;

d. Maximum limits of liability;

e. Applicable exclusions;

f. Territorial limitations;

g. Policy cancellation provisions; and

h. The maximum policy period.

The insurer shall have the right to cancel or nonrenew any policy of insurance subject to the applicable laws and regulations.

7. If the contract permits the managing general agent to settle claims on behalf of the insurer:

a. All claims must be reported to the insurer in a timely manner.

b. A copy of the claim file will be sent to the insurer at its request or as soon as it becomes known that the claim:

(1) Has the potential to exceed one percent of the insurer's surplus to policyholders as of December 31 of the last completed calendar year, an amount set by the company, or any other amount deemed appropriate by the Commission, whichever is less;

(2) Involves a coverage dispute;

(3) May exceed the managing general agent's claims settlement authority;

(4) Is open for more than six months; or

(5) Is closed by payment of an amount exceeding one percent of the insurer's surplus to policyholders as of December 31 of the last completed calendar year, an amount set by the company, or any other amount deemed appropriate by the Commission, whichever is less.

c. All claim files will be the joint property of the insurer and the managing general agent. However, upon entry of an order of liquidation or the appointment of a receiver for the liquidation of an insurer, such files shall become the sole property of the insurer or its estate; the managing general agent shall have reasonable access to and the right to copy the files on a timely basis.

d. Any settlement authority granted to the managing general agent may be terminated for cause upon the insurer's written notice to the managing general agent or upon the termination of the contract. The insurer may suspend the settlement authority during the pendency of any dispute regarding the cause for termination.

8. Where electronic claims files are in existence, the contract must address the timely transmission of the data.

9. If the contract provides for a sharing of interim profits by the managing general agent, and the managing general agent has the authority to determine the amount of the interim profits by establishing loss reserves or controlling claim payments, or in any other manner, interim profits will not be paid to the managing general agent until the profits have been verified pursuant to subsection B of § 38.2-1361 (i) one year after they are earned for property insurance business and health insurance business and (ii) five years after they are earned on casualty insurance business.

10. The managing general agent shall not:

a. Bind reinsurance contracts or similar risk sharing arrangements, except that a managing general agent who acts on behalf of a ceding insurer may bind facultative reinsurance contracts by placing individual risks pursuant to obligatory facultative agreements provided that the contract between the insurer and the managing general agent contains reinsurance underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with which such automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured and commission schedules;

b. Commit the insurer to participate in insurance or reinsurance syndicates;

c. Appoint any agent unless (i) the agent is lawfully licensed to transact the type of insurance for which he is appointed and (ii) the insurer has notified the Commission of the managing general agent's authorization to appoint agents on its behalf;

d. Without prior approval of the insurer, pay or commit the insurer to pay a claim over a specified amount, net of reinsurance, which amount shall not exceed one percent of the insurer's surplus to policyholders as of December 31 of the last completed calendar year;

e. Collect any payment from a reinsurer or commit the insurer to any claim settlement with a reinsurer, without prior approval of the insurer. If prior approval is given, a report must be promptly forwarded to the insurer;

f. Permit any agent appointed by the managing general agent to serve on the insurer's board of directors;

g. Jointly employ an individual who is employed with the insurer; or

h. Utilize or engage a submanaging general agent.

2001, c. 706.

§ 38.2-1361. Duties of insurers utilizing managing general agents.

A. The insurer shall annually obtain a copy of the current financial statement, which shall be certified by an independent public accountant and in a form acceptable to the Commission, of each managing general agent with which it transacts business.

B. If the managing general agent establishes loss reserves, the insurer shall annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the managing general agent. This is in addition to any other required loss reserve certification.

C. The insurer shall conduct, at least semiannually, an on-site review of the underwriting and claims processing operations of the managing general agent.

D. Binding authority for participation in insurance syndicates or reinsurance syndicates shall rest with an officer of the insurer, who shall not be affiliated with the managing general agent.

E. At least annually and more frequently if requested by the Commission, the insurer shall report to the Commission, in a form acceptable to the Commission, concerning its transactions with a managing general agent. The report shall identify the managing general agent through which the insurer has transacted business, and for each managing general agent shall report the nature of the contract, the types of authority granted, the types of business written, the amount of premium written, and any other information the Commission may request.

F. An insurer shall review its books and records each quarter to determine if any agent as defined by § 38.2-1800 has become a managing general agent as defined in § 38.2-1358. If the insurer determines

that an agent has become a managing general agent pursuant to the above, the insurer shall promptly notify the agent and the Commission of such determination, and the insurer and agent must fully comply with the provisions of this article within thirty calendar days.

G. An insurer shall not appoint to its board of directors an officer, director, employee, agent or controlling shareholder of its managing general agent. This subsection shall not apply to relationships governed by Article 5 (§ 38.2-1322 et seq.) of this chapter or Article 2 (§ 38.2-4230 et seq.) of Chapter 42 of this title.

H. The insurer shall not delegate to any person, other than one of its officers, the authority to enter into or bind any reinsurance agreement by which the insurer agrees to cede any risk to a reinsurer, except that an insurer may delegate the specific authority to bind facultative reinsurance contracts by placing individual risks pursuant to the provisions of subdivision 1 of § 38.2-1353 or subdivision 10 of § 38.2-1360. The officer shall be a regular salaried employee of the insurer and shall not be affiliated with the managing general agent. The insurer is not prohibited by the provisions of this subsection from delegating to its managing general agent the authority to enter into or bind an agreement to assume a risk provided the managing general agent is licensed to act as a reinsurance intermediary manager under the provisions of Article 8 (§ 38.2-1347 et seq.) of this chapter and the authority to both cede and assume a given risk is not simultaneously vested in the same intermediary.

2001, c. 706.

§ 38.2-1362. Examination authority.

The acts of a managing general agent are considered to be the acts of the insurer on whose behalf it is acting. A managing general agent may be examined pursuant to Article 4 (§ 38.2-1317 et seq.) of this chapter as if it were the insurer. In addition, the managing general agent shall be subject to examination pursuant to § 38.2-1809 if it or any of its officers, directors, agents, or employees is licensed as a producer under Chapter 18 (§ 38.2-1800 et seq.) of this title.

2001, c. 706.

§ 38.2-1363. Penalties and liabilities; grounds for placing on probation, refusal to issue or renew, revocation, or suspension of license.

A. If the Commission finds, after providing an opportunity to be heard, that any person under its jurisdiction has violated any provision of this article, the Commission may, in addition to any other remedies authorized by this title, order the managing general agent to reimburse the insurer, the rehabilitator or liquidator, or the receiver of the insurer for any losses incurred by the insurer caused by a violation of this article committed by the managing general agent.

B. The Commission may, in addition to or in lieu of a penalty imposed under § 38.2-218, place on probation, suspend, revoke or refuse to issue or renew any person's license as a managing general agent for any one or more of the following causes:

1. Providing materially incorrect, misleading, incomplete or untrue information in the license application or any other document filed with the Commission;

2. Violating any insurance laws or violating any regulation, subpoena, or order of the Commission or of another state's insurance regulatory authority;

3. Obtaining or attempting to obtain a license through misrepresentation or fraud;

4. Improperly withholding, misappropriating, or converting any moneys or properties received in the course of doing business;

5. Engaging in the practice of rebating;

6. Engaging in twisting or any form thereof, where "twisting" means inducing an insured to terminate an existing policy and purchase a new policy through misrepresentation;

7. Intentionally misrepresenting the terms of an actual or proposed insurance contract;

8. Having been convicted of a felony;

9. Having admitted or been found to have committed any insurance unfair trade practice or fraud;

10. Using fraudulent, coercive, or dishonest practices, or demonstrating incompetence, or untrustworthiness in the conduct of business in this Commonwealth or elsewhere, or demonstrating financial irresponsibility in the handling of applicant, policyholder, agency, or insurance company funds;

11. Having an insurance producer license, or its equivalent, denied, suspended or revoked in any other state, province, or territory;

12. Forging another's name to an application for insurance or reinsurance, or to any document related to an insurance transaction;

13. Knowingly accepting insurance business from an individual who is not licensed;

14. Failing to comply with an administrative or court order imposing a child support obligation;

15. Failing to pay state income tax or comply with any administrative or court order directing payment of state income tax; or

16. If the managing general agent is a business entity, having its corporate existence terminated, its certificate of organization, trust, limited liability company, or limited partnership canceled, or its certificate of authority or registration to transact business in the Commonwealth revoked or canceled, as the case may be.

C. If the Commission believes that any applicant for a managing general agent's license is not of good character or does not have a good reputation for honesty, it may refuse to issue the license, subject to the right of the applicant to demand a hearing on the application. The Commission shall not revoke or suspend an existing license until the licensee is given an opportunity to be heard before the Commission. If the Commission refuses to issue a new license or proposes to revoke or suspend an existing license, it shall give the applicant or licensee at least 10 calendar days' notice in writing of the time and place of the hearing, if a hearing is requested. The notice shall contain a statement of the objections to the issuance of the license, or the reason for its proposed revocation or suspension as the

case may be. The notice may be given to the applicant or licensee by registered or certified mail, sent to the last known address of record pursuant to § 38.2-1364, or the last known business address if the address of record is incorrect, or in any other lawful manner the Commission prescribes. The Commission may summon witnesses to testify with respect to the applicant or licensee, and the applicant or licensee may introduce evidence in his or its behalf. No applicant to whom a license is refused after a hearing, nor any licensee whose license is revoked, shall again apply for a license until after the expiration of a period of five years from the date of the Commission's order, or such other period of time as the Commission prescribes in its order.

D. Nothing contained in this article is intended to or shall in any manner limit or restrict the rights of policyholders, claimants, and auditors.

E. If an order of rehabilitation or liquidation of the insurer has been entered pursuant to Chapter 15 (§ 38.2-1500 et seq.) of this title or the rehabilitation and liquidation statutes of a reciprocal state, and the receiver appointed under that order determines that the managing general agent or any other person has not materially complied with the provisions of this article, or any rule, regulation or order promulgated thereunder, and the insurer suffered any loss or damage therefrom, the receiver may maintain a civil action for recovery of damages or other appropriate sanctions for the benefit of the insurer.

2001, c. 706; 2006, c. 762.

§ 38.2-1364. Requirement to report to Commission.

A. Each licensed managing general agent shall report within thirty calendar days to the Commission and to any contracted insurer any change in business or residence address or name.

B. In addition to the requirements of §§ 59.1-69 and 59.1-70, any individual or business entity licensed as a managing general agent in this Commonwealth and operating under an assumed or fictitious name shall notify the Commission, at the earlier of the time the application for a managing general agent license is filed or within thirty calendar days from the date the assumed or fictitious name is adopted, setting forth the name under which the managing general agent intends to operate in Virginia. The Commission shall also be notified within thirty calendar days from the date of cessation of the use of such assumed or fictitious name.

C. Each licensed managing general agent convicted of a felony shall report within thirty calendar days to the Commission the facts and circumstances regarding the criminal conviction.

2001, c. 706.

Article 10 - STANDARD VALUATION

§ 38.2-1365. Definitions.

As used in this article, unless the context requires a different meaning:

"Accident and health insurance" means contracts that incorporate morbidity risk and provide protection against economic loss resulting from accident, sickness, or medical conditions and as may be specified in the valuation manual.

"Appointed actuary" means a qualified actuary who is appointed in accordance with the valuation manual to prepare the actuarial opinion required in subsection B of § 38.2-1367.

"Deposit-type contract" means contracts that do not incorporate mortality or morbidity risks and as may be specified in the valuation manual.

"Insurance company" or "insurer" means an entity that (i) has written, issued, or reinsured life insurance contracts, accident and health insurance contracts, or deposit-type contracts in the Commonwealth and has at least one such policy in force or on claim or (ii) has written, issued, or reinsured life insurance contracts, accident and health insurance contracts, or deposit-type contracts in any state and is required to hold a certificate of authority to write life insurance, accident and health insurance, or deposit-type contracts in the Commonwealth.

"Life insurance" means contracts that incorporate mortality risk, including annuity and pure endowment contracts, and as may be specified in the valuation manual.

"NAIC" means the National Association of Insurance Commissioners.

"Policyholder behavior" means any action a policyholder, contract holder or any other person with the right to elect options, such as a certificate holder, may take under a policy or contract subject to this article, including, but not limited to, lapse, withdrawal, transfer, deposit, premium payment, loan, annuitization, or benefit elections prescribed by the policy or contract but excluding events of mortality or morbidity that result in benefits prescribed in their essential aspects by the terms of the policy or contract.

"Principle-based valuation" means a reserve valuation that uses one or more methods or one or more assumptions determined by the insurer and is required to comply with § 38.2-1380 as specified in the valuation manual.

"Qualified actuary" means an individual who is qualified to sign the applicable statement of actuarial opinion in accordance with the American Academy of Actuaries qualification standards for actuaries signing such statements and who meets the requirements specified in the valuation manual.

"Tail risk" means a risk that occurs either where the frequency of low probability events is higher than expected under a normal probability distribution or where there are observed events of very significant size or magnitude.

"Valuation manual" means the manual of valuation instructions adopted by the NAIC as specified in this article or as subsequently amended.

2014, c. 571.

§ 38.2-1366. Reserve valuation.

A. For policies and contracts issued prior to the operative date of the valuation manual:

1. The Commission shall annually value, or cause to be valued, the reserve liabilities (hereinafter called reserves) for all outstanding life insurance policies and annuity and pure endowment contracts

of every life insurance company doing business in the Commonwealth issued prior to the operative date of the valuation manual. In calculating reserves, the Commission may use group methods and approximate averages for fractions of a year or otherwise. In lieu of the valuation of the reserves required of a foreign or alien company, the Commission may accept a valuation made, or caused to be made, by the insurance supervisory official of any state or other jurisdiction when the valuation complies with the minimum standard provided in this article.

2. The provisions set forth in §§ 38.2-1368 through 38.2-1378 shall apply to all policies and contracts, as appropriate, subject to this article issued prior to the operative date of the valuation manual and the provisions set forth in §§ 38.2-1379 and 38.2-1380 shall not apply to any such policies and contracts.

B. For policies and contracts issued on or after the operative date of the valuation manual:

1. The Commission shall annually value, or cause to be valued, the reserve liabilities (hereinafter called reserves) for all outstanding life insurance contracts, annuity and pure endowment contracts, accident and health contracts, and deposit-type contracts of every insurance company issued on or after the operative date of the valuation manual. In lieu of the valuation of the reserves required of a foreign or alien company, the Commission may accept a valuation made, or caused to be made, by the insurance supervisory official of any state or other jurisdiction when the valuation complies with the minimum standard provided in this article.

2. The provisions set forth in §§ 38.2-1379 and 38.2-1380 shall apply to all policies and contracts issued on or after the operative date of the valuation manual.

C. On or before the last day of February of each year, every domestic incorporated life insurer shall furnish the Commission the necessary data for determining the valuation of all of its policies outstanding on the last preceding December 31. For good cause shown, the Commission may extend an insurer's deadline for submitting this data.

2014, c. 571.

§ 38.2-1367. Actuarial opinion of reserves.

A. The actuarial opinion prior to the operative date of the valuation manual shall require:

1. Every life insurance company doing business in the Commonwealth to annually submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the Commission by regulation are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts, and comply with applicable laws of the Commonwealth. The Commission shall define by regulation the specifics of this opinion and add any other items deemed to be necessary to its scope.

2. Every life insurance company, except as exempted by regulation, to annually include in the opinion required by subdivision 1, an opinion of the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the Commission by regulation, when considered in light of the assets held by the insurer with respect to the reserves and

related actuarial items, including but not limited to the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the insurer's obligations under the policies and contracts, including but not limited to the benefits under and expenses associated with the policies and contracts. The Commission shall specify by regulation the types of reserves and related actuarial items on which the opinion is to be expressed.

The Commission may provide by regulation for a transition period for establishing any higher reserves that the qualified actuary may deem necessary in order to render the opinion required by this section.

3. Each opinion required by subdivision 2 to be governed by the following provisions:

a. A memorandum, in form and substance acceptable to the Commission as specified by regulation, shall be prepared to support each actuarial opinion; and

b. If the insurance company fails to provide a supporting memorandum at the request of the Commission within a period specified by regulation or the Commission determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the regulations or is otherwise unacceptable to the Commission, the Commission may engage a qualified actuary at the expense of the insurance company to review the opinion and the basis for the opinion and prepare the supporting memorandum required by the Commission.

4. Every opinion required by this subsection to be governed by the following provisions:

a. The opinion shall be submitted with the annual statement filed pursuant to § 38.2-1300 and shall reflect the valuation of such reserve liabilities for each year ending on or after December 31, 1992.

b. The opinion shall apply to all business in force including individual and group health insurance plans, in form and substance acceptable to the Commission as specified by regulation.

c. The opinion shall be based on standards adopted from time to time by the Actuarial Standards Board and on such additional standards as the Commission may by regulation prescribe.

d. In the case of an opinion required to be submitted by a foreign or alien insurer, the Commission may accept the opinion filed by that insurer with the insurance supervisory official of another state if the Commission determines that the opinion reasonably meets the requirements applicable to an insurer domiciled in the Commonwealth.

e. For the purposes of this section, "qualified actuary" means a member in good standing of the American Academy of Actuaries who meets the requirements set forth in regulations adopted by the Commission.

f. Except in cases of fraud or willful misconduct, the qualified actuary shall not be liable for damages to any person, other than the insurer and the Commission, for any act, error, omission, decision, or conduct with respect to the actuary's opinion.

g. Disciplinary action by the Commission against the insurer or the qualified actuary shall be defined in regulations adopted by the Commission.

h. Except as provided in subdivisions 4 l, m, and n, documents, materials, or other information in the possession or control of the Commission that is a memorandum in support of the opinion, and any other material provided by the insurer to the Commission in connection with the memorandum, shall be confidential by law and privileged, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the Commission is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the Commission's official duties.

i. Neither the Commission nor any person who received documents, materials, or other information while acting under the authority of the Commission shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subdivision 4 h.

j. In order to assist in the performance of the Commission's duties, the Commission:

(1) May share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to subdivision 4 h, with other state, federal, and international regulatory agencies, with the NAIC and its affiliates and subsidiaries, and with state, federal, and international law-enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material, or other information;

(2) May receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information, from the NAIC and its affiliates and subsidiaries, and from regulatory and law-enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information; and

(3) May enter into agreements governing sharing and use of information consistent with subdivisions 4 h, i, and j.

k. No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the Commission under this section or as a result of sharing as authorized in subdivision 4 j.

l. A memorandum in support of the opinion, and any other material provided by the insurer to the Commission in connection with the memorandum, may be subject to subpoena for the purpose of defending an action seeking damages from the actuary submitting the memorandum by reason of an action required by this section or by regulations adopted hereunder.

m. The memorandum or other material may otherwise be released by the Commission with the written consent of the insurer or to the American Academy of Actuaries upon request stating that the

memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the Commission for preserving the confidentiality of the memorandum or other material.

n. Once any portion of the confidential memorandum is cited by the insurer in its marketing, is cited before a governmental agency other than a state insurance department, or is released by the insurer to the news media, all portions of the confidential memorandum shall be no longer confidential.

B. The actuarial opinion of reserves after the operative date of the valuation manual shall require:

1. Every insurer with outstanding life insurance contracts, accident and health insurance contracts, or deposit-type contracts in the Commonwealth and subject to regulation by the Commission to annually submit the opinion of the appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts, and comply with applicable laws of the Commonwealth. The valuation manual will prescribe the specifics of this opinion, including any items deemed to be necessary to its scope.

2. Every insurer with outstanding life insurance contracts, accident and health insurance contracts, or deposit-type contracts in the Commonwealth and subject to regulation by the Commission, except as exempted in the valuation manual, to annually include in the opinion required by subdivision 1 an opinion of the same appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified in the valuation manual, when considered in light of the assets held by the insurer with respect to the reserves and related actuarial items, including but not limited to the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the insurer's obligations under the policies and contracts, including but not limited to the benefits under and expenses associated with the policies and contracts.

3. Each opinion required by subdivision 2 to be governed by the following provisions:

a. A memorandum, in form and substance as specified in the valuation manual, and acceptable to the Commission, shall be prepared to support each actuarial opinion.

b. If the insurance company fails to provide a supporting memorandum at the request of the Commission within a period specified in the valuation manual or the Commission determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the valuation manual or is otherwise unacceptable to the Commission, the Commission may engage a qualified actuary at the expense of the insurer to review the opinion and the basis for the opinion and prepare the supporting memorandum required by the Commission.

4. Every opinion required by this subsection to be governed by the following provisions:

a. The opinion shall be in form and substance as specified in the valuation manual and acceptable to the Commission;

b. The opinion shall be submitted with the annual statement reflecting the valuation of such reserve liabilities for each year ending on or after the operative date of the valuation manual;

c. The opinion shall apply to all policies and contracts subject to subdivision 2, plus other actuarial liabilities as may be specified in the valuation manual;

d. The opinion shall be based on standards adopted from time to time by the Actuarial Standards Board or its successor, and on such additional standards as may be prescribed in the valuation manual;

e. In the case of an opinion required to be submitted by a foreign or alien insurer, the Commission may accept the opinion filed by that insurer with the insurance supervisory official of another state if the Commission determines that the opinion reasonably meets the requirements applicable to an insurer domiciled in the Commonwealth;

f. Except in cases of fraud or willful misconduct, the appointed actuary shall not be liable for damages to any person, other than the insurance company and the Commission, for any act, error, omission, decision, or conduct with respect to the appointed actuary's opinion; and

g. Disciplinary action by the Commission against the insurer or the appointed actuary shall be defined in regulations adopted by the Commission.

2014, c. 571.

§ 38.2-1368. Minimum valuation standard for policies issued prior to certain dates.

The following provisions of this section shall apply only to those policies and contracts issued prior to the operative date stated in § 38.2-3214:

1. The legal minimum standard for the valuation of life insurance contracts issued prior to January 1, 1937, shall be on the basis of the American Experience Table of Mortality, with interest at four percent per year, and strictly in accordance with the terms and conditions of such contracts, and for life insurance contracts issued on and after that date shall be the one-year preliminary term method of valuation, as hereinafter modified, on the basis of the American Experience Table of Mortality or, at the option of the insurer, the American Men Ultimate Table of Mortality with interest at three and one-half percent per year.

2. If the net renewal premium under a limited payment life preliminary term policy providing for the payment of less than 20 annual premiums under the policy, or under an endowment preliminary term policy, exceeds that under a 20-payment life preliminary term policy, the reserve for that policy at the end of any year, including the first, shall be at least the reserve on a 20-payment life preliminary term policy issued in the same year and at the same age, together with an amount equivalent to the accumulation of a net level premium sufficient to provide for a pure endowment maturing one year after the date on which the last annual premium is due, or at the end of 20 years if the policy provides for the payment of premiums for more than 20 years, equal to the difference between the value on the maturity date of a 20-payment life preliminary term policy and the full net level premium reserve at such time

of such a limited payment life or endowment policy. Policies valued by the above method shall contain a clause specifying either that the reserve of the policies shall be computed in accordance with the 20-payment life modification of the preliminary term method of valuation or that the first year's insurance is term insurance.

3. Except as otherwise provided in § 38.2-1370 for group annuity and pure endowment contracts, the legal minimum standard for the valuation of annuities issued on and after January 1, 1937, shall be the Combined Annuity Table, with interest at four percent per year, but annuities deferred 10 or more years and written in connection with life insurance shall be valued on the same basis as that used in computing the consideration or premium for the life insurance, or upon any higher standard, at the insurer's option.

4. The legal minimum standard for the calculation of the reserve liability for insurance against disability incorporated in life insurance policies issued on and after January 1, 1937, shall be on the basis of any table adopted by the insurer and approved by the Commission, with interest at three and one-half percent per year. However, in no case shall such liability be less than one-half of the net annual premium for the disability benefit computed by the table.

5. The legal standard for the valuation of group insurance written as yearly renewable term insurance issued on and after January 1, 1937, shall be on the basis of the American Men Ultimate Table of Mortality with interest at three and one-half percent per year.

6. The legal minimum standard for the valuation of industrial policies issued on and after January 1, 1937, shall be the American Experience Table of Mortality, with interest at three and one-half percent per year; however, any insurer may voluntarily value its industrial policies on the basis of the standard industrial mortality table or the substandard industrial mortality table, and by the level net premium method or in accordance with their terms by the modified preliminary term method as described in subdivision 2, or the full preliminary term method.

All industrial policies issued on and after January 1, 1937, shall be valued under the rules set forth in this section, whether or not the policies provide for surrender values, either in cash, paid-up insurance, or extended insurance.

7. The Commission may vary the standards of interest and mortality in the case of alien insurers as to contracts issued by those insurers in countries other than the United States, and in particular cases of invalid lives and other extra hazards.

8. If the actual annual premium charged for insurance is less than the net annual premium for the insurance, computed as specified in this section, the insurer shall set up an additional reserve equal to the value of an annuity of the difference between the actual premium charged and the net premium required by this section, and the term of which at the date of the valuation shall equal the period during which future premium payments are to become due on the insurance. The annuity shall be valued according to the table of mortality with the rate of interest at which the net annual premium is calculated.

9. Reserves for all of these policies and contracts, or all of any class of these policies and contracts, may be calculated, at the insurer's option, according to any standards that produce greater aggregate reserves for all the policies and contracts, or all of the class of the policies and contracts so valued, than the minimum reserves required by this section; and in each case the insurer shall report to the Commission in its annual statement the standards it used in making the valuation.

2014, c. 571.

§ 38.2-1369. Computation of minimum standard.

Except as otherwise provided in §§ 38.2-1370, 38.2-1371, and 38.2-1378, the minimum standard for the valuation of all policies and contracts issued on or after the operative date stated in § 38.2-3214 shall be the Commissioners reserve valuation methods defined in §§ 38.2-1372, 38.2-1373, 38.2-1376, and 38.2-1378, three and one-half percent interest, or in the case of life insurance policies and contracts, other than annuity and pure endowment contracts, issued on or after July 1, 1975, four percent interest for policies issued prior to July 1, 1979, five and one-half percent interest for single premium life insurance policies and four and one-half percent interest for all other policies issued on and after July 1, 1979, and the following tables:

1. For ordinary policies of life insurance issued on the standard basis, excluding any disability and accidental death benefits in the policies: The Commissioners 1941 Standard Ordinary Mortality Table for policies issued prior to the operative date of § 38.2-3215; the Commissioners 1958 Standard Ordinary Mortality Table for policies issued on or after the operative date of § 38.2-3215 and prior to the operative date of § 38.2-3209, provided that for any category of policies issued on female risks, all modified net premiums and present values referred to in this article may be calculated according to an age not more than six years younger than the actual age of the insured; and for policies issued on or after the operative date of § 38.2-3209:

a. The Commissioners 1980 Standard Ordinary Mortality Table;

b. At the election of the insurer for any one or more specified plans of life insurance, the Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors; or

c. Any ordinary mortality table, adopted after 1980 by the NAIC, that is approved by regulation adopted by the Commission for use in determining the minimum standard of valuation for those policies;

2. For industrial life insurance policies issued on the standard basis, excluding any disability and accidental death benefits in those policies: The 1941 Standard Industrial Mortality Table for policies issued prior to the operative date of § 38.2-3216, and for policies issued on or after the operative date of § 38.2-3216, the Commissioners 1961 Standard Industrial Mortality Table or any industrial mortality table adopted after 1980 by the NAIC and approved by regulation adopted by the Commission for use in determining the minimum standard of valuation for the policies;

3. For individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in those contracts: The 1937 Standard Annuity Mortality Table or, at the insurer's option, the

Annuity Mortality Table for 1949 Ultimate, or any modification of either of these tables approved by the Commission;

4. For group annuity and pure endowment contracts, excluding any disability and accidental death benefits in those contracts: The Group Annuity Mortality Table for 1951, any modification of that table approved by the Commission, or, at the insurer's option, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts;

5. For total and permanent disability benefits in or supplementary to ordinary policies or contracts: For policies or contracts issued on or after January 1, 1966, the tables of Period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 Disability Study of the Society of Actuaries, with due regard to the type of benefit or any tables of disablement rates and termination rates adopted after 1980 by the NAIC, and approved by regulation adopted by the Commission for use in determining the minimum standard of valuation for those policies; for policies or contracts issued on or after January 1, 1961, and prior to January 1, 1966, either those tables or, at the insurer's option, the Class (3) Disability Table (1926); and for policies issued prior to January 1, 1961, the Class (3) Disability Table (1926). Any such table shall, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance policies;

6. For accidental death benefits in or supplementary to policies issued on or after January 1, 1966: The 1959 Accidental Death Benefits Table or any accidental death benefits table adopted after 1980 by the NAIC and approved by regulation adopted by the Commission for use in determining the minimum standard of valuation for those policies; for policies issued on or after January 1, 1961, and prior to January 1, 1966, either that table or, at the insurer's option, the Inter-Company Double Indemnity Mortality Table; and for policies issued prior to January 1, 1961, the Inter-Company Double Indemnity Mortality Table. Either table shall be combined with a mortality table for calculating the reserves for life insurance policies; and

7. For group life insurance, life insurance issued on the substandard basis, and other special benefits: Any table approved by the Commission.

2014, c. 571.

§ 38.2-1370. Computation of minimum standard for annuities.

A. Except as provided in § 38.2-1371, the minimum standard of valuation for individual annuity and pure endowment contracts issued on or after the operative date of this section and for annuities and pure endowments purchased on or after the operative date under group annuity and pure endowment contracts shall be the Commissioners reserve valuation methods defined in §§ 38.2-1372 and 38.2-1373 and the following tables and interest rates:

1. For individual annuity and pure endowment contracts issued prior to July 1, 1979, excluding any disability and accidental death benefits in those contracts: The 1971 Individual Annuity Mortality Table, or any modification of that table approved by the Commission, and six percent interest for single

premium immediate annuity contracts and four percent interest for all other individual annuity and pure endowment contracts;

2. For individual single premium immediate annuity contracts issued on or after July 1, 1979, excluding any disability and accidental death benefits in those contracts: The 1971 Individual Annuity Mortality Table or any individual annuity mortality table adopted after 1980 by the NAIC and approved by regulation adopted by the Commission for use in determining the minimum standard of valuation for these contracts, or any modification of those tables approved by the Commission, and seven and one-half percent interest;

3. For individual annuity and pure endowment contracts issued on or after July 1, 1979, other than single premium immediate annuity contracts, excluding any disability and accidental death benefits in those contracts: The 1971 Individual Annuity Mortality Table or any individual annuity mortality table adopted after 1980 by the NAIC and approved by regulation adopted by the Commission for use in determining the minimum standard of valuation for those contracts, or any modification of those tables approved by the Commission, and five and one-half percent interest for single premium deferred annuity and pure endowment contracts and four and one-half percent interest for all other individual annuity and pure endowment contracts;

4. For annuities and pure endowments purchased prior to July 1, 1979, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under those contracts: The 1971 Group Annuity Mortality Table or any modification of that table approved by the Commission, and six percent interest; and

5. For annuities and pure endowments purchased on or after July 1, 1979, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under those contracts: The 1971 Group Annuity Mortality Table, or any group annuity mortality table adopted after 1980 by the NAIC and approved by regulation adopted by the Commission for use in determining the minimum standard of valuation for those annuities and pure endowments, or any modification of those tables approved by the Commission, and seven and one-half percent interest.

B. After July 1, 1975, any insurer may file with the Commission a written notice of its election to comply with the provisions of this section after a specified date before January 1, 1979, which shall be the operative date of this section for that insurer. However, an insurer may elect a different operative date for individual annuity and pure endowment contracts from that elected for group annuity and pure endowment contracts. If an insurer makes no election, the operative date of this section for that insurer shall be January 1, 1979.

2014, c. 571.

§ 38.2-1371. Computation of minimum standard by calendar year of issue.

A. The interest rates used in determining the minimum standard for the valuation of the following shall be the calendar year statutory valuation interest rates determined as provided in subsection B:

1. Life insurance policies issued in a particular calendar year on or after the operative date of § 38.2-3209;

2. Individual annuity and pure endowment contracts issued in a particular calendar year on or after January 1, 1983, except that an insurer may elect for this to apply to all individual annuity and pure endowment contracts issued after July 1, 1982;

3. Annuities and pure endowments purchased in a particular calendar year on or after January 1, 1983, under group annuity and pure endowment contracts; and

4. The net increase, if any, in a particular calendar year after January 1, 1983, in amounts held under guaranteed interest contracts.

B. The calendar year statutory valuation interest rates, referred to in this section as "I," shall be determined as follows and the results rounded to the nearer one-quarter of one percent:

1. For life insurance:

I =.03 + W(R1 -.03) + (W/2)(R2 -.09);

2. For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and from guaranteed interest contracts with cash settlement options:

I =.03 + W(R -.03).

For purposes of subdivisions 1 and 2:

R1 is the lesser of R and.09;

R2 is the greater of R and.09;

R is the reference interest rate defined in this section; and

W is the weighting factor defined in this section;

3. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on an issue year basis, except as stated in subdivision 2, the formula for life insurance stated in subdivision 1 shall apply to annuities and guaranteed interest contracts with guarantee durations in excess of 10 years, and the formula for single premium immediate annuities stated in subdivision 2 shall apply to annuities and guaranteed interest contracts with guarantee duration of 10 years or less;

4. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the formula for single premium immediate annuities stated in subdivision 2 shall apply; and

5. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, the formula for single premium immediate annuities stated in subdivision 2 shall apply.

However, if the calendar year statutory valuation interest rate for a life insurance policy issued in any calendar year determined without reference to this sentence differs from the corresponding actual rate for similar policies issued in the immediately preceding calendar year by less than one-half of one percent, the calendar year statutory valuation interest rate for the life insurance policies shall be equal to the corresponding actual rate for the immediately preceding calendar year. For purposes of applying the immediately preceding sentence, the calendar year statutory valuation interest rate for life insurance policies issued in a calendar year shall be determined for 1980, using the reference interest rate defined in 1979, and shall be determined for each subsequent calendar year regardless of when § 38.2-3209 becomes operative.

C. The weighting factors referred to in the formulas stated in subsection B are given in the following tables:

1. Weighting factors for life insurance:

a	Guarantee Duration (Years)	Weighting Factors
b	10 or less	.50
c	More than 10, but not more than 20	.45
d	More than 20	.35

For life insurance, the guarantee duration is the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under options to convert to plans of life insurance with premium rates or nonforfeiture values, or both, that are guaranteed in the original policy.

2. Weighting factor for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options:

a	.80

3. Weighting factors for other annuities and for guaranteed interest contracts, except as stated in subdivision 2, shall be as specified in tables a, b, and c of this subdivision, according to the rules and definitions in subdivisions d, e, and f of this subdivision:

a. For annuities and guaranteed interest contracts valued on an issue year basis:

a	Guarantee Duration	Weighting Factor For Plan Type		
b	(Years)	A	B	C
c	5 or less:	.80	.60	.50
d	More than 5, but not more than 10:	.75	.60	.50
e	More than 10, but not more than 20:	.65	.50	.45
f	More than 20:	.45	.35	.35

b. For annuities and guaranteed interest contracts valued on a change in fund basis, the factors shown in table a increased by:

a	Plan Type		
b	A	B	C
c	.15	.25	.05

c. For annuities and guaranteed interest contracts valued on an issue year basis, other than those with no cash settlement options, that do not guarantee interest on considerations received more than one year after issue or purchase and for annuities and guaranteed interest contracts valued on a change in fund basis that do not guarantee interest rates on considerations received more than 12 months beyond the valuation date, the factors shown in table a or derived in table b increased by:

a	Plan Type		
b	A	B	C
c	.05	.05	.05

d. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the guarantee duration is the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance policies with guarantee duration in excess of 20 years. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the guaranteed duration is the number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to commence.

e. "Plan Type" as used in tables a, b, and c is defined as follows:

Plan Type A: At any time policyholder (i) may withdraw funds only with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company, (ii) may withdraw funds without an adjustment but in installments over five years or more, (iii) may withdraw funds as an immediate life annuity, or (iv) is not permitted to withdraw funds.

Plan Type B: Before expiration of the interest rate guarantee, policyholder may withdraw funds only (i) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company, (ii) without an adjustment but in installments over five years or more, or (iii) no withdrawal permitted. At the end of interest rate guarantee, funds may be withdrawn without an adjustment in a single sum or installments over less than five years.

Plan Type C: Policyholder may withdraw funds before expiration of interest rate guarantee in a single sum or installments over less than five years either (i) without adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company or (ii) subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.

f. An insurer may elect to value guaranteed interest contracts with cash settlement options and annuities with cash settlement options on either an issue year basis or on a change-in-fund basis. Guaranteed interest contracts with no cash settlement options and other annuities with no cash settlement options must be valued on an issue year basis. As used in this section, an issue year basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation

standard for the entire duration of the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of issue or year of purchase of the annuity or guaranteed interest contract, and the change-in-fund basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard applicable to each change in the fund held under the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of the change in the fund.

D. The reference interest rate referred to in subsection B shall be defined as follows:

1. For life insurance, the lesser of the average over a period of 36 months and the average over a period of 12 months, ending on June 30 of the calendar year preceding the year of issue, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

2. For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the average over a period of 12 months, ending on June 30 of the calendar year of issue or year of purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

3. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year-of-issue basis, except as stated in subdivision 2, with guarantee duration in excess of 10 years, the lesser of the average over a period of 36 months and the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

4. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in subdivision 2, with guarantee duration of 10 years or less, the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

5. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

6. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change-in-fund basis, except as stated in subdivision 2, the average over a period of 12 months, ending on June 30 of the calendar year of the change in the fund, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

E. In the event that the monthly average of the composite yield on seasoned corporate bonds is no longer published by Moody's Investors Service, Inc., or in the event that the NAIC determines that the monthly average of the composite yield on seasoned corporate bonds as published by Moody's Investors Service, Inc., is no longer appropriate for the determination of the reference interest rate, then an alternative method for determination of the reference interest rate adopted by the NAIC and approved by regulation adopted by the Commission may be substituted.

2014, c. 571.

§ 38.2-1372. Reserve valuation method; life insurance and endowment benefits.

A. Except as otherwise provided in §§ 38.2-1373, 38.2-1376, and 38.2-1378, reserves according to the Commissioners reserve valuation method for the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums shall be the excess, if any, of the present value, at the date of valuation, of the future guaranteed benefits provided for by those policies, over the then-present value of any future modified net premiums for those policies. The modified net premiums for a policy shall be the uniform percentage of the respective contract premiums for the benefits, excluding any extra premiums charged because of impairments or special hazards, such that the present value, at the date of issue of the policy, of all modified net premiums shall be equal to the sum of the then-present value of the benefits provided for by the policy and the excess of subdivision 1 over subdivision 2, as follows:

1. A net level annual premium equal to the present value, at the date of issue, of the benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one per annum payable on the first and each subsequent anniversary of the policy on which a premium falls due. However, the net level annual premium shall not exceed the net level annual premium on the nineteen-year premium whole life plan for insurance of the same amount at an age one year higher than the age at issue of the policy.

2. A net one-year term premium for the benefits provided for in the first policy year.

B. For a life insurance policy issued on or after January 1, 1986, for which the contract premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for the excess, and that provides an endowment benefit or a cash surrender value or a combination in an amount greater than the excess premium, the reserve according to the Commissioners reserve valuation method as of any policy anniversary occurring on or before the assumed ending date, defined herein as the first policy anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than the excess premium, shall, except as otherwise provided in § 38.2-1376, be the greater of the reserve as of the policy anniversary calculated as described in subsection A and the reserve as of the policy anniversary calculated as described in that subsection but with (i) the value defined in subdivision A 1 being reduced by 15 percent of the amount of such excess first-year premium, (ii) all present values of benefits and premiums being determined without reference to premiums or benefits provided for by the policy after the

assumed ending date, (iii) the policy being assumed to mature on that date as an endowment, and (iv) the cash surrender value provided on that date being considered as an endowment benefit. In making the above comparison, the mortality and interest bases stated in §§ 38.2-1369 and 38.2-1371 shall be used.

C. Reserves according to the Commissioners reserve valuation method shall be calculated by a method consistent with the principles of the preceding subsections for:

1. Life insurance policies providing for a varying amount of insurance or requiring the payment of varying premiums;

2. Group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under § 408 of the Internal Revenue Code, as now or hereafter amended;

3. Disability and accidental death benefits in all policies and contracts; and

4. All other benefits, except life insurance and endowment benefits in life insurance policies and benefits provided by all other annuity and pure endowment contracts.

2014, c. 571.

§ 38.2-1373. Reserve valuation method; annuity and pure endowment benefits.

A. This section shall apply to all annuity and pure endowment contracts other than group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or both, other than a plan providing individual retirement accounts or individual retirement annuities under § 408 of the Internal Revenue Code, as now or hereafter amended.

B. Reserves according to the Commissioners annuity reserve method for benefits under annuity or pure endowment contracts, excluding any disability and accidental death benefits in the contracts, shall be the greatest of the respective excesses of the present values, at the date of valuation, of the future guaranteed benefits, including guaranteed nonforfeiture benefits, provided for by the contracts at the end of each respective contract year, over the present value, at the date of valuation, of any future valuation considerations derived from future gross considerations, required by the terms of the contract, that become payable prior to the end of the respective contract year. The future guaranteed benefits shall be determined by using the mortality table, if any, and the interest rate, or rates, specified in those contracts for determining guaranteed benefits. The valuation considerations are the portions of the respective gross considerations applied under the terms of those contracts to determine nonforfeiture values.

2014, c. 571.

§ 38.2-1374. Minimum reserves.

A. In no event shall an insurer's aggregate reserves for all life insurance policies, excluding disability and accidental death benefits, be less than the aggregate reserves calculated in accordance with the methods set forth in §§ 38.2-1372, 38.2-1373, 38.2-1376, and 38.2-1377 and the mortality table or tables and rate or rates of interest used in calculating nonforfeiture benefits for those policies.

B. In no event shall the aggregate reserves for all policies, contracts, and benefits be less than the aggregate reserves determined by the appointed actuary to be necessary to render the opinion required by § 38.2-1367.

2014, c. 571.

§ 38.2-1375. Optional reserve calculation.

A. Reserves for any category of policies, contracts, or benefits as established by the Commission may be calculated, at the insurer's option, according to any standards that produce greater aggregate reserves for the category than those calculated according to the minimum standard provided in this article, but the rate or rates of interest used for policies and contracts other than annuity and pure endowment contracts shall not be higher than the corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided for in those policies and contracts.

B. An insurer that adopts at any time a standard of valuation producing greater aggregate reserves than those calculated according to the minimum standard provided under this article may adopt a lower standard of valuation with the approval of the Commission, but not lower than the minimum provided herein, provided that, for the purposes of this section, the holding of additional reserves previously determined by the appointed actuary to be necessary to render the opinion required by § 38.2-1367 shall not be deemed to be the adoption of a higher standard of valuation.

2014, c. 571.

§ 38.2-1376. Reserve calculation; valuation net premium exceeding the gross premium charged.

A. If in any contract year the gross premium charged by an insurer on a policy or contract is less than the valuation net premium for the policy or contract calculated by the method used in calculating the reserve but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for the policy or contract shall be the greater of either the reserve calculated according to the mortality table, rate of interest, and method actually used for the policy or contract or the reserve calculated by the method actually used for the policy or contract but using the minimum valuation standards of mortality and rate of interest and replacing the valuation net premium by the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium. The minimum valuation standards of mortality and rate of interest referred to in this section are those standards stated in §§ 38.2-1369 and 38.2-1371.

B. For a life insurance policy issued on or after January 1, 1986, for which the gross premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for the excess and which provides an endowment benefit or a cash surrender value or a combination in an amount greater than the excess premium, the provisions of this section

shall be applied as if the method actually used in calculating the reserve for the policy were the method described in § 38.2-1372, ignoring subsection B of § 38.2-1372. The minimum reserve at each policy anniversary of such a policy shall be the greater of the minimum reserve calculated in accordance with § 38.2-1372, including subsection B of that section, and the minimum reserve calculated in accordance with this section.

2014, c. 571.

§ 38.2-1377. Reserve calculation; indeterminate premium plans.

In the case of a plan of life insurance that provides for future premium determination, the amounts of which are to be determined by the insurance company based on then estimates of future experience, or in the case of a plan of life insurance or annuity that is of such a nature that the minimum reserves cannot be determined by the methods described in §§ 38.2-1372, 38.2-1373, and 38.2-1376, the reserves that are held under the plan shall:

1. Be appropriate in relation to the benefits and the pattern of premiums for that plan; and

2. Be computed by a method that is consistent with the principles of this article, as determined by regulations adopted by the Commission.

2014, c. 571.

§ 38.2-1378. Minimum standard for accident and health insurance contracts.

For accident and health insurance contracts issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under subsection B of § 38.2-1366. For disability and accident and sickness insurance contracts issued on or after January 1, 1937, and prior to the operative date of the valuation manual, the minimum standard of valuation is the standard adopted by the Commission by regulation.

2014, c. 571.

§ 38.2-1379. Valuation manual for policies issued on or after the operative date of the valuation manual.

A. For policies issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under subsection B of § 38.2-1366, except as provided under subsection E or subsection G.

B. The operative date of the valuation manual is January 1 of the first calendar year following the first July 1 as of which all of the following have occurred:

1. The valuation manual has been adopted by the NAIC by an affirmative vote of at least 42 members, or three-fourths of the members voting, whichever is greater.

2. The Standard Valuation Law, as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by states representing greater than 75 percent of the direct premiums written as reported in the following annual statements submitted for 2008: life, accident and health annual statements; health annual statements; or fraternal annual statements.

3. The Standard Valuation Law, as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by at least 42 of the following 55 jurisdictions: The 50 states of the United States, American Samoa, the American Virgin Islands, the District of Columbia, Guam, and Puerto Rico.

C. Unless a change in the valuation manual specifies a later effective date, changes to the valuation manual shall be effective on January 1 following the date when the following have occurred:

1. The change to the valuation manual has been adopted by the NAIC by an affirmative vote representing:

a. At least three-quarters of the members of the NAIC voting, but not less than a majority of the total membership; and

b. Members of the NAIC representing jurisdictions totaling greater than 75 percent of the direct premiums written as reported in the following annual statements most recently available prior to the vote in subdivision C 1 a: life, accident and health annual statements, health annual statements, or fraternal annual statements; or

2. The valuation manual becomes effective pursuant to an order of regulation adopted by the Commission.

D. The valuation manual shall specify all of the following:

1. Minimum valuation standards for and definitions of the policies or contracts subject to subsection B of § 38.2-1366. Such minimum valuation standards shall be:

a. The Commissioners reserve valuation method for life insurance contracts, other than annuity contracts, subject to subsection B of § 38.2-1366;

b. The Commissioners annuity reserve valuation method for annuity contracts subject to subsection B of § 38.2-1366; and

c. Minimum reserves for all other policies or contracts subject to subsection B of § 38.2-1366.

2. Which policies or contracts or types of policies or contracts are subject to the requirements of a principle-based valuation in subsection A of § 38.2-1380 and the minimum valuation standards consistent with those requirements;

3. For policies and contracts subject to a principle-based valuation under § 38.2-1380:

a. Requirements for the format of reports to the commissioner under subdivision B 3 of § 38.2-1380 and which reports shall include information necessary to determine if the valuation is appropriate and in compliance with this article.

b. Assumptions shall be prescribed for risks over which the company does not have significant control or influence.

c. Procedures for corporate governance and oversight of the actuarial function, and a process for appropriate waiver or modification of such procedures.

4. For policies not subject to a principle-based valuation under § 38.2-1380, the minimum valuation standard shall either:

a. Be consistent with the minimum standard of valuation prior to the operative date of the valuation manual; or

b. Develop reserves that quantify the benefits and guarantees, and the funding, associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring.

5. Other requirements, including those relating to reserve methods, models for measuring risk, generation of economic scenarios, assumptions, margins, use of company experience, risk measurement, disclosure, certifications, reports, actuarial opinions and memorandums, transition rules, and internal controls; and

6. The data and form of the data required under § 38.2-1381 and to whom the data is required to be submitted.

The valuation manual may specify other requirements, including those for data analyses and reporting of analyses.

E. If a specific valuation requirement is absent or if a specific valuation requirement in the valuation manual is not, in the opinion of the Commission, in compliance with this article, then the insurer shall, with respect to such requirements, comply with minimum valuation standards prescribed by the Commission by regulation.

F. The Commission may engage a qualified actuary, at the expense of the insurer, to perform an actuarial examination of the insurer and opine on the appropriateness of any reserve assumption or method used by the insurer, or to review and opine on an insurer's compliance with any requirement set forth in this article. The Commission may rely upon the opinion, regarding provisions contained within this article, of a qualified actuary engaged by the Commissioner of another state, district, or territory of the United States. As used in this subsection, the term "engage" includes employment and contracting.

G. The Commission may require an insurer to change any assumption or method that in the opinion of the Commission is necessary in order to comply with the requirements of the valuation manual or this article; and the insurer shall adjust the reserves as required by the Commission. The Commission may take other disciplinary action as permitted pursuant to § 38.2-219.

2014, c. 571.

§ 38.2-1380. Requirements of a principle-based valuation.

A. An insurer shall establish reserves using a principle-based valuation that meets the following conditions for policies or contracts as specified in the valuation manual:

1. Quantify the benefits and guarantees, and the funding, associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring during the lifetime of the contracts. For policies or contracts with significant tail risk, reflects conditions appropriately adverse to quantify the tail risk;

2. Incorporate assumptions, risk analysis methods and financial models, and management techniques that are consistent with, but not necessarily identical to, those utilized within the insurer's overall risk assessment process, while recognizing potential differences in financial reporting structures and any prescribed assumptions or methods;

3. Incorporate assumptions that are derived in one of the following manners:

a. The assumption is prescribed in the valuation manual.

b. For assumptions that are not prescribed, the assumptions shall:

(1) Be established utilizing the insurer's available experience, to the extent it is relevant and statistically credible; or

(2) To the extent that insurer data is not available, relevant, or statistically credible, be established utilizing other relevant, statistically credible experience; and

4. Provide margins for uncertainty, including adverse deviation and estimation error, such that the greater the uncertainty the larger the margin and resulting reserve.

B. An insurer using a principle-based valuation for one or more policies or contracts subject to this section as specified in the valuation manual shall:

1. Establish procedures for corporate governance and oversight of the actuarial valuation function consistent with those described in the valuation manual.

2. Provide to the Commission and the board of directors an annual certification of the effectiveness of the internal controls with respect to the principle-based valuation. Such controls shall be designed to assure that all material risks inherent in the liabilities and associated assets subject to such valuation are included in the valuation, and that valuations are made in accordance with the valuation manual. The certification shall be based on the controls in place as of the end of the preceding calendar year.

3. Develop, and file with the Commission upon request, a principle-based valuation report that complies with standards prescribed in the valuation manual.

C. A principle-based valuation may include a prescribed formulaic reserve component.

2014, c. 571.

§ 38.2-1381. Experience reporting for policies in force on or after the operative date of the valuation manual.

An insurer shall submit mortality, morbidity, policyholder behavior, or expense experience and other data as prescribed in the valuation manual.

2014, c. 571.

§ 38.2-1382. Confidentiality.

A. For purposes of this section, "confidential information" means:

1. A memorandum in support of an opinion submitted under § 38.2-1367 and any other documents, materials, and other information, including all working papers, and copies thereof, created, produced, or obtained by or disclosed to the Commission or any other person in connection with such memorandum;

2. All documents, materials, and other information, including all working papers and copies thereof created, produced, or obtained by or disclosed to the Commission or any other person in the course of an examination made under subsection F of § 38.2-1379, provided, however, that if an examination report or other material prepared in connection with an examination made under Article 4 (§ 38.2-1317 et seq.) of Chapter 13 is not held as private and confidential information under Article 4, an examination report or other material prepared in connection with an examination made under subsection F of § 38.2-1379 shall not be "confidential information" to the same extent as if such examination report or other material had been prepared under Article 4;

3. Any reports, documents, materials, and other information developed by an insurer in support of, or in connection with, an annual certification by the insurer under subdivision B 2 of § 38.2-1380 evaluating the effectiveness of the insurer's internal controls with respect to a principle-based valuation and any other documents, materials, and other information, including all working papers and copies thereof created, produced, or obtained by or disclosed to the Commission or any other person in connection with such reports, documents, materials, and other information;

4. Any principle-based valuation report developed under subdivision B 3 of § 38.2-1380 and any other documents, materials, and other information, including all working papers and copies thereof created, produced, or obtained by or disclosed to the Commission or any other person in connection with such report; and

5. Any documents, materials, data, and other information submitted by an insurer under § 38.2-1381 (which are collectively referred to in this section as "experience data") and any other documents, materials, data, and other information, including all working papers and copies thereof created or produced in connection with such experience data, in each case that includes any potentially company-identifying or personally identifiable information, that is provided to or obtained by the Commission (which, together with any experience data, are referred to in this section as the "experience materials"), and any other documents, materials, data, and other information, including all working papers and copies thereof created, produced, or obtained by or disclosed to the Commission or any other person in connection with such experience materials.

B. Privilege for, and confidentiality of, confidential information shall be governed by the following provisions:

1. Except as provided in this section, an insurer's confidential information is confidential by law and privileged, and shall not be subject to subpoena and shall not be subject to discovery or admissible in evidence in any private civil action, provided, however, that the Commission is authorized to use the confidential information in the furtherance of any regulatory or legal action brought against an insurer as a part of the Commission's official duties;

2. Neither the Commission nor any person who received confidential information while acting under the authority of the Commission shall be permitted or required to testify in any private civil action concerning any confidential information;

3. In order to assist in the performance of the Commission's duties, the Commission may share confidential information (i) with other state, federal, and international regulatory agencies and with the NAIC and its affiliates and subsidiaries and (ii) in the case of confidential information specified in subdivisions A 1 and A 4 only, with the Actuarial Board for Counseling and Discipline or its successor upon request stating that the confidential information is required for the purpose of professional disciplinary proceedings and with state, federal, and international law-enforcement officials; in the case of clauses (i) and (ii), provided that such recipient agrees, and has the legal authority to agree, to maintain the confidentiality and privileged status of such documents, materials, data, and other information in the same manner and to the same extent as required for the Commission;

4. The Commission may receive documents, materials, data, and other information, including otherwise confidential and privileged documents, materials, data, or information, from the NAIC and its affiliates and subsidiaries, from regulatory or law-enforcement officials of other foreign or domestic jurisdictions, and from the Actuarial Board for Counseling and Discipline or its successor and shall maintain as confidential or privileged any document, material, data, or other information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or other information;

5. The Commission may enter into agreements governing sharing and use of information consistent with this subsection;

6. No waiver of any applicable privilege or claim of confidentiality in the confidential information shall occur as a result of disclosure to the Commission under this section or as a result of sharing as authorized in subdivision 3;

7. A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this subsection shall be available and enforced in any proceeding in, and in any court of, the Commonwealth; and

8. As used in this section, "regulatory agency," "law-enforcement agency," and "NAIC" include their employees, agents, consultants, and contractors.

C. Notwithstanding subsection B, any confidential information specified in subdivisions A 1 and A 4:

1. May be subject to subpoena for the purpose of defending an action seeking damages from the appointed actuary submitting the related memorandum in support of an opinion submitted under § 38.2-1367 or principle-based valuation report developed under subdivision B 3 § 38.2-1380 by reason of an action required by this article or by regulations adopted hereunder;

2. May otherwise be released by the Commission with the written consent of the insurer; and

3. Once any portion of a memorandum in support of an opinion submitted under § 38.2-1367 or a principle-based valuation report developed under subdivision B 3 § 38.2-1380 is cited by an insurer in its marketing or is publicly volunteered to or before a governmental agency other than a state insurance department or is released by an insurer to the news media, all portions of such memorandum or report shall no longer be confidential.

2014, c. 571.

§ 38.2-1383. Single state exemption.

A. The Commission may exempt specific product forms or product lines of a domestic insurer that is licensed and doing business only in the Commonwealth from the requirements of § 38.2-1379 provided:

1. The Commission has issued an exemption in writing to the insurer and has not subsequently revoked the exemption in writing; and

2. The insurer computes reserves using assumptions and methods used prior to the operative date of the valuation manual in addition to any requirements established by the Commission and adopted by regulation.

B. For any insurance company granted an exemption under this section, §§ 38.2-1367 through 38.2-1378 shall be applicable. With respect to any insurance company applying this exemption, any reference to § 38.2-1379 found in §§ 38.2-1367 through 38.2-1378 shall not be applicable.

2014, c. 571.

§ 38.2-1384. Assessment against insurers whose policies are valued.

The Commission is hereby authorized to assess against every insurer whose policies are valued a sum equal to the cost of valuation, which shall be collected by the Commission and paid directly into the state treasury and credited to the "Bureau of Insurance Special Fund -- State Corporation Commission" for the maintenance of the Bureau of Insurance as provided in subsection B of § 38.2-400.

2014, c. 571.

§ 38.2-1385. Article not applicable in certain cases.

Nothing in this article shall be construed to apply to any insurer in the transaction of industrial sick benefit insurance as defined in § 38.2-3544, nor to fraternal benefit societies, except for § 38.2-1367.

2014, c. 571.

Chapter 14 - INVESTMENTS

Article 1 - General Provisions

§ 38.2-1400. Scope and purpose of chapter.

This chapter applies to and regulates the investments of all domestic insurers as defined in this chapter. Upon petition to, and approval by, the Commission, any one or more provisions of this chapter shall not apply to a domestic insurer in receivership in this Commonwealth pursuant to Chapter 15 (§ 38.2-1500 et seq.) of this title. A foreign or alien insurer may invest its funds and assets in any investments that are permitted by the laws of its state or country of domicile and are of the same general character and quality as those authorized under this chapter. A foreign or alien insurer whose domiciliary jurisdiction does not regulate the investments of its insurers shall be subject to the provisions of this chapter.

1983, c. 457, § 38.1-217.1; 1986, c. 562; 1990, c. 893; 1992, c. 588; 1993, c. 55.

§ 38.2-1401. Definitions.

As used in this chapter:

"Admitted assets" means, for purposes of the limitations and standards imposed by Articles 1 and 2 of this chapter, the amount thereof as permitted to be reported on the statutory financial statement of the insurer most recently required to be filed with the Commission pursuant to §§ 38.2-1300 and 38.2-1301 or other similar provisions within this title, but excluding the assets allocated to separate accounts pursuant to Article 3 (§ 38.2-1443 et seq.) of this chapter.

"Business entity" means a corporation, association, partnership, joint venture, trust, church, or religious body.

"Cap" means an agreement obligating the seller to make payments to the buyer, with each payment based on the amount by which a reference price or level or the performance or value of one or more underlying interests exceeds a predetermined number, sometimes called the strike rate or strike price.

"Category 1 investment" means any investment complying with Article 1 (§ 38.2-1400 et seq.) and either Article 2 (§ 38.2-1412 et seq.) or 3 (§ 38.2-1443 et seq.), or both Articles 2 and 3, of this chapter.

"Category 2 investment" means any investment complying with Article 1, but with neither Article 2 nor Article 3, of this chapter.

"Claimants" means any owners, beneficiaries, assignees, certificate holders, or third-party beneficiaries of any insurance benefit or right arising out of and within the coverage of an insurance policy, annuity contract, benefit contract, or subscription contract.

"Collar" means an agreement to receive payments as the buyer of an option, cap, or floor and to make payments as the seller of a different option, cap, or floor.

"Counterparty exposure amount" means the amount of credit risk attributable to an over-the-counter derivative instrument, which amount of credit risk is equal to (i) the market value of the over-the-

counter derivative instrument if the liquidation of the derivative instrument would result in a final cash payment to the insurer or (ii) zero if the liquidation of the derivative instrument would not result in a final cash payment to the insurer. However, if an over-the-counter derivative instrument is entered into under a written master agreement that provides for netting of payments owed by the respective parties, and the domicile of the counterparty is either within the United States or, if not within the United States, within a foreign jurisdiction listed in the Purposes and Procedures Manual of the Securities Valuation Office as eligible for netting, the amount of credit risk attributable to the over-the-counter derivative instrument shall be the greater of zero or the net sum of (a) the market value of the over-the-counter derivative instruments entered into under the agreement, the liquidation of which would result in a final cash payment to the insurer, and (b) the market value of the over-the-counter derivative instruments entered into under the agreement, the liquidation of which would result in a final cash payment by the insurer to the business entity. With respect to open transactions, the market value of the over-the-counter derivative instrument shall be determined at the end of the most recent quarter of the insurer's fiscal year and shall be reduced by the market value of acceptable collateral held by the insurer or placed in escrow by one or both parties.

"Date of investment" means the date on which funds are disbursed for an investment.

"Derivative instrument" means an agreement, instrument, or a series or combination thereof (i) to make or take delivery of, or assume or relinquish, a specified amount of one or more underlying interests or to make a cash settlement in lieu thereof or (ii) that has a price, performance, value, or cash flow based primarily upon the actual or expected price, level, performance, value, or cash flow of one or more underlying interests. Derivative instruments include options, warrants used in a hedging transaction and not attached to another financial instrument, caps, floors, collars, swaps, forwards, futures, and any other agreements, options, or instruments substantially similar thereto or any series or combination thereof and any agreements or instruments permitted under rules adopted under § 38.2-1428.

"Derivative transaction" means a transaction involving the use of one or more derivative instruments.

"Domestic governmental entity" means the United States, any state, or any municipality or district in any such state, or any political subdivision, civil division, agency or instrumentality of one or more of the foregoing.

"Fair market value" means the price that property will bring when (i) offered for sale by one who desires, but who is not obligated, to sell it; (ii) bought by one who is under no necessity of having it; and (iii) sufficient time has elapsed to allow interested buyers the opportunity to become informed of the offer for sale.

"Fixed charges" means actual interest incurred in each year on funded and unfunded debt, excluding interest on bank deposit accounts, and annual apportionment of debt discount or premium. Where interest is partially or entirely contingent upon earnings, "fixed charges" includes contingent interest payments.

"Floor" means an agreement obligating the seller to make payments to the buyer in which each payment is based on the amount by which a predetermined number, sometimes called the floor rate or price, exceeds a reference price, a level, or the performance or value of one or more underlying interests.

"Forward" means an agreement, other than a future, to make or take delivery of, or effect a cash settlement based on the actual or expected price, level, performance or value of, one or more underlying interests.

"Future" means an agreement, traded on a qualified exchange or qualified foreign exchange, to make or take delivery of, or effect a cash settlement based on the actual or expected price, level, performance or value of, one or more underlying interests and includes an insurance future.

"Hedging transaction" means:

1. A derivative transaction that is entered into and maintained to reduce:

a. The risk of a change in the value, yield, price, cash flow, or quantity of assets or liabilities that the insurer has acquired or incurred or anticipates acquiring or incurring; or

b. The currency exchange rate risk or the degree of exposure as to assets or liabilities that the insurer has acquired or incurred or anticipates acquiring or incurring; or

2. Any other derivative transaction specified as constituting a hedging transaction in rules adopted pursuant to § 38.2-1428.

"High grade obligations" means obligations which (i) are rated one or two by the Securities Valuation Office of the National Association of Insurance Commissioners or (ii) if not rated by the Securities Valuation Office, are rated in an equivalent grade by a national rating agency recognized by the Commission.

"Insurance future" means a future relating to an index or pool that is based on insurance-related items.

"Insurance futures option" means an option on an insurance future.

"Insurer" means a company licensed pursuant to Chapter 10 (§ 38.2-1000 et seq.), 11 (§ 38.2-1100 et seq.), 12 (§ 38.2-1200 et seq.), 25 (§ 38.2-2500 et seq.), 26 (§ 38.2-2600 et seq.), 38 (§ 38.2-3800 et seq.), 39 (§ 38.2-3900 et seq.), 40 (§ 38.2-4000 et seq.), 41 (§ 38.2-4100 et seq.), 42 (§ 38.2-4200 et seq.), 43 (§ 38.2-4300 et seq.), 45 (§ 38.2-4500 et seq.), 46 (§ 38.2-4600 et seq.), 51 (§ 38.2-5100 et seq.), or 61 (§ 38.2-6100 et seq.) of this title.

"Life insurer" means any insurer authorized to transact life insurance or to grant annuities as defined in §§ 38.2-102 through 38.2-107 or authorized pursuant to the provisions of Chapter 38, 39, 40 or 41, or any other chapter of this title, to provide any one of the following contractual benefits in any form: death benefits, endowment benefits, annuity benefits or monument or tombstone benefits.

"Lower grade obligations" means obligations which (i) are rated four, five, or six by the Securities Valuation Office of the National Association of Insurance Commissioners or (ii) if not rated by the

Securities Valuation Office, are rated in an equivalent grade by a national rating agency recognized by the Commission.

"Medium grade obligations" means obligations which (i) are rated three by the Securities Valuation Office of the National Association of Insurance Commissioners or (ii) if not rated by the Securities Valuation office, are rated in an equivalent grade by a national rating agency recognized by the Commission.

"Minimum capital and surplus" means the minimum surplus to policyholders, or minimum net worth, a particular insurer must have to obtain and maintain its license to transact business in this Commonwealth pursuant to the applicable provisions of this title. In no case shall an insurer's minimum capital and surplus be less than zero.

"Net earnings available for fixed charges" means income minus operating expenses, maintenance expenses, taxes other than income taxes, depreciation, and depletion. Extraordinary nonrecurring income and expense items are excluded from the calculation of "net earnings available for fixed charges."

"Obligation" means a bond, debenture, note or other evidence of indebtedness.

"Option" means an agreement giving the buyer the right to buy or receive, sell or deliver, enter into, extend, terminate, or effect a cash settlement based on the actual or expected price, level, performance, or value of one or more underlying interests. "Option" includes an insurance futures option.

"Over-the-counter derivative instrument" means a derivative instrument that is entered into with a business entity other than through a qualified exchange or qualified foreign exchange or that is cleared other than through a qualified clearinghouse.

"Potential exposure" means the amount determined in accordance with the National Association of Insurance Commissioners Annual Statement Instructions.

"Prohibited investment" means any investment prohibited by § 38.2-1407.

"Qualified clearinghouse" means a clearinghouse for, and that is subject to the rules of, a qualified exchange or a qualified foreign exchange, which clearinghouse provides clearing services, including acting as a counterparty to each of the parties to a transaction such that the parties no longer have credit risk as to each other.

"Qualified exchange" means:

1. A securities exchange registered as a national securities exchange, or a securities market regulated under the Securities Exchange Act of 1934 (15 U.S.C. § 78a et seq.), as amended;

2. A board of trade or commodities exchange designated as a contract market by the Commodity Futures Trading Commission or any successor thereof;

3. Private Offerings, Resales and Trading through Automated Linkages (PORTAL);

4. A designated offshore securities market as defined in Securities Exchange Commission Regulation S, 17 C.F.R. Part 230, as amended; or

5. A qualified foreign exchange.

"Qualified foreign exchange" means a foreign exchange, board of trade, or contract market located outside the United States:

1. That has received regulatory comparability relief under Commodity Futures Trading Commission (CFTC) Rule 30.10 (as set forth in Appendix C to Part 30 of the CFTC's regulations at 17 C.F.R. Part 30);

2. That is, or whose members are, subject to the jurisdiction of a foreign futures authority that has received regulatory comparability relief under CFTC Rule 30.10 (as set forth in Appendix C to Part 30 of the CFTC's regulations at 17 C.F.R. Part 30) as to futures transactions in the jurisdiction where the exchange, board of trade, or contract market is located; or

3. Upon which foreign stock index futures contracts are listed that are the subject of no-action relief issued by the CFTC's Office of General Counsel, provided that an exchange, board of trade, or contract market that qualifies as a "qualified foreign exchange" only under this subsection shall only be a "qualified foreign exchange" as to foreign stock index futures contracts that are the subject of no-action relief.

"Replication transaction" means a derivative transaction that is intended to replicate the performance of one or more assets that an insurer is authorized to acquire under this chapter. A derivative transaction that is entered into as a hedging transaction shall not be considered a replication transaction.

"Reserve liabilities" means those liabilities which are required to be established by an insurer for all of its outstanding insurance policies, annuity contracts, benefit contracts and subscription contracts, in accordance with this title, as amended or as hereafter amended.

"Statement value" means the amount determined in accordance with the National Association of Insurance Commissioners Annual Statement Instructions.

"Swap" means an agreement to exchange or to net payments at one or more times based on the actual or expected price, level, performance, or value of one or more underlying interests.

"Underlying interest" means the assets, liabilities, or other interests, or a combination thereof, underlying a derivative instrument, such as any one or more securities, currencies, rates, indices, commodities, or derivative instruments.

"Warrant" means an instrument that gives the holder the right to purchase an underlying financial instrument at a given price and time or at a series of prices and times outlined in the warrant agreement. Warrants may be issued alone or in connection with the sale of other securities.

"Wrap-around mortgage" means a loan made by an insurer to a borrower, secured by a mortgage or deed of trust on real property encumbered by a first mortgage or first deed of trust, where the total

amount of the obligation of the borrower to the insurer under the loan is not less than the sum of (i) the principal amount initially disbursed by the insurer on account of the loan and (ii) the unpaid principal balance of the obligation secured by the preexisting mortgage or deed of trust.

1983, c. 457, § 38.1-217.2; 1986, c. 562; 1992, c. 588; 1994, c. 503; 1998, c. 42; 2004, c. 668; 2008, c. 216; 2011, c. 198.

§ 38.2-1402. Authority to invest; classification of investments by category.

A. A domestic insurer may invest its funds and assets in accordance with this chapter. All investments of a domestic insurer shall be classified as (i) Category 1 investments, (ii) Category 2 investments, or (iii) prohibited investments.

B. The Commission, upon application by an insurer, may classify any investments made or proposed to be made and not otherwise specifically classified in Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et seq.) of this chapter as a Category 1 investment.

1983, c. 457, § 38.1-217.3; 1986, c. 562.

§ 38.2-1403. Category 2 investments limits.

The value of Category 2 investments shall be excluded from the value of admitted assets to the extent the value of Category 2 investments exceeds seventy-five percent of the amount by which an insurer's surplus to policyholders exceeds its minimum capital and surplus.

1983, c. 457, § 38.1-217.4; 1986, c. 562; 1992, c. 588; 1998, c. 414.

§ 38.2-1404. Classification of existing investments.

Any investment held on July 1, 1983, that was permitted at the time it was made under former § 38.1-181 or former §§ 38.1-183 through 38.1-217, shall be classified as a Category 1 investment.

1983, c. 457, § 38.1-217.5; 1986, c. 562.

§ 38.2-1405. Dates of determination.

A. The classification by investment category of each investment, based on type of investment as set forth in §§ 38.2-1415 through 38.2-1442, inclusive, shall be determined as of the date of investment.

B. In applying any percentage limitations based on the insurer's total admitted assets or surplus to policyholders, there shall be used as a base, without regard to percentage limitations, those assets or surplus to policyholders as shown by the insurer's most recent annual or quarterly statement on file with the Commission pursuant to §§ 38.2-1300 and 38.2-1301.

1983, c. 457, § 38.1-217.6; 1986, c. 562; 1992, c. 588.

§ 38.2-1406. Investment conversions.

Investments converted to a new form and resulting in a different investment classification under § 38.2-1402, at the election of the insurer, shall retain their previous investment classification for a period not exceeding three years unless the Commission prescribes in writing that a longer period is reasonable. Any prohibited investments shall be divested within that period. The investment

conversions shall include those resulting (i) from investments acquired in satisfaction of or on account of loans, mortgages, liens, judgments, or other debts previously owing to the insurer in the course of its business, or (ii) from investments acquired through lawful distributions of assets, lawful plans of reorganization, or lawful and bona fide agreements of bulk reinsurance or of consolidation.

1983, c. 457, § 38.1-217.7; 1986, c. 562.

§ 38.2-1407. Prohibited investments.

A. No domestic insurer shall invest in or loan funds secured by:

1. Issued shares of its own capital stock without the Commission's approval. This approval shall be based on an evaluation that indicates the investment does not adversely affect the insurer or its policyholders. The insurer shall not invest in or own more than 20 percent of its outstanding issued stock, except for the purpose of mutualization;

2. Securities of an insolvent entity;

3. Securities that, by their terms, will subject the insurer to any assessment other than for taxes or for wages; however, the term "assessment" shall not include ordinary contractual payments or the transfer of collateral or margin made under derivative instruments invested in or owned under § 38.2-1428;

4. Investments that, as determined by the Commission, are designed to evade any prohibition of this title; or

5. Any obligation or investment prohibited by § 38.2-1411.2.

B. Notwithstanding the provisions of this chapter, the Commission may order a domestic insurer to limit or withdraw from certain investments, or discontinue certain investment practices, to the extent the Commission finds that such investment or investment practice endangers the solvency of the insurer or is otherwise hazardous to policyholders, creditors or the public in this Commonwealth.

1983, c. 457, § 38.1-217.8; 1986, c. 562; 1992, c. 588; 2011, c. 198.

§ 38.2-1408. Authorization of investments.

No domestic insurer shall make any loan, investment, or any sale or exchange of a loan or investment, except policy loans of an insurer issuing life insurance policies or annuities, unless authorized or approved. Authorization or approval shall be made by (i) its board of directors, or other governing body, or (ii) a committee authorized by the governing body or bylaws, to make investments, loans, sales or exchanges. The minutes of the committee shall be recorded, and reports of the investments, loans, sales or exchanges authorized or approved shall be submitted to the board or other governing body at its next meeting.

1983, c. 457, § 38.1-217.9; 1986, c. 562.

§ 38.2-1409. Powers with respect to property.

Subject to any applicable limitations and restrictions in this chapter, a domestic insurer may own, hold, maintain, manage, operate, lease, sell, convey, and collect and receive income from any property acquired as permitted in this chapter.

1983, c. 457, § 38.1-217.10; 1986, c. 562.

§ 38.2-1410. Items not deemed to be prior liens or encumbrances.

In construing and applying this title, the following shall not be deemed prior liens or encumbrances: easements; rights-of-way; joint driveways; party wall agreements; current taxes and assessments not delinquent; restrictions as to building, use and occupancy unless there is a right of reentry or forfeiture for violation; instruments reserving mineral, oil, or timber rights; title matters for which the insurer is insured against loss by a title insurer; and leases under which rents are reserved to the owner of the real estate.

1983, c. 457, § 38.1-217.11; 1986, c. 562.

§ 38.2-1411. Repealed.

Repealed by Acts 1992, c. 588.

§ 38.2-1411.1. Investment limits generally.

A. Any securities described in 15 U.S.C. § 77r-1 shall be subject to all the limitations prescribed by this chapter for investments not guaranteed by the full faith and credit of the United States. However, upon prior written application by an insurer, the Commission may, until July 1, 1992, at its discretion, allow such insurer to increase its investments in § 77r-1 securities to an amount not to exceed ten percent of the insurer's total admitted assets.

B. On and after July 1, 1992, investments made in any securities described in 15 U.S.C. § 77r-1 shall be subject to the percentage limitations and requirements set forth in this chapter.

1991, c. 283; 1992, c. 588.

§ 38.2-1411.2. Investment limits in medium grade and lower grade obligations.

A. No domestic insurer shall acquire, directly or indirectly, any medium grade or lower grade obligations of any business entity if, after giving effect to any such acquisition, the aggregate amount of all medium grade and lower grade obligations then held by the domestic insurer would exceed twenty percent of its admitted assets, provided that:

1. No more than ten percent of its admitted assets consists of lower grade obligations;

2. No more than three percent of its admitted assets consists of lower grade obligations rated five or six by the Securities Valuation Office of the National Association of Insurance Commissioners; and

3. No more than one percent of its admitted assets consists of lower grade obligations rated six by the Securities Valuation Office of the National Association of Insurance Commissioners.

Attaining or exceeding the limit of any one category shall not preclude an insurer from acquiring obligations in other categories subject to the specific and multi-category limits.

B. No domestic insurer may invest more than an aggregate of one percent of its admitted assets in medium grade obligations issued, guaranteed or insured by any one business entity nor may it invest more than one-half of one percent of its admitted assets in lower grade obligations issued, guaranteed or insured by any one business entity. In no event may a domestic insurer invest more than one percent of its admitted assets in any medium or lower grade obligations issued, guaranteed or insured by any one business entity.

C. Nothing contained in this section shall prohibit a domestic insurer from acquiring any obligation which it has committed to acquire if the insurer would have been permitted to acquire that obligation pursuant to the provisions of this chapter on the date on which such insurer committed to purchase that obligation.

D. Notwithstanding the foregoing, a domestic insurer may acquire any obligation of a business entity in which the insurer already has one or more obligations, if the obligation is acquired in order to protect an investment previously made in the obligations of the business entity; however, all such acquired obligations shall not exceed one-half of one percent of the insured's admitted assets.

E. Nothing contained in this section shall prohibit a domestic insurer from acquiring any obligation as a result of a restructuring of any obligation already held.

F. Nothing contained in this section shall require a domestic insurer to sell or otherwise dispose of any obligations legally acquired prior to July 1, 1992.

G. The Board of Directors of any domestic insurer which acquires or invests, directly or indirectly, more than two percent of its admitted assets in medium grade or lower grade obligations of any individual business entity, shall adopt a written plan for the making of such investments. The plan shall contain, in addition to guidelines with respect to the quality of the issues invested in, diversification standards including, but not limited to, standards for issuer, industry, duration, liquidity and geographic location.

H. If the Commission finds that economic or other conditions render any rating of any obligation by the Securities Valuation Office of the National Association of Insurance Commissioners obsolete or unreflective of a diminished creditworthiness of the business entity issuing such obligations, the Commission may assign the obligations to a lower grade based on the findings of a national rating agency recognized by the Commission.

1992, c. 588; 2000, c. 187.

Article 2 - CATEGORY 1 INVESTMENTS

§ 38.2-1412. Scope of article.

This article sets forth requirements for qualifying as a Category 1 investment. If an investment or portion thereof does not comply either with this article or Article 3 (§ 38.2-1443 et seq.) of this chapter, then that investment or portion of it shall be classified as a Category 2 investment or a prohibited investment, as provided in this chapter.

1983, c. 457, § 38.1-217.15; 1986, c. 562.

§ 38.2-1413. Investment limits for one obligor, one issue or one loan.

A. No domestic insurer shall have at any one time any combination of investments in or loans upon the security of the property and securities of any one obligor or issuer aggregating an amount exceeding the lesser of five percent of the insurer's total admitted assets or twenty percent of the insurer's surplus to policyholders. The limitations prescribed by this section shall not apply to the following:

1. Investments in or loans upon the security of general obligations of the United States;

2. Investments in foreign securities made eligible by subsection A of § 38.2-1433;

3. Investments in mortgage pass-through securities made eligible by § 38.2-1437.1;

4. Deposits in institutions insured by a federal deposit insuring agency to the extent of coverage by such deposit insuring agency;

5. Investments in subsidiaries made eligible by § 38.2-1427.3;

6. Investments in obligations of an agency or instrumentality of the United States made eligible by subsection B of § 38.2-1415; provided that at no time shall the insurer invest pursuant to subsection B of § 38.2-1415 in excess of ten percent of its total admitted assets in any one obligor or issuer of such obligations; or

7. Other assets defined or classified by the National Association of Insurance Commissioners accounting practices and procedure manual, or any successor publication, as cash or cash equivalents or as a short term investment that is rated "AAA" or better or the equivalent rating by Moody's Investors Service, Inc., Standard & Poor's or Fitch IBCA, or any successor to the rating business of any of them, provided that at no time shall the amount of any such asset placed for or by the insurer in or with any one depository, issue, obligor, or issuer exceed the lesser of ten percent of the insurer's total admitted assets or twenty percent of the insurer's surplus to policyholders.

B. No domestic insurer shall invest in excess of one percent of its total admitted assets in any one issue of any obligations made eligible for investment under § 38.2-1423 or § 38.2-1424.

C. No domestic insurer shall invest in excess of one-half of one percent of its total admitted assets in any one loan made eligible by subdivision 3 of § 38.2-1434.

D. The principal loan amount disbursed, excluding advances made to enforce or protect the security for the loan, by a domestic insurer under any single wrap-around mortgage made pursuant to § 38.2-1435 shall not exceed one percent of its total admitted assets.

E. The amount loaned under § 38.2-1430 shall be subject to the limitations of this section applicable to the kinds of securities or obligations pledged in connection with the loan.

1983, c. 457, § 38.1-217.16; 1986, c. 562; 1990, c. 893; 1992, c. 588; 1995, c. 60; 1998, c. 414; 2002, c. 73.

§ 38.2-1414. Limits by type of investment.

A. The portion of a domestic insurer's total admitted assets in the following types of investments shall not exceed:

1. Ten percent for the aggregate of investments made eligible by §§ 38.2-1416 and 38.2-1417;

2. Five percent for the investments in each agency made eligible by § 38.2-1418, and 10 percent for the aggregate of investments made eligible by § 38.2-1418;

3. Ten percent for the investments made eligible by § 38.2-1419;

4. Ten percent for the investments made eligible by § 38.2-1420;

5. For the aggregate of investments made eligible under §§ 38.2-1421 and 38.2-1422, (i) 90 percent for any life insurer and (ii) 40 percent for all other insurers;

6. Ten percent for the investments made eligible by subsection B of § 38.2-1421; and two percent for the investments made eligible by subsection C of § 38.2-1421;

7. Twenty percent for the investments made eligible by § 38.2-1422;

8. Ten percent for the investments made eligible by § 38.2-1423;

9. Five percent for the investments made eligible by § 38.2-1424;

10. Five percent for the investments made eligible by § 38.2-1425;

11. The lesser of 15 percent or the amount by which an insurer's surplus to policyholders exceeds its minimum capital and surplus for the aggregate of investments made eligible by §§ 38.2-1427, 38.2-1427.1 and 38.2-1427.2, of which no more than five percent of the total admitted assets shall be in investments made eligible by § 38.2-1427.1;

12. For the aggregate of investments made eligible by § 38.2-1427.3, when combined with the insurer's total investment in affiliates, the lesser of 10 percent of the insurer's admitted assets or 50 percent of the insurer's surplus to policyholders in excess of its minimum capital and surplus, provided that total investments in affiliates do not include investments made by the insurer in money market mutual funds made eligible by § 38.2-1432;

13. Fifteen percent for investments made eligible by subsection B of § 38.2-1433, and an amount equal to its deposit and reserve obligations incurred in a foreign country for the investments made eligible by subsection A of § 38.2-1433;

14. Two percent for the investments made eligible (including those that the insurer is obligated to make as well as those made) by subdivision 3 of § 38.2-1434;

15. Two percent for the investments made eligible by § 38.2-1435;

16. Ten percent for the investments made eligible by § 38.2-1436;

17. For the aggregate of investments made eligible by § 38.2-1437.1, when combined with the insurer's investments in mortgages under §§ 38.2-1434 through 38.2-1436 and § 38.2-1439, (i) 60 percent for any life insurer and (ii) 30 percent for all other insurers;

18. Two percent for the investments made eligible by § 38.2-1440; and

19. Twenty-five percent for the total of investments made eligible by § 38.2-1441, of which no more than five percent of the total admitted assets shall be in investments in real property to be used primarily for hotel purposes.

B. The amount loaned under § 38.2-1430 shall be subject to the limitations of this section applicable to the kinds of securities or obligations pledged in connection with the loan.

1983, c. 457, § 38.1-217.17; 1986, c. 562; 1992, c. 588; 1993, c. 47; 1995, c. 60; 1998, c. 414; 2014, cc. 159, 206.

§ 38.2-1415. Obligations of domestic governmental entities.

A. United States obligations. A domestic insurer may invest in any bonds, notes, warrants, and other evidences of indebtedness which are direct obligations of the United States or for which the full faith and credit of the United States are pledged for the payment of principal and interest.

B. United States agencies obligations. A domestic insurer may invest in any bonds, notes, warrants and other evidence of indebtedness which are direct obligations for the payment of money, issued by an agency or instrumentality of the United States, or obligations for the payment of money to the extent guaranteed or insured as to the payment of principal and interest by an agency or instrumentality of the United States.

C. State government obligations. A domestic insurer may invest in direct, general obligations of any state of the United States for the payment of money, or obligations for the payment of money to the extent guaranteed or insured as to the payment of principal and interest by any state of the United States, on the following conditions:

1. The state has the power to levy taxes for the prompt payment of the principal and interest of its obligations;

2. The state is not in default in the payment of principal or interest on any of its direct, guaranteed or insured obligations as of the date of investment;

3. An insurer shall not invest under this subsection more than five percent of its admitted assets in obligations issued or guaranteed by any one state; and

4. An insurer shall not invest under this subsection more than thirty percent of its admitted assets.

D. Local government obligations. A domestic insurer may invest in direct, general obligations of any political subdivision, of any state of the United States, for the payment of money, or obligations for the payment of money, to the extent guaranteed as to the payment of principal and interest, by any such political subdivision, on the following conditions:

1. The obligations are payable or guaranteed from ad valorem taxes;

2. Such political subdivision is not in default in the payment of principal or interest on any of its direct or guaranteed obligations;

3. No investment shall be made under this subsection in obligations which are secured only by special assessments for local improvements;

4. An insurer shall not invest more than five percent of its admitted assets in obligations issued or guaranteed by any one such political subdivision; and

5. An insurer shall not invest more than thirty percent of its admitted assets under this subsection.

E. Anticipation obligations. An insurer may invest in the anticipation obligations of any political subdivision of any state, all within the United States, including but not limited to bond anticipation notes, tax anticipation notes, preliminary loan anticipation notes, revenue anticipation notes and construction anticipation notes, for the payment of money within twelve months from the issuance of the obligation, on the following conditions:

1. The anticipation notes must be a direct obligation of the issuer under conditions set forth in subsection D of § 38.2-1415;

2. The political subdivision is not in default in the payment of the principal or interest on any of its direct general obligations or any obligation guaranteed by such political subdivision;

3. The anticipation funds shall be specifically pledged to secure the obligation;

4. An insurer shall not invest more than two percent of its admitted assets in the anticipation obligations issued by any one such political subdivision; and

5. An insurer shall not invest more than ten percent of its admitted assets under this subsection.

F. State or municipal revenue obligations. A domestic insurer may invest in obligations of any state of the United States, a political subdivision thereof, or a public instrumentality of any one or more of the foregoing, for the payment of money, on the following conditions:

1. The obligations are payable from revenues or earnings of a public utility of such state, political subdivision, or public instrumentality which are specifically pledged therefor;

2. The law under which the obligations are issued requires that rates for service shall be charged and collected at all times such that they will produce sufficient revenue or earnings which, together with any other revenues or moneys pledged, are sufficient to pay all operating and maintenance charges of the public utility and all principal and interest on such obligations;

3. No prior or parity obligations payable from the revenues or earnings of that public utility are in default as of the date of the investment;

4. An insurer shall not invest under this subsection more than two percent of its admitted assets in the revenue obligations issued in connection with any one facility;

5. An insurer shall not invest under this subsection more than two percent of its admitted assets in revenue obligations payable from revenue or earning sources which are the contractual responsibility of any one single credit risk; and

6. An insurer shall not invest under this subsection more than twenty-five percent of its admitted assets.

G. Other revenue obligations of state and local governments. A domestic insurer may invest in other state and local government revenue obligations of any state of the United States, a political subdivision thereof, or a public instrumentality of any of the foregoing, for the payment of money, on the following conditions:

1. The obligations are payable from revenues or earnings, excluding revenues or earnings from public utilities, specifically pledged therefor by such state, political subdivision, or public instrumentality;

2. An insurer shall not invest under this subsection more than two percent of its admitted assets in the revenue obligations issued in connection with any one facility;

3. No prior or parity obligation of the same issuer payable from revenues or earnings from the same source has been in default as to principal or interest during the five years next preceding the date of such investment, but the issuer need not have been in existence for that period, and obligations acquired under this subsection may have been newly issued;

4. An insurer shall not invest under this subsection more than two percent of its admitted assets in revenue obligations payable from sources which are the contractual responsibility of any one single credit risk; and

5. An insurer shall not invest under this subsection more than twenty-five percent of its admitted assets.

1983, c. 457, § 38.1-217.18; 1986, c. 562; 1992, c. 588; 1998, c. 414.

§ 38.2-1416. Canadian governmental obligations.

A. Obligations of Canada. -- A domestic insurer may invest in bonds, notes, warrants, and other evidences of indebtedness which are direct obligations of the government of Canada or for which the full faith and credit of the government of Canada are pledged for the payment of principal and interest.

B. No domestic insurer shall invest in any obligation under this section unless the obligation is payable both as to principal and interest in lawful money of the United States or of Canada.

C. Obligations of provinces. -- A domestic insurer may invest in direct, general obligations of any province of Canada for the payment of money, or obligations for the payment of money to the extent guaranteed or insured as to the payment of principal and interest by any province of Canada, on the following conditions:

1. The province has the power to levy taxes for the prompt payment of the principal and interest of its obligations;

2. The province is not in default in the payment of principal or interest on any of its direct, guaranteed or insured obligations as of the date of investment; and

3. An insurer shall not invest under this subsection more than five percent of its admitted assets in obligations issued or guaranteed by any one province.

D. Local government obligations. -- A domestic insurer may invest in direct, general obligations of any political subdivision of any province of Canada for the payment of money, or obligation for the payment of money, to the extent guaranteed as to the payment of principal and interest, by any such political subdivision, on the following conditions:

1. The obligations are payable or guaranteed from ad valorem taxes;

2. Such political subdivision is not in default in the payment of principal or interest on any of its direct or guaranteed obligations;

3. No investment shall be made under this subsection in obligations which are secured only by special assessments for local improvements; and

4. An insurer shall not invest more than two percent of its admitted assets in obligations issued or guaranteed by any one such political subdivision.

1983, c. 457, § 38.1-217.19; 1986, c. 562; 1992, c. 588.

§ 38.2-1417. Canadian corporate obligations.

A domestic insurer may invest in obligations issued, assumed or guaranteed by any solvent corporation created or existing under the laws of Canada, or any province of Canada. However, those obligations shall meet the standards specified in § 38.2-1421 for obligations of any business entity created or existing under the laws of the United States or any state.

1983, c. 457, § 38.1-217.20; 1986, c. 562; 1992, c. 588.

§ 38.2-1418. Obligations of certain international agencies.

A domestic insurer may invest in valid and legally authorized high grade obligations issued, assumed or guaranteed by an international development bank of which the United States is a member.

1983, c. 457, § 38.1-217.21; 1985, c. 370; 1986, c. 562; 1992, c. 588.

§ 38.2-1419. Railroad terminal and other securities.

A domestic insurer may invest in obligations secured by first mortgages, first deeds of trust or other similar liens upon terminal, depot or tunnel property, including lands, buildings and appurtenances, used in the service of transportation by one or more railroad corporations whose obligations are eligible as investments under § 38.2-1421. However, these obligations shall be (i) the direct obligation of the corporation or corporations, or (ii) guaranteed by endorsement by, or guaranteed by endorsement assumed by the corporation for the payment of principal and interest of those obligations. If the guarantee or assumption of guarantee is by two or more of the corporations, it shall be joint and several as

to each. No such investment shall be made if there has been any default in the payment of principal or interest since the issuance of the obligations but not to exceed five years from the date of investment.

1983, c. 457, § 38.1-217.22; 1986, c. 562.

§ 38.2-1420. Transportation equipment trust certificates.

A domestic insurer may invest in adequately secured equipment trust certificates or other adequately secured instruments evidencing (i) an interest in transportation equipment wholly or partly within the United States and (ii) a right to receive determined portions of rental, purchase or other fixed obligatory payments for the use or purchase of the transportation equipment.

1983, c. 457, § 38.1-217.23; 1986, c. 562.

§ 38.2-1421. Business entity obligations.

A. High grade. A domestic insurer may invest in any high grade obligations issued, assumed or guaranteed by any solvent business entity that is not in default as to principal or interest on the date of investment and which is created or existing under the laws of the United States or any state.

B. Medium grade. A domestic issuer may invest in medium grade obligations issued, assumed or guaranteed by any solvent business entity that is not in default as to principal or interest on the date of investment and which is created or existing under the laws of the United States or any state.

C. Lower grade. A domestic insurer may invest in lower grade obligations rated 4 by the Securities Valuation Office of the National Association of Insurance Commissioners or, if not rated by the Securities Valuation Office, rated in an equivalent grade by a national rating agency recognized by the Commission that are issued, assumed or guaranteed by any solvent business entity that is not in default as to principal or interest on the date of investment and which is created or existing under the laws of the United States or any state.

D. As used in this section, "business entity obligations" shall not include any mortgage pass-through securities described in § 38.2-1437.1.

1983, c. 457, § 38.1-217.24; 1986, c. 562; 1992, c. 588; 1998, c. 414.

§ 38.2-1422. Obligations secured by certain leases.

A. A domestic insurer may invest in obligations of any solvent company other than companies referred to in § 38.2-1419, incorporated under the laws of the United States or of any state if:

1. The obligations are secured by an assignment to the insurer of a lease, and the rents payable under the lease, of real or personal property or both to (i) a domestic governmental entity; (ii) Canada, or any province of Canada; or (iii) one or more companies incorporated under the laws of the United States, any state, Canada or any province of Canada;

2. The rentals assigned are sufficient to repay the indebtedness within the unexpired term of the lease, excluding any term that may be provided by an enforceable option of renewal;

3. The lessee on any lease securing an obligation under this section, or the guarantor of the lease, is an entity whose obligations would be eligible for investment by an insurer in accordance with §§ 38.2-1415, 38.2-1421 or § 38.2-1425;

4. The lessee or guarantor has not defaulted in payment of interest or principal on any of its obligations during the five fiscal years immediately preceding the date of investment; and

5. A first lien on the interest of the lessor in the unencumbered leased property is obtained as additional security for any obligation acquired pursuant to this section.

B. No domestic insurer shall invest under this section more than two percent of the insurer's admitted assets in the obligations of any one business entity or in the obligations secured by leases to any one business entity.

1983, c. 457, § 38.1-217.25; 1986, c. 562; 1992, c. 588.

§ 38.2-1423. Preferred stocks.

A domestic insurer may invest in preferred stocks of any company incorporated under the laws of the United States or any state if:

1. a. The preferred stock under consideration is not in arrears as to dividends if cumulative, or

b. Full dividends on the preferred stock under consideration have been paid in the last three years, or since issue if issued less than three years before the date of investment, if noncumulative;

2. Required sinking fund payments are on a current basis; and

3. The preferred stock is rated highest quality, high quality, or medium quality by the Securities Valuation Office of the National Association of Insurance Commissioners, or if not rated by the Securities Valuation Office, is rated in an equivalent grade by a national rating agency recognized by the Commission.

1983, c. 457, § 38.1-217.26; 1986, c. 562; 1998, c. 414; 2008, c. 93.

§ 38.2-1424. Guaranteed stocks.

A domestic insurer may invest in stocks guaranteed by a solvent company incorporated under the laws of the United States or of any state if for the past three years the guarantor's net earnings available for meeting fixed charges is at least 1 1/4 times the sum of (i) the fixed charges of the guarantor and (ii) the dividends on the guaranteed stock.

1983, c. 457, § 38.1-217.27; 1986, c. 562.

§ 38.2-1425. Common stock of banks or trust companies.

A. A domestic insurer may invest in the common capital stock of any bank or trust company that is a member of the Federal Deposit Insurance Corporation.

B. No domestic insurer shall invest in more than ten percent of the actually issued and outstanding common capital stock of any one such bank or trust company.

C. For the purpose of this section, the term "bank" includes a registered bank holding company as defined by the Federal Bank Holding Act of 1956, as amended, and a registered bank holding company shall be considered a member of the Federal Deposit Insurance Corporation if all its subsidiary banks are members of the Federal Deposit Insurance Corporation.

1983, c. 457, § 38.1-217.28; 1986, c. 562; 2000, c. 155.

§ 38.2-1426. Application of earnings tests.

If the issuing, assuming or guaranteeing business entity has not been in operation for the entire period for which earnings are being applied pursuant to § 38.2-1424, the earnings tests shall be based upon pro forma statements incorporating statements of any predecessor or constituent business entity for that portion of the earnings tests period that the current business entity was not in operation, if:

1. The current business entity was formed as a consolidation or a merger of two or more business entities, at least one of which was in operation at the beginning of the period; or

2. The current business entity has acquired all of the assets of a business entity or any division or other unit of a business entity that was in operation at the beginning of the test period.

1983, c. 457, § 38.1-217.29; 1986, c. 562; 1992, c. 588; 2000, c. 155; 2002, c. 147.

§ 38.2-1427. Common stock; covered call options.

A. A domestic insurer may invest in the common capital stock of any company incorporated under the laws of the United States or any state, if the common capital stock of the corporation is traded on a securities exchange or on an over-the-counter market regulated under the Securities Exchange Act of 1934, as amended.

B. A domestic insurer also may write exchange-traded, covered call options on shares of common capital stock it owns.

C. No domestic insurer shall invest, pursuant to this section, in more than ten percent of the issued and outstanding common capital stock of any one corporation or issuer.

1983, c. 457, § 38.1-217.30; 1986, c. 562; 1992, c. 588.

§ 38.2-1427.1. Limited partnerships.

A domestic insurer may become a limited partner in a partnership organized and governed under the laws of the United States or any state for the purpose of making or participating in investments otherwise permissible for domestic insurers under the provisions of this chapter.

1992, c. 588.

§ 38.2-1427.2. Investment company shares and units of beneficial interest.

A domestic insurer may invest in shares of common stock or units of beneficial interest issued by any solvent business corporation or trust incorporated or organized under the laws of the United States, or of any state of the United States, under the following conditions:

1. If the issuing corporation or trust is advised by an investment advisor which is the insurer or an affiliate of the insurer, the issuing corporation or trust shall have assets of $100,000 or more (which may be provided by the insurer or affiliate), or if the issuing corporation or trust has an unaffiliated investment advisor, the issuing corporation or trust shall have net assets of ten million dollars or more, and

2. The issuing corporation or trust is registered as an investment company with the Federal Securities and Exchange Commission under the Investment Company Act of 1940, as amended.

1992, c. 588; 2002, c. 147.

§ 38.2-1427.3. Investment authority; subsidiary corporations.

A domestic insurer may invest in common stock, preferred stock, debt obligations, and other securities of a subsidiary.

For investments in subsidiary corporations made prior to July 1, 1995, July 1, 1995, may be deemed the date of investment.

1992, c. 588; 1993, c. 47; 1995, c. 60.

§ 38.2-1428. Derivative instruments.

A. A domestic insurer may engage in derivative transactions under this section subject to the following general conditions:

1. A domestic insurer may use derivative instruments under this section to engage in hedging transactions and replication transactions.

2. Each domestic insurer utilizing derivative instruments shall establish written guidelines with respect to derivative transactions stating the insurer's objectives for engaging in derivative transactions and derivative strategies, permissible derivative strategies and the relationship of those strategies to the insurer's operations, and such other details as the Commission may from time to time require. The insurer's board of directors or committee thereof charged with the responsibility of overseeing investments shall approve the written guidelines and any amendment thereto and shall establish a procedure to determine, at least annually, that all derivative transactions were made in accordance with such guidelines. The guidelines established pursuant to this section, and any amendment thereto, shall be submitted to the Commission for prior approval. The Commission shall, in writing, either approve the guidelines or amendment, request any additional information needed to approve the guidelines or amendment, or deny the guidelines or amendment within (i) 90 days of receipt of the guidelines or (ii) 60 days of receipt of any amendment; otherwise the guidelines or amendment shall be deemed approved.

3. The Commission may adopt reasonable rules and regulations for derivative transactions including, but not limited to, rules and regulations that impose financial solvency standards, valuation standards, and reporting requirements.

B. A domestic insurer may enter into hedging transactions if:

1. The domestic insurer is able to demonstrate to the Commission the intended hedging characteristics and the ongoing effectiveness of the derivative transaction or combination of the transactions through cash flow testing or other appropriate analyses; and

2. As a result of and after giving effect to the hedging transaction:

a. The aggregate statement value of options, caps, floors, and warrants not attached to another financial instrument purchased and used in hedging transactions then engaged in by the domestic insurer does not exceed 7.5 percent of its admitted assets;

b. The aggregate statement value of options, caps, and floors written in hedging transactions then engaged in by the domestic insurer does not exceed 3 percent of its admitted assets; and

c. The aggregate potential exposure of collars, swaps, forwards, and futures used in hedging transactions then engaged in by the domestic insurer does not exceed 6.5 percent of its admitted assets.

C. A domestic insurer may enter into replication transactions if the asset being replicated shall comply with all of the provisions and limitations specified in this article with respect to investments by the insurer, as if such replicated asset constituted a direct investment by the insurer in the asset being replicated. The aggregate statement value of all assets being replicated shall not exceed 10 percent of the insurer's admitted assets.

D. The counterparty exposure amount under a derivative instrument entered into pursuant to this section shall be deemed an obligation of a business entity to which the insurer is exposed to credit risk for the purpose of determining compliance with the limitations of §§ 38.2-1411.2 and 38.2-1413.

E. Pursuant to rules promulgated under § 38.2-223, the Commission may approve additional transactions involving the use of derivative instruments in excess of the limits set forth in this section or for other risk management purposes.

1983, c. 457, § 38.1-217.31; 1985, c. 36; 1986, c. 562; 2001, c. 387; 2011, c. 198.

§ 38.2-1429. Lending of securities.

A. A domestic insurer may lend securities held by it pursuant to §§ 38.2-1415 through 38.2-1427.2 if:

1. Simultaneously with the delivery of the securities, the insurer receives collateral from the borrower consisting of cash or consisting of securities issued, assumed or guaranteed by the United States, an agency of the United States or any state. The securities shall have a present market value of at least 102 percent of the market value of the securities loaned;

2. The securities are loaned only for the purpose of making delivery of securities in the case of short sales, in the case of failure to receive securities requested for delivery or in other similar cases;

3. Prior to the loan, the borrower furnishes the insurer with the most recent statement of the borrower's financial condition and a representation by the borrower that there has been no material adverse change in its financial condition since the date of that statement;

4. The insurer receives a reasonable fee related to the value of the borrowed securities and to the duration of the loan;

5. The loan is made pursuant to a written loan agreement; and

6. The borrower is required to furnish by the close of each business day during the term of the loan a report of the market value of all collateral and the market value of all borrowed securities as of the close of trading on the previous business day. If at the close of any business day the market value of the collateral is less than 102 percent of the market value of the securities loaned, then the borrower shall deliver by the close of the next business day an additional amount of cash or securities. The market value of these additional securities, together with the market value of all previously delivered collateral, shall equal at least 102 percent of the market value of the securities loaned.

B. For the purposes of this section, "market value" includes accrued interest.

1983, c. 457, § 38.1-217.32; 1986, c. 562; 1992, c. 588.

§ 38.2-1430. Collateral loans.

A domestic insurer may make loans secured by securities eligible for investment under this article. At the date of investment, the loan shall not exceed eighty percent of the market value of the collateral pledged. However, if the collateral consists of obligations issued, assumed or guaranteed by the United States, the loan may equal the market value of the collateral pledged.

1983, c. 457, § 38.1-217.33; 1986, c. 562.

§ 38.2-1431. Policy loans.

A domestic insurer issuing life insurance policies or annuities may loan any sum not exceeding the cash surrender value specified in the policy to its policyholder upon the pledge of the policy as collateral.

1983, c. 457, § 38.1-217.34; 1986, c. 562.

§ 38.2-1432. Savings, certificates, etc.

A domestic insurer may invest in any of the following:

1. Interest-bearing checking or savings accounts, certificates of deposit, or other short-term investments made available or issued by any solvent bank or trust company that is a member of the Federal Deposit Insurance Corporation;

2. Interest-bearing savings or share accounts, certificates of deposit or any other short-term investments made available or issued by any solvent building and loan or savings institution insured by the Federal Deposit Insurance Corporation or other federal insurance agency;

3. Bankers acceptances of the kinds and maturities made eligible by law for rediscount with Federal Reserve Banks, provided that these securities are accepted by a bank or trust company that is a member of the Federal Reserve System;

4. Money market mutual funds, provided that the Commission has granted prior written approval to the insurer with respect to its investment in any money market mutual fund sponsored by affiliates of the insurer and that such money market fund sponsored by affiliates meets the requirements set forth in subdivisions 1 and 2 of § 38.2-1427.2; or

5. United States government bond mutual funds.

1983, c. 457, § 38.1-217.35; 1986, c. 562; 1990, c. 3; 1995, c. 60; 1996, c. 77.

§ 38.2-1433. Foreign securities.

A. A domestic insurer transacting the business of insurance in a foreign country may invest in securities of or issued in that country of substantially the same kinds, classes, and investment grades as the insurer may acquire in the United States.

B. A domestic insurer may invest in securities of or issued in a foreign country of substantially the same kinds, classes and investment grades as the insurer may acquire in the United States, provided (i) all such securities are rated medium grade or higher by the Securities Valuation Office of the National Association of Insurance Commissioners or by a national rating agency recognized by the Commission and no more than one percent of the insurer's admitted assets are invested in such securities which are rated medium grade, and (ii) the aggregate amount of foreign investment held by the insurer under this section for a single foreign jurisdiction does not exceed (a) five percent of the insurer's admitted assets as to a foreign jurisdiction that has a sovereign debt rating of SVO 1 by the Securities Valuation Office of the National Association of Insurance Commissioners or (b) three percent of the insurer's admitted assets as to any other foreign jurisdiction.

C. Investments made eligible by this section shall be payable in lawful currency of the United States, except (i) where payment in other lawful currencies is required to match obligations denominated in such other lawful currencies or (ii) if the investment is denominated in other lawful currency, the investment is effectively hedged, substantially in its entirety, against the lawful currency of the United States in accordance with § 38.2-1428.

1983, c. 457, § 38.1-217.36; 1986, c. 562; 1998, c. 414; 2014, cc. 159, 206.

§ 38.2-1434. Mortgage loans.

Subject to the provisions of § 38.2-1437, a domestic insurer may invest in:

1. Obligations secured by first mortgages or first deeds of trust on improved unencumbered real property located in the United States;

2. Obligations secured by first mortgages or first deeds of trust upon leasehold estates on improved and otherwise unencumbered real property where:

a. The leasehold interest lasts for a term of not less than ten years beyond the maturity of the loan as made or as extended; and

b. The mortgagee is subrogated to all the rights of the lessee on foreclosure or on taking a deed in lieu of foreclosure; or

3. Obligations secured by first mortgages or first deeds of trust on unimproved and unencumbered real property in the United States for the purpose of financing the construction of a building or other improvements on the real property subject to the mortgage or deed of trust, if:

a. These obligations mature not more than sixty months from the effective date of the mortgage or deed of trust and are the unlimited and unconditional liability of the obligor;

b. The obligor provides the insurer with a completion bond for the building or improvements at the time of making the loan; and

c. The insurer at or prior to the making of the loan (i) enters into an agreement with another party to provide permanent financing or (ii) agrees to provide permanent financing upon completion of the building or other improvement.

1983, c. 457, § 38.1-217.37; 1986, c. 562.

§ 38.2-1435. Second mortgages; wrap-around mortgages.

A domestic insurer may invest in obligations secured by second mortgages or second deeds of trust on real property encumbered only by a first mortgage or first deed of trust complying with §§ 38.2-1434 and 38.2-1437, subject to either of the following conditions:

1. The insurer also owns the obligation secured by the first mortgage or first deed of trust, and the aggregate value of both loans does not exceed the applicable loan-to-value ratio specified in § 38.2-1437; or

2. The obligation is secured by a wrap-around mortgage where:

a. Only one preexisting mortgage or deed of trust encumbers the real property;

b. The mortgage or deed of trust securing the loan is (i) recorded and (ii) insured for at least the total amount of the obligation of the borrower to the insurer by title insurance; and

c. The insurer agrees to make the payments due under the first mortgage or first deed of trust upon receipt of payments due from the borrower under the wrap-around mortgage.

1983, c. 457, § 38.1-217.38; 1986, c. 562.

§ 38.2-1436. Mortgage participations.

Notwithstanding the provisions of §§ 13.1-627 and 13.1-826, a domestic insurer may acquire or sell participation interests in any loans secured by a mortgage or deed of trust qualifying under § 38.2-1434 if the insurer has all or substantially all the rights of a first mortgagee.

1983, c. 457, § 38.1-217.39; 1986, c. 562.

§ 38.2-1437. Limitations on mortgages.

A. The amount of any loan secured by a mortgage or deed of trust referred to in §§ 38.2-1434 through 38.2-1436 shall not exceed the following percentages of the fair market value of the real estate:

1. Seventy-five percent for a leasehold loan made pursuant to subdivision 2 of § 38.2-1434;

2. Ninety percent for a loan made to an employee of the insurer, other than a director or trustee thereof, whether such loan be made in connection with the initial employment of the employee or in connection with the transfer of the place of employment of the employee; or

3. Eighty percent for all other loans.

However, the percentage limits specified in this subsection may be exceeded if the excess is (i) insured or guaranteed or is to be insured or guaranteed by the United States, any state or any agency of either or (ii) insured by an insurer licensed to insure mortgage guaranty risks in this Commonwealth.

B. Any loan made pursuant to §§ 38.2-1434 through 38.2-1436 not in compliance with the requirements of subsection A of this section shall be classified as a Category 2 investment in its entirety.

C. The fair market value of the real estate interest mortgaged shall be determined by a written appraisal of at least one competent real estate appraiser as of the date of the initial loan commitment, which appraiser shall not be an employee of the insurer nor an employee of any company controlled by or under common control with the insurer. If the loan commitment is revised to reflect a change in the value of the real estate, the fair market value shall be determined as of the date of that revision.

D. Buildings and other improvements on the mortgaged premises shall be insured against fire loss for the benefit of the mortgagee in an amount not less than the lesser of their insurable value or the unpaid principal balance of the obligation.

E. The maximum term of any mortgage or deed of trust referred to in §§ 38.2-1434 through 38.2-1436 secured by real property primarily improved by a single-family residence shall not exceed thirty years.

F. A domestic insurer shall not invest, under §§ 38.2-1434 through 38.2-1436, more than two percent of its admitted assets, directly or indirectly, in mortgages covering any one secured location, nor more than four percent in the mortgages of any one obligor.

1983, c. 457, § 38.1-217.40; 1986, c. 562; 1992, c. 588.

§ 38.2-1437.1. Mortgage pass-through securities.

A domestic insurer may invest in mortgage pass-through securities backed by a pool of mortgages of the kind, class and investment quality as those eligible for investment under §§ 38.2-1434 through 38.2-1437, under the following conditions:

1. The servicer of the pool of mortgages shall be a business entity created under the laws of the United States or any state;

2. The pool of mortgages is assigned to a business entity, other than a sole proprietorship, having a net worth of at least five million dollars, as trustee for the benefit of the holders of the securities;

3. A domestic insurer shall not invest under this section more than two percent of its admitted assets in securities backed by any single mortgage pass-through pool;

4. All mortgage pass-through securities acquired by a domestic insurer under this section shall provide for flow-through of both principal and interest payments payable on the underlying mortgage

loan assets; mortgage pass-through securities promising principal-only, interest-only or residual interests-only in the underlying mortgage assets shall not be acquired; and

5. The securities on the date of investment shall be high grade obligations.

1992, c. 588; 1999, c. 483.

§ 38.2-1438. Renewals and extensions when value of property decreases.

Nothing in this chapter shall prohibit a domestic insurer from renewing or extending, or consenting to the renewal or extension of, evidences of indebtedness secured by real property or leasehold estates for the original or a lesser amount when a decrease in value of the property or estate causes the indebtedness to exceed the applicable loan-to-value ratio specified by § 38.2-1437. Nothing in this chapter shall prohibit a domestic insurer from accepting as part payment for any real property or leasehold estate sold by it, a mortgage or other lien on the real property or leasehold estate securing a loan that exceeds the applicable loan-to-value ratio specified in § 38.2-1437.

1983, c. 457, § 38.1-217.41; 1986, c. 562.

§ 38.2-1439. Chattel mortgages.

A. In connection with a mortgage loan on the security of real property designed and used primarily for residential purposes and acquired pursuant to § 38.2-1434, a domestic insurer may make a loan on the security of a chattel mortgage, deed of trust or other appropriate lien. The chattel mortgage or other lien may be created separately or in combination with the mortgage loan on the real estate. It shall not exceed five years and shall constitute a first and prior lien, except for taxes not then delinquent, on personal property comprised of durable equipment owned by the mortgagor and kept and used on the mortgaged premises.

B. The term "durable equipment" includes only mechanical refrigerators, mechanical laundering machines, heating and cooking stoves and ranges, mechanical kitchen aids, vacuum cleaners, and fire extinguishing devices; and, for apartment houses and hotels, may also include room furniture and furnishings.

C. Before any loan or investment is made under this section, the items of property included in the security shall be separately appraised by a competent appraiser and the fair market value of the items determined. No loan made under this section shall exceed the lesser of (i) an amount obtained by multiplying the loan to the value ratio applicable to the companion loan on the real property by the fair market value of the personal property or (ii) an amount equal to twenty percent of the amount secured by the lien on the real property.

1983, c. 457, § 38.1-217.42; 1986, c. 562.

§ 38.2-1440. Investment in personal property.

A. A domestic insurer may invest in interests in tangible personal property for the production of income, evidenced by trust certificates or other instruments.

B. The investments shall be accompanied by (i) a right to receive rental, charter hire, purchase or other payments for the use or purchase of the personal property, (ii) a valid, binding and enforceable contract or lease for the purchase or use of the tangible personal property, and (iii) a provision for contractual payments to be made that will return the cost of the property and provide earnings on the investments within the anticipated useful life of the property which shall be at least three years.

C. The payments must be made payable or guaranteed by one or more domestic governmental entities or business entities whose obligations would qualify for investment under § 38.2-1421.

D. The unit cost of such property shall not be less than $25,000, and the cost of all property covered by any single contract or lease shall not be less than $100,000.

E. The tangible personal property shall not include furniture or fixtures.

1983, c. 457, § 38.1-217.43; 1986, c. 562; 1992, c. 588.

§ 38.2-1441. Real estate.

A. A domestic insurer may invest in real estate, as set forth in subsections B, C and D of this section, unless the property is to be used primarily for agricultural, horticultural, ranch, recreational, amusement or club purposes. The term "real estate" as used in this section shall include a leasehold of real estate having an unexpired term of not less than twenty years.

B. A domestic insurer may invest in dwellings, offices and other properties (including leasehold estates) for the production of income, other than real estate which is the subject of subsection C, situated in the United States, and the construction thereon of improvements, under the following conditions:

1. The insurer shall either directly or through a land trust own the entire property, except that it may share ownership with one or more insurers authorized to do business in this state, or other business entities, excluding sole proprietorships, having a net worth of at least five million dollars under agreements that will assume concerted action in management and control of the property in case of the insolvency of any participating company, provided that each investment made pursuant to this subsection by the insurer and by each participant shall not be less than $100,000;

2. The insurer alone or in conjunction with participants qualified under subdivision B 1 may let contracts for construction and pay costs of construction and leasing, hold, maintain, lease, and manage the property, collect rents and other income therefrom, and sell the property in whole or in part;

3. The property may be encumbered by lease to tenants and by rights-of-way, easements, mineral reservations, building restrictions, and restrictive covenants, provided none of them can interfere substantially with the use of the property or result in a forfeiture of the property, unless a policy of title insurance, issued by a responsible title insurer qualified to do business in the state wherein the property is located, insures the insurer against loss or damage arising from such encumbrances or reversionary rights; and

4. An insurer shall not invest under this subsection more than four percent of its admitted assets in any one property or in any one grouping of contiguous properties.

C. A domestic insurer may invest in real estate, including leasehold estates, for the convenient accommodation of the insurer's business operations, including home office, branch office and field office operations, under the following conditions:

1. Any parcel of real estate acquired under this subsection may include excess space for rent to others if it is reasonably anticipated that the excess will be required by the insurer for expansion or if the excess is reasonably required in order to have one or more buildings that will function as an economic unit;

2. The real estate may be subject to a mortgage;

3. An insurer shall not invest under this subsection more than ten percent of the insurer's admitted assets, except with the permission of the Commission if it is found that such percentage of the insurer's admitted assets is insufficient to provide convenient accommodation for the insurer's business; and

4. The permission of the Commission shall be obtained by an insurer prior to the purchase of any real estate under this subsection if the insurer has been authorized in this Commonwealth for a period of less than five years.

D. Real property serving as the residence of an employee of any domestic insurer, other than a director or trustee of the insurer, may be acquired only in connection with the (i) relocation by the insurer of the place of employment of the employee, or (ii) any relocation in connection with the initial employment of the employee. The purchase price shall not exceed the fair market value of the property as determined by written appraisals of at least two competent independent real estate appraisers for the purpose of the acquisition. The employee shall have made reasonable efforts otherwise to dispose of the property for a period of not less than one month immediately prior to the acquisition.

1983, c. 457, § 38.1-217.44; 1986, c. 562; 1992, c. 588.

§ 38.2-1442. Guaranty association obligations.

A domestic insurer may invest in any obligation not in default of the Virginia Life, Accident and Sickness Insurance Guaranty Association issued pursuant to subdivision L 3 of § 38.2-1704 or the Virginia Property and Casualty Insurance Guaranty Association issued pursuant to subdivision 2 of subsection B of § 38.2-1606.

1986, c. 562; 2010, c. 510.

Article 3 - SEPARATE ACCOUNTS

§ 38.2-1443. Investment of amounts allocated to separate accounts for variable life insurance and variable annuities.

The amounts allocated to separate accounts for variable life insurance and variable annuities, pursuant to the provisions of § 38.2-3113, and accumulations on them, may be invested and reinvested by a domestic insurer in any type of Category 1 investment. Any percentage limitations based on the insurer's total admitted assets or surplus to policyholders shall not apply to investments made pursuant to this section.

1983, c. 457, § 38.1-217.45; 1986, c. 562; 1992, c. 588.

§ 38.2-1443.1. Investment of amounts allocated to separate accounts for modified guaranteed life insurance, modified guaranteed annuities, and funding agreements.

A. Unless otherwise provided by regulation, the amounts allocated to separate accounts for modified guaranteed life insurance and modified guaranteed annuities pursuant to the provisions of § 38.2-3113.1, and for funding agreements pursuant to the provisions of § 38.2-3100.2, and accumulations on them, may be invested and reinvested by a domestic insurer in any type of Category 1 investment.

B. Investments made pursuant to this section shall be taken into account in applying the investment limitations of §§ 38.2-1413 and 38.2-1414 to investments made by the insurer, by combining the investments under this section with all other investments subject to such limitations. In addition to the general account meeting these investment limitations, both the separate account and the general account together shall meet these investment limitations. The limitations of §§ 38.2-1413 and 38.2-1414 shall not otherwise apply to investments made pursuant to this section.

1992, c. 210; 2008, c. 216.

§ 38.2-1444. Establishment of separate accounts for pension, retirement or profit-sharing plans; investment of funds in such accounts.

A. A domestic insurer, after adoption of a resolution by its board of directors and certification of that adoption to the Commission, may allocate to one or more separate accounts, in accordance with the terms of a written agreement, any amounts paid to or held by the insurer in connection with a pension, retirement or profit-sharing plan. The plan may provide (i) retirement benefits pursuant to the terms of the agreement or under the insurer's policies or contracts and (ii) other benefits incidental to the agreement or policies. The retirement benefits may vary according to the terms of the agreement, policies or contracts and any standards incorporated in them. Any income and any realized or unrealized gain or loss on each account shall be credited to or charged against that account in accordance with the agreement, without regard to the other income, gains or losses of the insurer.

B. Notwithstanding any other provision in this title, the amounts allocated to the accounts and accumulations on them may be invested and reinvested in any kinds of investment specified in the agreement other than those prohibited by § 38.2-1407. The investments shall not be taken into account in applying the investment limitations of this chapter to investments made by the insurer.

C. Amounts allocated by an insurer to separate accounts pursuant to this section shall be owned by the insurer, and the insurer shall not be, nor hold itself out to be, a trustee for the amounts. The insurer's liability under the accounts shall be limited to the amount of funds in the account.

1983, c. 457, § 38.1-217.46; 1986, c. 562.

§ 38.2-1445. Separate accounts deemed Category 1 investments.

All investments made in compliance with this article shall be deemed Category 1 investments except that nothing contained in this section shall be construed to affect or apply to any insurer licensed pursuant to the provisions of Chapter 42 (§ 38.2-4200 et seq.) or 45 (§ 38.2-4500 et seq.) of this title.

1983, c. 457, § 38.1-217.47; 1986, c. 562; 1992, c. 588.

Article 4 - ASSET PROTECTION ACT

§ 38.2-1446. Prohibition of hypothecation.

A. Every domestic insurer subject to the provisions of this chapter shall at all times have and maintain free and unencumbered admitted assets in an amount equal to the sum total of its reserve liabilities and minimum capital and surplus, and no such insurer shall pledge, hypothecate, or otherwise encumber its assets in an amount in excess of the amount of its surplus to policyholders; nor shall such insurer pledge, hypothecate or otherwise encumber more than five percent of its admitted assets. However, the Commission, upon written application, may approve the hypothecation or encumbrance of any of the assets of such an insurer in any amount upon a determination that such hypothecation or encumbrance will not adversely affect the solvency of such insurer.

B. Any such insurer which pledges, hypothecates, or otherwise encumbers any of its assets shall within ten days thereafter report in writing to the Commission the amount and identity of the assets so pledged, hypothecated, or encumbered and the terms and conditions of such transaction. In addition, each such insurer shall annually, or more often if required by the Commission, file with the Commission a statement sworn to by an executive officer of the insurer that (i) title to assets in an amount equal to the reserve liability and minimum capital and surplus of the insurer that are not pledged, hypothecated or otherwise encumbered is vested in the insurer, (ii) the only assets of the insurer that are pledged, hypothecated or otherwise encumbered are as identified and reported in the sworn statement and no other assets of the insurer are pledged, hypothecated or otherwise encumbered, and (iii) the terms and limitations of any such transaction of pledge, hypothecation or encumbrance are as reported in the sworn statement.

C. Any person who accepts a pledge, hypothecation or encumbrance of any asset of a domestic insurer as security for a debt or other obligation of such insurer not in accordance with the terms and limitations of this article shall be deemed to have accepted such asset subject to a superior, preferential and automatically perfected lien in favor of claimants; however, such superior, preferential and automatically perfected lien in favor of claimants shall not apply to assets of a company in receivership pursuant to Chapter 15 (§ 38.2-1500 et seq.) of this title, if the receiver approves the pledge, hypothecation or encumbrance of such assets.

D. In the event of involuntary or voluntary liquidation of any domestic insurer subject to this chapter, claimants of such insurer shall have a prior and preferential claim against all assets of the insurer except those that have been pledged, hypothecated or encumbered in accordance with the terms and

limitations of this article. All claimants shall have equal status and their prior and preferential claim shall be superior to any claim or cause of action against the insurer by any person, corporation, association or legal entity.

1992, c. 588; 2002, c. 147.

§ 38.2-1447. Exception.

A. This article shall not apply to those assets of any insurer that are held, deposited, pledged, hypothecated or otherwise encumbered as provided herein to secure, offset, protect, or meet those reserve liabilities of such insurer which are established, incurred, or required under the provisions of a reinsurance agreement whereby such insurer has reinsured the insurance policy liabilities of a ceding insurer, provided:

1. The ceding insurer and the reinsurer are both licensed to transact business in this Commonwealth; and

2. Pursuant to a written agreement between the ceding insurer and the reinsurer, reserve assets substantially equal to the reserve liabilities required to be established by the ceding insurer on the reinsured business are either (i) deposited by or are withheld from the reinsurer and are in the custody of the ceding insurer as security for the payment of the reinsurer's obligations under the reinsurance agreement, and such assets are held subject to withdrawal by and under control of the ceding insurer or (ii) are deposited and held in a trust account for such purpose and under such conditions with a qualified United States financial institution defined as eligible to act as a fiduciary of a trust by § 38.2-1316.1.

B. The Commission shall have the right to examine any such assets, reinsurance agreements, or deposit arrangements at any time in accordance with its authority to make examinations of insurers as conferred by other provisions of this title.

1992, c. 588.

Chapter 15 - REHABILITATION AND LIQUIDATION OF INSURERS

§ 38.2-1500. Scope of chapter.

This chapter shall, except as otherwise stated, apply to every insurer transacting, attempting to transact, or representing itself as transacting an insurance business in this Commonwealth, or which is in the process of organization as an insurer.

1952, c. 317, § 38.1-126; 1986, c. 562.

§ 38.2-1501. Definitions.

As used in this chapter:

"Actual direct compensatory damages" does not include punitive damages, damages for lost profit or lost opportunity, or damages for pain and suffering, but does include normal and reasonable costs of

cover or other reasonable measures of damages utilized in the derivatives, securities, or other market for the contract and agreement claims.

"Association" means the Virginia Property and Casualty Insurance Guaranty Association created by Chapter 16 (§ 38.2-1600 et seq.) or the Virginia Life, Accident and Sickness Insurance Guaranty Association created by Chapter 17 (§ 38.2-1700 et seq.) or any person performing a similar function in another state.

"Commodity contract" means:

1. A contract for the purchase or sale of a commodity for future delivery on, or subject to the rules of, a board of trade or contract market under the Commodity Exchange Act (7 U.S.C. § 1 et seq.) or a board of trade outside the United States;

2. An agreement that is subject to regulation under § 19 of the Commodity Exchange Act (7 U.S.C. § 1 et seq.) and that is commonly known to the commodities trade as a margin account, margin contract, leverage account, or leverage contract;

3. An agreement or transaction that is subject to regulation under § 4c(b) of the Commodity Exchange Act (7 U.S.C. § 1 et seq.) and that is commonly known to the commodities trade as a commodity option;

4. Any combination of the agreements or transactions referred to in this definition; or

5. Any option to enter into an agreement or transaction referred to in this definition.

"Contractual right" as used in § 38.2-1522 includes any right set forth in a rule or bylaw of a derivatives clearing organization as defined in the Commodity Exchange Act, a multilateral clearing organization as defined in the Federal Deposit Insurance Corporation Improvement Act of 1991, a national securities exchange, a national securities association, a securities clearing agency, a contract market designated under the Commodity Exchange Act, a derivatives transaction execution facility registered under the Commodities Exchange Act, or a board of trade as defined in the Commodity Exchange Act, or in a resolution of the governing board thereof and any right, whether or not evidenced in writing, arising under statutory or common law, under law merchant, or by reason of normal business practice.

"Delinquency proceeding" means any proceeding commenced against an insurance company for the purpose of liquidating, rehabilitating, reorganizing, or conserving an insurer.

"Forward contract," "repurchase agreement," "securities contract," and "swap agreement" have the meanings set forth with respect thereto in 12 U.S.C. § 1821(e)(8)(D), as amended.

"Insolvent" means (i) the condition of an insurer that has liabilities in excess of assets or (ii) the inability of an insurer to pay its obligations as they become due in the usual course of business.

"Netting agreement" means:

1. A contract or agreement, including terms and conditions incorporated by reference in it, including a master agreement, which master agreement, together with all schedules, confirmations, definitions,

and addenda to it and transactions under any of them, shall be treated as one netting agreement, that documents one or more transactions between the parties to the agreement for or involving one or more qualified financial contracts and that provides for the netting, liquidation, setoff, termination, acceleration, or close-out, under or in connection with one or more qualified financial contracts or present or future payment or delivery obligations or payment or delivery entitlements under it, including liquidation or close-out values relating to those obligations or entitlements, among the parties to the netting agreement;

2. Any master agreement or bridge agreement for one or more master agreements described in subdivision 1 of this definition; or

3. Any security agreement or arrangement or other credit enhancement or guarantee or reimbursement obligation related to any contract or agreement described in subdivision 1 or 2 of this definition, provided that any contract or agreement described in subdivision 1 or 2 of this definition relating to agreements or transactions that are not qualified financial contracts shall be deemed to be a netting agreement only with respect to those agreements or transactions that are qualified financial contracts.

"Qualified financial contract" means any commodity contract, forward contract, repurchase agreement, securities contract, swap agreement, or any similar agreement that the Commission determines to be a qualified financial contract for the purposes of this chapter.

"Receiver" means the Commission or any person appointed to manage delinquency proceedings.

1952, c. 317, § 38.1-127; 1986, c. 562; 2011, c. 198; 2015, c. 710.

§ 38.2-1502. Jurisdiction and procedure.

The jurisdiction of delinquency proceedings shall be determined by general law, except that if the Commission files a delinquency proceeding application, it shall be filed with the Circuit Court of the City of Richmond. Unless otherwise provided, all delinquency proceedings shall be conducted as a suit in equity.

1952, c. 317, § 38.1-128; 1986, c. 562.

§ 38.2-1503. Grounds for delinquency proceedings commenced by Commission against domestic insurer.

Delinquency proceedings may be commenced by the Commission against any domestic insurer whenever the insurer:

1. Has been determined to be insolvent by the Commission;

2. Has refused to submit its books, papers, accounts, records, or affairs to the reasonable inspection of the Commission or its representative;

3. Has refused or failed to comply with any order of the Commission to make good within the time prescribed by law (i) any impairment of its minimum capital and surplus if the insurer is a stock insurer, (ii) any impairment of its minimum surplus if the insurer is other than a stock insurer, or (iii) membership

requirements as set forth in § 38.2-2515 if the insurer is a mutual assessment property and casualty insurer and has had its license revoked;

4. Has transferred or attempted to transfer substantially its entire property, or has entered into any transaction which merges substantially its entire property or business, into the property or business of any other company without prior written approval of the Commission;

5. Has removed, attempted to remove, or is about to remove from this Commonwealth any material part of its property or business necessary for the continued conduct of its business if it endangers the interests of its policyholders, stockholders or members;

6. Has reinsured all or substantially all of its risks without prior written approval of the Commission;

7. Is found, after an examination, to be in a condition where any further transaction of business will be hazardous to its policyholders, creditors, members, subscribers, stockholders, or to the public;

8. Has willfully violated its charter or any law of this Commonwealth;

9. Has an officer, director or manager who has refused to be examined under oath concerning its affairs;

10. Has had any material part of its entire property sequestered in any other state or country;

11. Has not organized or completed its organization and obtained a license to transact the business of insurance in this Commonwealth within the period of time set by law; or

12. Has failed to pay a final judgment rendered against it in any state upon any insurance contract issued or assumed by it (i) within sixty days after the judgment has become final, (ii) within sixty days after time for taking an appeal has expired, or (iii) within sixty days after dismissal of an appeal before final determination, whichever date is the latest.

Code 1950, § 38-138; 1952, c. 317, § 38.1-129; 1986, c. 562.

§ 38.2-1504. Requirements when proceedings instituted by any person other than Commission.

A. No circuit court in this Commonwealth shall appoint a receiver for any domestic insurer on application of any person other than the Commission until:

1. The applicant has presented to the Commission a copy of a bill in equity for receivership and has given reasonable notice to the affected insurer that a copy of the bill has been presented to the Commission.

2. The affected insurer has been given ten days after the service of this notice to present to the Commission a copy of the answer that it proposes to file.

3. The Commission has investigated the merits of the application for receivership and has held a hearing on the results of the investigation. The Commission shall act within a reasonable period of time.

4. Within a reasonable time after completing its investigation, the Commission shall make a recommendation to the proper court regarding the appointment of the proposed receiver.

B. The court shall appoint or refuse to appoint the proposed receiver after considering the merits of the application for a receiver.

1952, c. 317, § 38.1-130; 1986, c. 562.

§ 38.2-1505. Commission may apply for receiver and for other relief; what orders court may enter.

A. Whenever the Commission finds that any of the grounds for rehabilitation or liquidation of a domestic insurer set out in § 38.2-1503 exist, it may apply to the Circuit Court of the City of Richmond for an order directing the insurer to show cause on or before a designated date (i) why a receiver other than the Commission should not be appointed for the insurer, (ii) why an order should not be entered authorizing the Commission, as a receiver, to proceed with the rehabilitation or liquidation of the insurer or (iii) why other appropriate steps authorized by this chapter should not be taken. The application and order may include any other relief as the nature of the case and the interests of the policyholders, creditors, stockholders, members of the insurer and of the public may require. A copy of the application and the order to show cause shall be served upon the insurer and shall constitute legal process. The State Treasurer shall be made a party to the proceeding.

B. On or after the return of the order to show cause, and after a full hearing, the court shall either deny the application, appoint a receiver for the insurer, authorize the Commission to proceed with the rehabilitation or liquidation of the insurer or to take any other appropriate proceedings as the Commission considers advisable.

Code 1950, §§ 38-138, 38-139; 1952, c. 317, § 38.1-131; 1986, c. 562.

§ 38.2-1506. Requirements when receiver appointed; disbursement of available assets to association, etc.

A. Whenever a receiver, other than the Commission, is appointed pursuant to § 38.2-1504 for any domestic insurer other than an insurer writing exclusively title, fidelity and surety, credit or ocean marine insurance, the receiver shall petition the court for approval of a plan to disburse the assets. This shall be completed within 120 days of a final determination by the Commission that the insurer is insolvent. After the application of an association for an insolvent insurer's available assets has been granted, the insolvent insurer's assets will be disbursed to any association entitled to them as they become available.

B. The plan shall include provisions for the receiver to take all the actions required by subsections B and C of § 38.2-1509.

C. Notice of the petition by the receiver to the court for approval of a plan to disburse an insurer's assets shall be given to the associations and the commissioners of insurance of the other states. This notice shall be deemed given when sent by certified mail at least thirty days before submission of the petition to the court. Action on the petition may be taken by the court or a judge of the court if the required notice has been given and the plan of the receiver contains the provisions set forth in this section.

1978, c. 696, § 38.1-131.1; 1986, c. 562.

§ 38.2-1507. Further procedure; injunction may be issued.

The court may issue an injunction restraining the insurer and its officers, directors, stockholders, members, trustees, agents, employees and all other persons from transacting any business of the insurer, and from transferring, removing or disposing of its property or business until a further order of the court. The injunction may be issued on or after the institution of any delinquency proceeding, except where the rehabilitation or liquidation of the insurer has been referred to the Commission. If the Commission is authorized to proceed with the rehabilitation or liquidation, it may issue injunctions or enter any other appropriate order for the protection of the insurer's policyholders and creditors and the preservation of its property.

Code 1950, § 38-139; 1952, c. 317, § 38.1-132; 1986, c. 562.

§ 38.2-1508. Powers of Commission when authorized to rehabilitate or liquidate companies.

Whenever the Commission is authorized to act as a receiver to rehabilitate or liquidate an insurer or to take any other authorized steps that it considers advisable in connection with the affairs of the insurer, it shall have all the power and authority of a court of record as provided in Article IX, Section 3 of the Constitution of Virginia. All further proceedings in connection with the rehabilitation or liquidation shall be conducted by the Commission without any control or supervision by the court to which the application was made. For the violation of any injunction or order issued under this chapter, the Commission shall have the same power to punish for contempt as a court. The Commission may deal with the property and affairs of the insurer in its own name or in the name of the insurer. The Commission shall be vested by law with the title to all of the property, contracts and rights of action of the insurer as of the date shown by the order of the court referred to in § 38.2-1507. The filing or recording of the order in any clerk's office in this Commonwealth shall give the same notice that a deed, bill of sale or other evidence of properly filed or recorded title have given.

Code 1950, § 38-140; 1952, c. 317, § 38.1-133; 1971, Ex. Sess., c. 1; 1986, c. 562; 1992, c. 468.

§ 38.2-1509. Powers of Commission when authorized to rehabilitate or liquidate insurers by court order; disbursement of available assets to an association, etc.

A. Whenever the Commission is authorized by order of the Circuit Court of the City of Richmond to rehabilitate or liquidate any domestic insurer other than an insurer writing exclusively title, fidelity and surety, credit or ocean marine insurance, the Commission shall disburse the assets as they become available to an association. Disbursal shall not be made until an application has been filed with the Commission by an association for an insolvent insurer's available assets.

B. The Commission shall disburse the assets of an insolvent insurer as they become available in the following manner:

1. Pay, after reserving for the payment of the costs and expenses of administration, according to the following priorities: (i) claims of secured creditors with a perfected security interest not voidable under § 38.2-1513 to the extent of the value of their security, (ii) claims of the associations for "covered claims" and "contractual obligations" as defined in §§ 38.2-1603 and 38.2-1701 and claims of other

policyholders arising out of insurance contracts apportioned without preference, (iii) taxes owed to the United States and other debts owed to any person, including the United States, which by the laws of the United States are entitled to priority, (iv) wages entitled to priority as provided in § 38.2-1514, and (v) other creditors; and

2. Equitably allocate disbursements to each of the entitled associations; and

3. Secure an agreement from each of the entitled associations requiring the return to the Commission of any assets previously disbursed to the association required to pay claims entitled to priority in subdivision 1 of this subsection. No bond shall be required of any entitled association; and

4. Require a full report to be made by the association to the Commission accounting for all assets disbursed to the association, all disbursements made from these assets, any interest earned on these assets and any other matter as the Commission may require.

C. The Commission shall provide for disbursements to the association in an amount estimated at least equal to the claim payments made or to be made by the association for which the association could assert a claim against the Commission. In addition, the Commission shall provide that if the assets available for disbursement do not equal or exceed the amount of claim payments made or to be made by the associations, then disbursements shall be in the amount of available assets.

D. The Commission shall notify the affected associations and the commissioners of insurance in the other states of any disbursement made according to this section. The notice shall be deemed given when sent by certified mail at least thirty days prior to disbursement.

1978, c. 696, § 38.1-133.1; 1979, c. 385; 1986, c. 562; 1996, c. 81.

§ 38.2-1510. Commission may appoint assistants in connection with rehabilitation or liquidation.

The Commission shall have power to appoint one or more special deputies as its agent and to employ the counsel, clerks, and assistants considered necessary to efficiently conduct the rehabilitation or liquidation. The Commission may delegate to its agent any of its powers which are necessary to carry out the rehabilitation or liquidation. The compensation of the special deputy commissioners, counsel, clerks and assistants, and all expenses relating to the rehabilitation or liquidation of any insurer shall be set by the Commission and upon certification by the Commission be paid out of the insurer's assets.

Code 1950, § 38-141; 1952, c. 317, § 38.1-134; 1986, c. 562.

§ 38.2-1511. Borrowing on pledge of assets.

For the purpose of facilitating the delinquency proceeding of an insurer, the Commission, or a receiver other than the Commission with the approval of the court, may borrow money and execute, acknowledge, and deliver notes or other evidences of indebtedness and secure the repayment by mortgage, pledge, assignment, transfer in trust, or hypothecation of any or all of the property, real, personal or mixed, of the insurer. The Commission, or a receiver other than the Commission with the approval of the court, shall have power to take any action necessary and proper to consummate any loans and to

provide for repayment. No note or other evidence of indebtedness made or executed by the receiver shall impose upon the receiver any liability except with respect to the assets and other property of the insurer.

1952, c. 317, § 38.1-135; 1986, c. 562.

§ 38.2-1512. Rights and liabilities fixed upon liquidation.

The rights and liabilities of an insurer and of its creditors, policyholders, stockholders, members, and all other persons interested in the property and assets of the insurer, shall be fixed as of the date of the entry of the order directing the liquidation of the insurer unless otherwise provided by law. The rights of claimants holding contingent claims on that date shall be determined by this chapter.

1952, c. 317, § 38.1-136; 1986, c. 562.

§ 38.2-1513. Voidable transfers.

A. Any transfer of or lien upon the property of an insurer that is made or created within four months before the institution of delinquency proceedings under this chapter shall be voidable if (i) done with the intent of giving or enabling any creditor to obtain a greater percentage of payment of the debt than any other creditor of the same class and (ii) the creditor accepting the transfer has reasonable cause to believe that a preference will occur.

B. Every director, officer, employee, stockholder, member, subscriber, and other person acting on behalf of an insurer who is involved in any act described in subsection A of this section, and every person receiving property of an insurer as a result of this act, shall be personally liable and held accountable to the receiver.

C. A receiver in any proceeding under this chapter may avoid any transfer of or lien upon the property of an insurer that any creditor, stockholder, subscriber or member of the insurer might have avoided. The receiver may also recover the transferred property unless the person was a valid holder for value before the date of the institution of delinquency proceedings under this chapter. The property or its value may be recovered from anyone who has received it except as a valid holder for value as specified in this subsection.

1952, c. 317, § 38.1-137; 1986, c. 562.

§ 38.2-1514. Priority of claims for wages.

Before the payment of any other debt or claim, other than those for which a higher priority is established in § 38.2-1509, compensation shall be paid to employees other than officers of an insurer for services rendered within three months before the commencement of the delinquency proceedings. The payment shall not exceed $1,000 for each employee. At the discretion of the Commission, or a receiver other than the Commission with the approval of the court, payment may be made as soon as practicable. This priority shall be superior to any other similar priority authorized by law regarding wages or compensation of the employees.

Nothing in this section shall prohibit a receiver from allocating sufficient funds to cover the expenses of administration.

1952, c. 317, § 38.1-138; 1986, c. 562; 1996, c. 81.

§ 38.2-1515. Mutual debts or credits, how treated.

A. In all cases of mutual debts or mutual credits between the insurer and another person in connection with any action or proceeding under this chapter, the credits and debts shall be set off and the balance only shall be allowed or paid, except as provided in subsection B of this section.

B. No offset shall be allowed in favor of any person where:

1. The obligation of the insurer to the person would not entitle him at the date of the entry of any rehabilitation or liquidation order to share as a claimant in the assets of the insurer;

2. The obligation of the insurer to the person was purchased by or transferred to the person with a view of its being used as an offset; or

3. The obligation of the person is to pay (i) an assessment levied against the members of a mutual insurer or the subscribers of a reciprocal insurer, or (ii) a balance upon a subscription to the capital stock of a stock insurer.

1952, c. 317, § 38.1-139; 1986, c. 562.

§ 38.2-1516. Receivers to file reports, etc., with Commission.

Each receiver appointed in delinquency proceedings shall file with the Commission annually a report of the affairs of the insurer in the form prescribed by the Commission. Each receiver shall file with the Commission copies of all reports, petitions, court orders, and other pertinent papers dealing with the delinquency proceeding.

Code 1950, § 38-142; 1952, c. 317, § 38.1-140; 1986, c. 562.

§ 38.2-1517. What included in annual report of Commission.

The Commission shall include in its annual report the names of all insurers against which delinquency proceedings are pending under this chapter, and the names and addresses of any receivers of the insurers. The report shall show whether or not the insurers have resumed business or have been liquidated, and shall contain any other matter that will inform the policyholders, creditors, stockholders, members and the public of the current status of the proceeding regarding each insurer.

Code 1950, § 38-142; 1952, c. 317, § 38.1-141; 1986, c. 562.

§ 38.2-1518. Rehabilitation or mutualization of companies.

If at any time the Commission acting as the receiver finds that it is in the best interests of the policyholders and creditors of a delinquent insurer that it be rehabilitated or mutualized, the Commission shall prepare a plan of rehabilitation or mutualization. If at any time a receiver, other than the Commission, of a delinquent insurer reports to the court that it is in the best interests of the policyholders and creditors of the insurer that it be rehabilitated or mutualized, the receiver shall submit a plan of

rehabilitation or mutualization to the court for its approval. The plan may include a provision imposing liens upon the net equities of policyholders of the insurer, and in the case of life insurers, a provision imposing a moratorium upon the loan or cash surrender values of the policies for whatever period of time is necessary. A hearing on the plan shall be held and notice of the hearing given in a manner prescribed by either the Commission or the court. After the hearing, the plan may be approved, disapproved, or modified by the Commission or the court.

Code 1950, § 38-139; 1952, c. 317, § 38.1-142; 1986, c. 562.

§ 38.2-1519. Termination of rehabilitation; when liquidation may be entered.

A. If either the Commission or the court determines that the purposes of the rehabilitation proceeding have been accomplished and that the insurer can safely and properly resume possession of its property and the conduct of its business, an order may be entered terminating the rehabilitation proceeding and permitting the insurer to resume possession of its property and the management and conduct of its affairs. The order shall not be entered until a full hearing is held, subject to proper notice given in the manner prescribed by the Commission or the court.

B. If at any time it appears to either the Commission or the court that further efforts to rehabilitate the insurer would be useless, an order of liquidation may be entered.

Code 1950, § 38-139; 1952, c. 317, § 38.1-143; 1986, c. 562.

§ 38.2-1520. Liquidation of alien insurers.

Proceedings in liquidation of the business of the United States branch of an alien insurer having trusteed assets in this Commonwealth may be instituted and conducted in the manner prescribed in this chapter for domestic insurers. However, only the assets of the business of the United States branch shall be included in the proceedings.

1952, c. 317, § 38.1-144; 1986, c. 562.

§ 38.2-1521. Conservation of assets of foreign or alien insurer; when liquidation may be entered.

A. Proceedings against a foreign or alien insurer for the conservation of the insurer's assets within this Commonwealth may be instituted and conducted in the manner prescribed in this chapter for delinquency proceedings against a domestic insurer on any one or more of the applicable grounds specified in § 38.2-1503. The order of conservation shall direct the receiver to take possession of the assets of the insurer within this Commonwealth and conserve the assets for the benefit of its policyholders and for any other purpose as the nature of the cause and the interests of its policyholders, creditors, members, stockholders or the public require.

B. If the laws of any other state or country provide for the conservation, liquidation and distribution of a foreign or alien insurer's assets to creditors, policyholders, and other entitled persons, then the receiver appointed in this Commonwealth to conserve the foreign or alien insurer's assets within this Commonwealth may proceed to liquidate the business of the insurer in this Commonwealth and distribute the assets to those entitled to them. In all other cases the rights, powers, and duties of the Commission or the receiver with respect to the assets of a foreign or alien insurer shall be ancillary to the

rights, powers, and duties imposed upon any receiver or other person in charge of the property, business, and affairs of the insurer in its domiciliary state or country.

1952, c. 317, § 38.1-145; 1986, c. 562.

§ 38.2-1522. Qualified financial contracts.

A. Notwithstanding any other provision of this chapter, including any other provision of this chapter permitting the modification of contracts, or other state law, no person shall be stayed or prohibited from exercising:

1. A contractual right to cause the termination, liquidation, acceleration, or close-out of obligations under or in connection with any netting agreement or qualified financial contract with an insurer because of:

a. The insolvency, financial condition, or default of the insurer at any time, provided that the right is enforceable under applicable law other than this chapter; or

b. The commencement of a delinquency proceeding under this chapter;

2. Any right under a pledge, security, collateral, reimbursement, or guarantee agreement or arrangement or any other similar arrangement, or other credit enhancement relating to one or more netting agreements or qualified financial contracts;

3. Subject to subdivision B 2 of § 38.2-1515, any right to set off or net out any termination value, payment amount, or other transfer obligation arising under or in connection with one or more qualified financial contracts where the counterparty or its guarantor is organized under the laws of the United States or a state or a foreign jurisdiction approved by the Securities Valuation Office of the National Association of Insurance Commissioners as eligible for netting; or

4. A right to claim damages if a counterparty to a master netting agreement or a qualified financial contract with an insurer subject to a proceeding under this chapter terminates, liquidates, closes out, or accelerates the agreement or contract, which damages shall be measured as of the date or dates of termination, liquidation, close-out, or acceleration. The amount of a claim for damages shall be actual direct compensatory damages calculated in accordance with subsection F.

B. Upon termination of a netting agreement or qualified financial contract, the net or settlement amount, if any, owed by a nondefaulting party to an insurer against which an application has been filed under this chapter shall be transferred to or on the order of the receiver for the insurer, even if the insurer is the defaulting party, notwithstanding any walkaway clause in the netting agreement or qualified financial contract. For purposes of this subsection, "walkaway clause" means a provision in a netting agreement or a qualified financial contract that, after calculation of a value of a party's position or an amount due to or from one of the parties in accordance with its terms upon termination, liquidation, or acceleration of the netting agreement or qualified financial contract, either does not create a payment obligation of a party or extinguishes a payment obligation of a party in whole or in part solely because of the party's status as a nondefaulting party. Any limited two-way payment or first method

provision in a netting agreement or qualified financial contract with an insurer that has defaulted shall be deemed to be a full two-way payment or second method provision as against the defaulting insurer. Any such property or amount shall, except to the extent it is subject to one or more secondary liens or encumbrances, or rights of netting or setoff, be a general asset of the insurer.

C. In making any transfer of a netting agreement or qualified financial contract of an insurer subject to a proceeding under this chapter, the receiver shall either:

1. Transfer to one party, other than an insurer subject to a delinquency proceeding under this chapter, all netting agreements and qualified financial contracts between a counterparty or any affiliate of the counterparty and the insurer that is the subject of the proceeding, including:

a. All rights and obligations of each party under each netting agreement and qualified financial contract; and

b. All property, including any guarantees or other credit enhancement, securing any claims of each party under each netting agreement and qualified financial contract; or

2. Transfer none of the netting agreements, qualified financial contracts, rights, obligations, or property referred to in subdivision 1, with respect to the counterparty and any affiliate of the counterparty.

D. If a receiver of an insurer subject to a delinquency proceeding makes a transfer of one or more netting agreements or qualified financial contracts, then the receiver shall use its best efforts to notify any person who is party to the netting agreements or qualified financial contracts of the transfer by 12:00 noon, the receiver's local time, on the business day following the transfer. For purposes of this section, "business day" means a day other than a Saturday, Sunday, or any day on which either the New York Stock Exchange or the Federal Reserve Bank of New York is closed.

E. Notwithstanding any other provision of this chapter, including § 38.2-1513, a receiver may not avoid a transfer of money or other property arising under or in connection with a netting agreement or qualified financial contract, or any pledge, security, collateral, or guarantee agreement or any other similar security arrangement or credit support document relating to a netting agreement or qualified financial contract, that is made before the commencement of a delinquency proceeding under this chapter. However, a transfer may be avoided under § 38.2-1513 if the transfer was made with actual intent to hinder, delay, or defraud the insurer, a receiver appointed for the insurer, or existing or future creditors.

F. In exercising the receiver's rights of disaffirmance or repudiation with respect to any netting agreement or qualified financial contract to which an insurer is a party, the receiver for the insurer shall either:

1. Disaffirm or repudiate all netting agreements and qualified financial contracts between a counterparty or any affiliate of the counterparty and the insurer that is the subject of the proceeding; or

2. Disaffirm or repudiate none of the netting agreements and qualified financial contracts referred to in subdivision 1, with respect to the person or any affiliate of the person.

G. Notwithstanding any other provision of this chapter, provided the receiver disaffirms or repudiates a netting agreement or qualified financial contract within a reasonable period after the commencement of a delinquency proceeding, any claim of a counterparty against the estate arising from the receiver's disaffirmance or repudiation of a netting agreement or qualified financial contract that has not been previously affirmed in the liquidation or immediately preceding rehabilitation shall be determined and shall be allowed or disallowed as if the claim had arisen before the date of the filing of the petition for liquidation or, if a rehabilitation is converted to a delinquency proceeding, as if the claim had arisen before the date of the filing of the petition for rehabilitation. The amount of the claim shall be the actual direct compensatory damages determined as of the date of the disaffirmance or repudiation of the netting agreement or qualified financial contract.

H. The provisions of this section shall not apply to persons who are affiliates of the insurer that is the subject of the proceeding.

I. All rights of counterparties under this chapter shall apply to netting agreements and qualified financial contracts entered into on behalf of the general account and any separate account if the assets of such separate account are available only to counterparties to netting agreements and qualified financial contracts and entered into on behalf of such separate account.

2011, c. 198.

Chapter 16 - VIRGINIA PROPERTY AND CASUALTY INSURANCE GUARANTY ASSOCIATION

Article 1 - ESTABLISHMENT AND OPERATION OF THE ASSOCIATION

§ 38.2-1600. Purpose.

The purpose of this chapter is to establish an association that shall provide prompt payment of covered claims to reduce financial loss to claimants or policyholders resulting from the insolvency of an insurer. This association shall assist in the detection and prevention of insurer insolvencies and shall apportion the cost of this protection among insurers.

1970, c. 766, § 38.1-757; 1986, c. 562.

§ 38.2-1601. Application.

This chapter shall apply to all classes of direct insurance written by member insurers but shall not be applicable to the following:

1. Life, annuity, health or disability insurance;

2. Mortgage guaranty, financial guaranty or other forms of insurance offering protection against investment risks;

3. Fidelity or surety bonds, or any other bonding obligations;

4. Credit insurance, credit property insurance, and credit involuntary unemployment insurance;

5. Insurance of warranties or service contracts;

6. Title insurance;

7. Insurance of vessels or craft used primarily in a trade or business, their cargoes, and marine builders' risk and marine protection and indemnity;

8. Any transaction or combination of transactions between a person, including affiliates of such person, and an insurer, including affiliates of such insurer, which involves the transfer of investment or credit risk unaccompanied by transfer of insurance risk; or

9. Any class of insurance written by cooperative nonprofit life benefit companies, mutual assessment life, accident and sickness insurers, burial societies, fraternal benefit societies, captive insurers, risk retention groups, and home protection companies.

1970, c. 766, § 38.1-758; 1986, c. 562; 1987, c. 529; 1993, cc. 77, 774; 1998, c. 230; 2000, c. 526.

§ 38.2-1602. Liberal construction.

This chapter shall be liberally construed to effect the purpose under § 38.2-1600, which shall constitute an aid and guide to interpretation.

1970, c. 766, § 38.1-759; 1986, c. 562.

§ 38.2-1603. Definitions.

As used in this chapter:

"Account" means any one of the three accounts created by § 38.2-1604.

"Affiliate" means a person who directly, or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with an insolvent insurer on December 31 of the year next preceding the date the insurer becomes an insolvent insurer.

"Association" means the Virginia Property and Casualty Insurance Guaranty Association created under § 38.2-1604.

"Claimant" means any insured making a first party claim or any person instituting a liability claim; provided that no person who is an affiliate of the insolvent insurer may be a claimant.

"Control" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, 10 percent or more of the voting securities of any other person. This presumption may be rebutted by a showing that control does not exist in fact.

"Covered claim" means an unpaid claim, including one for unearned premiums, submitted by a claimant, that (i) arises out of and is within the coverage and is subject to the applicable limits of a policy covered by this chapter and issued by an insurer who has been declared to be an insolvent

insurer or (ii) arises out of and is within the coverage and is subject to the applicable limits of a policy that would not be excluded from the coverage of this chapter under the provisions of § 38.2-1601 if it were a policy of direct insurance and that has been assumed as a direct obligation by an insurer who has been declared to be an insolvent insurer, where such obligation is assumed through a merger or acquisition, or pursuant to an acquisition of assets and assumption of liabilities, an assumption under the provisions of subsection B or C of § 38.2-136 or a substantially similar law of another jurisdiction, or any other novation agreement. The claimant or insured shall be a resident of the Commonwealth at the time of the insured loss, provided that for entities other than an individual, the residence of a claimant or insured is the state in which its principal place of business is located at the time of the insured loss or the property from which the claim arises shall be permanently located in the Commonwealth. "Covered claim" shall not include any amount awarded as punitive damages or sought as a return of premium under any retrospective rating plan; any amount due any reinsurer, insurer, insurance pool, or underwriting association as subrogation recoveries, reinsurance recoveries, contribution, indemnification, or otherwise; any amount due under any policy originally issued by a surplus lines carrier or risk retention group; any obligation assumed by an insolvent insurer after the commencement of any delinquency proceeding, as defined in Chapter 15 (§ 38.2-1500 et seq.), involving the insolvent insurer or the original insurer, unless it would have been a "covered claim" absent such assumption; or any obligation assumed by an insolvent insurer in a transaction in which the original insurer remains separately liable. An obligation owing under a contract of reinsurance shall not be deemed a direct obligation for the purposes of this definition unless it shall have been assumed pursuant to the provisions of subsection B or C of § 38.2-136 or a substantially similar law of another jurisdiction. No claim for any amount due any reinsurer, insurer, insurance pool, or underwriting association may be asserted against a person insured under a policy issued by an insolvent insurer other than to the extent the claim exceeds the association obligation limitations set forth in § 38.2-1606.

"Insolvent insurer" means an insurer that is (i) licensed to transact the business of insurance in the Commonwealth either at the time the policy was issued, when the obligation with respect to the covered claim was assumed, or when the insured loss occurred and (ii) against whom an order of liquidation with a finding of insolvency has been entered after July 1, 1987, by a court of competent jurisdiction in the insurer's state of domicile or of the Commonwealth under the provisions of Chapter 15 (§ 38.2-1500 et seq.), and which order of liquidation has not been stayed or been the subject of a writ of supersedeas or other comparable order.

"Member insurer" means any person who (i) writes any class of insurance to which this chapter applies under § 38.2-1601, including reciprocal insurance contracts, and (ii) is licensed to transact the business of insurance in the Commonwealth but shall not include persons listed in subdivision 9 of § 38.2-1601.

"Net direct written premiums" means direct gross premiums written in the Commonwealth on insurance policies applicable to this chapter, less return premiums and dividends paid or credited to

policyholders on direct business. "Net direct written premiums" does not include premiums on contracts between insurers or reinsurers.

1970, c. 766, § 38.1-760; 1986, c. 562; 1987, c. 529; 1998, c. 230; 2004, c. 285; 2015, c. 710.

§ 38.2-1604. Association created; members; divided into three accounts.

The nonprofit unincorporated legal entity known as the Virginia Property and Casualty Insurance Guaranty Association, created by former § 38.1-761, shall continue in existence. All insurers defined as "member insurers" under § 38.2-1603 shall be and remain members of the Association as a condition of their license to transact the business of insurance in this Commonwealth. The Association shall perform its functions under a plan of operation established and approved under § 38.2-1607 and shall exercise its powers through a board of directors established under § 38.2-1605. For purposes of administration and assessment, the Association shall have three separate accounts: (i) the workers' compensation insurance account; (ii) the automobile insurance account; and (iii) the account for all other insurance to which this chapter applies. These accounts shall be in addition to and separate from the safety fund authorized by § 38.2-1619.

1970, c. 766, § 38.1-761; 1986, c. 562; 1998, c. 230.

§ 38.2-1605. Board of directors.

A. The board of directors of the Association shall consist of at least five but no more than nine persons serving terms specified in the plan of operation. The members of the board shall be elected by member insurers, giving consideration among other things to whether all types of member insurers are fairly represented. Vacancies on the board shall be filled for the remaining period of the term in the same manner as initial appointments.

B. Members of the board may be reimbursed from the assets of the Association for expenses incurred by them as members of the board of directors.

1970, c. 766, § 38.1-762; 1986, c. 562.

§ 38.2-1606. Duties and powers of Association.

A. The Association shall:

1. Be obligated to pay covered claims that existed prior to the determination of insolvency and which arose before the earliest of (i) ninety-one days after the determination of insolvency, (ii) the policy expiration date, or (iii) the date the insured replaces or cancels the policy.

a. Such obligation shall be satisfied by paying to the claimant an amount as follows:

(i) The full amount of a covered claim for benefits under a workers' compensation insurance coverage; or

(ii) An amount not exceeding $300,000 per claimant for all other covered claims.

b. In no event shall the Association be obligated to pay a claimant for an amount in excess of the insolvent insurer's obligation for a covered claim. Notwithstanding any other provision of this chapter,

a covered claim shall not include any claim filed with the Guaranty Association after the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer. The Association shall pay only that amount of each unearned premium which is in excess of fifty dollars. A covered claim shall not include any claim filed with the Association after the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer.

2. Be deemed the insurer to the extent of the insolvent insurer's obligation on the covered claims and to that extent shall have all the rights, duties, and obligations of the insolvent insurer as if the insurer had not become insolvent.

3. Allocate claims paid and expenses incurred among the three accounts and assess member insurers separately for each account (i) the amounts necessary to pay the obligations of the Association under subdivision 1 of this subsection subsequent to an insolvency, (ii) the expenses of handling covered claims subsequent to an insolvency, and (iii) other expenses authorized by this chapter. The assessment of each member insurer shall be based on the ratio of the net direct written premiums of the member insurer to the net direct written premiums of all member insurers. This ratio shall be determined using the premiums for the calendar year preceding the assessment on the classes of insurance in the account. Each member insurer shall be notified of the assessment at least thirty days before it is due. No member insurer may be assessed in any year on any account an amount greater than two percent of that member insurer's net direct written premiums for the calendar year preceding the assessment on the classes of insurance in the account. If the sum of the maximum assessment and the assets of the account does not provide in any one year an amount sufficient to make all necessary payments from that account, the funds available shall be prorated and the unpaid portion shall be paid as soon as funds become available. The Association shall pay claims in any order which it may deem reasonable, including the payment of claims as such are received from the claimants or in groups or categories of claims. The Association may exempt or defer, in whole or in part, the assessment of any member insurer if payment of the assessment would cause the member insurer's financial statement to reflect an impairment of the insurer's minimum capital and surplus in any jurisdiction in which the member insurer is authorized to transact insurance; provided, that during the period of deferment, no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payments shall not cause an impairment of minimum capital and surplus. These payments shall be refunded to those members receiving larger assessments by virtue of the deferment, or at the election of any such company, credited against future assessments. Each member insurer may set off against any assessment, payments authorized by the Association and made on covered claims and expenses incurred in the payment of those claims. The offset shall be allowed only if the payments are chargeable to the account for which the assessment is made.

3a. The Association shall issue to each insurer paying an assessment under this chapter, other than assessments paid pursuant to subdivision 3 (iii) of this subsection, a certificate of contribution in a form prescribed by the Commission, for the amount of the assessment paid, excluding interest penalties. All outstanding certificates shall be of equal priority without reference to amounts or dates of

issue. A certificate of contribution may be shown by the insurer on its financial statement as an asset. This shall be shown in a form, in an amount, and for a period of time approved by the Commission.

4. Investigate claims brought against the Association and adjust, compromise, settle, and pay covered claims to the extent of the Association's obligation and deny all other claims. The Association may review settlements, releases and judgments to which the insolvent insurer or its insureds were parties to determine the extent to which the settlements, releases and judgments may be properly contested.

5. Notify those persons as the Commission directs under subdivision 8 of this subsection.

6. Handle claims through its employees or through one or more insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to (i) the approval of the Commission and (ii) acceptance by the designated insurer.

7. Reimburse each servicing facility for the Association's obligations paid by the facility and for expenses incurred by the facility while handling claims on behalf of the Association. The Association shall pay the other expenses authorized by this chapter.

8. Notify the insureds of the insolvent insurer and any other interested parties of the determination of insolvency and of their rights under this chapter. Notification shall be sent by mail to the insureds' last known address. If the Association is unable to obtain the information required to mail the notice in a timely manner, the Association shall publish the notice in newspapers of general circulation likely to cover geographical areas occupied by the policyholders.

B. The Association may:

1. Employ or retain persons necessary to perform the duties of the Association.

2. Borrow funds necessary to effect the purposes of this chapter in accord with the plan of operation.

3. Sue or be sued.

4. Negotiate and become a party to those contracts necessary to carry out the purpose of this chapter.

5. Perform any other acts necessary or proper to achieve the purpose of this chapter.

6. Pay refunds to the member insurers in proportion to their contributions made to each account during the five years immediately preceding the date of the refund. The total refund shall be the amount by which the assets of the account are expected to exceed the liabilities for the coming year as determined by the board of directors.

7. Obtain commitments or lines of credit, and in the event a natural disaster such as an earthquake, windstorm or fire results in covered claims, with the approval of its board of directors and the Commission, secure indebtedness for borrowed money to be used for the purpose set forth in subsection A of § 38.2-1622 in an amount not to exceed the amount reasonably estimated by its board of directors and the Commission as the aggregate amount of assessments which the Association will be authorized to make during the succeeding calendar year, by pledge, assignment, transfer in trust or hypothecation of any or all of the assessments to be made against its member insurers.

1970, c. 766, §§ 38.1-763, 38.1-765; 1971, Ex. Sess., c. 1; 1982, c. 353; 1983, c. 486; 1986, c. 562; 1987, cc. 529, 565, 655; 1998, c. 230.

§ 38.2-1607. Plan of operation.

A. 1. The plan of operation and any amendments to it shall be submitted to the Commission by the Association and shall not become effective until approved by the Commission in writing. The Commission shall approve the plan or amendment to the plan if it complies with this chapter and assures the fair, reasonable, and equitable administration of the Association.

2. The plan of operation approved under former § 38.1-764 shall remain in effect until modified in accordance with subdivision 3 of this subsection.

3. If the Association fails to submit suitable amendments to the plan, the Commission shall, after notice and hearing, adopt and promulgate any reasonable rules that are necessary or advisable to effect this chapter. Those rules shall continue in force until modified by the Commission or superseded by a plan or amendments submitted by the Association and approved by the Commission.

B. All member insurers shall comply with the plan of operation.

C. The plan of operation shall:

1. Establish the procedures for exercising the powers and duties of the Association under § 38.2-1606.

2. Establish procedures for handling assets of the Association.

3. Establish the amount and method of reimbursing members of the board of directors under § 38.2-1605.

4. Establish procedures by which claims may be filed with the Association and establish acceptable forms of proof of covered claims. Notice of claims to the receiver or liquidator of the insolvent insurer shall be deemed notice to the Association or its agent and a list of those claims shall be periodically submitted to the Association or similar organizations in another state by the receiver or liquidator.

5. Establish regular places and times for meetings of the board of directors.

6. Establish procedures for records to be kept of all financial transactions of the Association, its agents, and the board of directors.

7. Provide that any member insurer aggrieved by any final action or decision of the Association may appeal to the Commission within thirty days after the action or decision.

8. Establish the procedures for submitting to the Commission the names of elected members of the board of directors.

9. Contain additional provisions necessary or proper for the execution of the powers and duties of the Association.

D. The plan of operation may provide that any or all powers and duties of the Association, except those under subdivision 3 of subsection A of § 38.2-1606 and subdivision 2 of subsection B of § 38.2-1606, shall be delegated to a corporation, association, or other organization that performs or will perform functions similar to those of this Association, or its equivalent, in two or more states. The corporation, association or organization shall be compensated for providing those and any other permissible services. A delegation under this subsection shall take effect only with the approval of both the board of directors and the Commission. The delegation may be made only to a corporation, association, or organization that extends protection which is substantially no less favorable or effective than that provided by this chapter.

1970, c. 766, § 38.1-764; 1986, c. 562.

§ 38.2-1608. Duties and powers of Commission; judicial review.

A. The Commission shall:

1. Notify the Association of the existence of an insolvent insurer within three days after it receives notice of the determination of the insolvency. The Association shall be entitled to a copy of any complaint seeking an order of liquidation with a finding of insolvency against a member company at the same time that such complaint is filed with a court of competent jurisdiction.

2. Upon request of the board of directors, provide the Association with a statement of the net direct written premiums of each member insurer.

B. The Commission may:

1. Suspend or revoke, after notice and hearing, the license to transact the business of insurance in this Commonwealth of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the Commission may levy a fine on any member insurer that fails to pay an assessment when due. The fine shall not exceed five percent of the unpaid assessment per month, except that no fine shall be less than $100 per month.

2. Revoke the designation of any servicing facility if it finds that claims are being handled unsatisfactorily.

1970, c. 766, § 38.1-765; 1971, Ex. Sess., c. 1; 1986, c. 562; 1987, c. 529.

§ 38.2-1609. Insured's rights and liabilities; settlements binding on receiver or liquidator; priority of claims; statements to be filed with receiver or liquidator.

A. 1. Any person recovering under this chapter shall be deemed to have assigned his rights under the policy to the Association to the extent of his recovery from the Association. Each insured or claimant seeking the protection of this chapter shall cooperate with the Association to the same extent as the person would have been required to cooperate with the insolvent insurer. The Association shall have no cause of action against the insured of the insolvent insurer for any sums it has paid out except the causes of action the insolvent insurer would have had if those sums had been paid by the insolvent insurer and except as provided in subdivision 2 of this subsection. In the case of an insolvent insurer

operating on an assessment plan, payments of claims by the Association shall not reduce the liability of insureds to the receiver, liquidator, or statutory successor for unpaid assessments previously made. However, the receiver, liquidator, or statutory successor shall under no circumstances levy an additional assessment against the insured, regardless of the terms of the policy.

2. The Association shall have the right to recover from the following persons the amount of any "covered claim" paid on behalf of such persons pursuant to this chapter:

a. Any insured whose net worth on December 31 of the year next preceding the date the insurer becomes an insolvent insurer exceeds fifty million dollars and whose liability obligations to other persons are satisfied in whole or in part by payments made under this chapter; and

b. Any person who is an affiliate of the insolvent insurer and whose liability obligations to other persons are satisfied in whole or in part by payments made under this chapter.

B. The receiver, liquidator, or statutory successor of an insolvent insurer shall be bound by settlements of covered claims by the Association or a similar organization in another state. The court having jurisdiction shall grant those claims priority equal to that which the claimant would have been entitled in the absence of this chapter against the assets of the insolvent insurer. The expenses of the Association or a similar organization incurred in handling claims shall be accorded the same priority as the liquidator's expenses.

C. The Association shall preserve its rights to the insolvent insurer by periodically filing with the receiver or liquidator statements of the covered claims paid by the Association and estimates of anticipated claims on the Association.

1970, c. 766, § 38.1-766; 1986, c. 562; 1987, c. 529.

§ 38.2-1610. Exhaustion of remedies under policy; claims recoverable from more than one association.

A. Any person having a claim against an insurer under any provision in an insurance policy, other than a policy of an insolvent insurer under which the claim is also covered, shall be required to first seek recovery under the policy covered by the insurer which is not insolvent. Any amount payable on a covered claim under this chapter shall be reduced by the amount of any recovery under the insurance policy.

A1. Any person having a claim or legal right of recovery under any governmental insurance or guaranty program which is also a covered claim, shall be required to exhaust first his right under such program. Any amount payable on a covered claim under this chapter shall be reduced by the amount of any recovery under such program.

B. Any person having a claim that may be recovered under more than one insurance guaranty association or its equivalent shall seek recovery first from the association of the state where the insured resides. However, if it is a first party claim for damage to property with a permanent location, the insured shall seek recovery first from the association of the state where the property is located. For a

workers' compensation claim recovery shall first be sought from the association of the state where the claimant resides. Any recovery under this chapter shall be reduced by the amount of the recovery from any other insurance guaranty association or its equivalent.

1970, c. 766, § 38.1-767; 1986, c. 562; 1987, c. 529.

§ 38.2-1611. Aids in detection and prevention of insurer insolvencies.

To aid in the detection and prevention of insurer insolvencies:

1. The Association's board of directors has the duty, upon a majority vote, (i) to make recommendations to the Commission for the detection and prevention of insurer insolvencies, and (ii) to respond to requests by the Commission to discuss and make recommendations regarding the status of any member insurer whose financial condition may be hazardous to the policyholders or the public.

2 through 5. [Repealed.]

6. At the request of the Commission and at the conclusion of any insurer's insolvency in which the Association was obligated to pay covered claims, the board of directors may prepare a report on the history and causes of the insolvency based on the information available to the Association. The report shall be submitted to the Commission.

1970, c. 766, § 38.1-768; 1986, c. 562; 1987, c. 529.

§ 38.2-1611.1. Tax write-offs of certificates of contribution.

A. A member insurer shall have at its option the right to show a certificate of contribution as an asset in the form approved by the Commission pursuant to subdivision 3a of subsection A of § 38.2-1606 at the original face amount for the calendar year of issuance. Such amount may be amortized as follows:

1. Certificates of contribution issued prior to January 1, 1998, shall be amortized in each succeeding calendar year through December 31, 1997, at an amount not to exceed 0.05 of one percent of the member's direct gross premium income for the classes of insurance in the account for which the member insurer is assessed. As used herein, the definition of direct gross premium income shall be the same as that specified in § 58.1-2500. If the amount of the certificate has not been fully amortized by the contributing insurer by December 31, 1997, the unamortized balance of the certificate amount shall be amortized, at the option of the contributing insurer, either (i) in the same manner as the certificate was amortized prior to January 1, 1998; however, if not amortized in full prior to calendar year 2010, the unamortized balance of the certificate shall be amortized in full during calendar year 2010, or (ii) over the 10 successive calendar years commencing January 1, 1998, in amounts each equal to 10 percent of such unamortized balance. A contributing insurer whose certificate has not been fully amortized by December 31, 1997, shall notify the Commission in writing of the amortization schedule option it has selected on or before March 1, 1998; however, if a contributing insurer fails to notify the Commission by such date, the insurer shall be deemed to have selected the option described in clause (i) of the preceding sentence.

2. Certificates of contribution issued on or after January 1, 1998, shall be amortized over the 10 calendar years following the year the contribution was paid in amounts each equal to 10 percent of the amount of the contribution.

B. The insurer may offset the amount of the certificate amortized in a calendar year as provided in subsection A. This amount shall be deducted from the premium tax liability incurred on business transacted in this Commonwealth for that year. However, the Association shall diligently pursue all rights available to it to recover its expenditures made in the fulfillment of its responsibilities under this chapter. In the event the Commission determines after a hearing that the Association is not diligently pursuing available measures of recovery, the Commission shall notify the Department of Taxation and participating insurers will not be able to offset amounts amortized during the period that the Commission determines that the Association has not been diligently pursuing available measures of recovery.

C. Any sums that have been (i) amortized by contributing insurers and offset against premium taxes as provided in subsection B and (ii) subsequently refunded pursuant to subdivision A 3 of § 38.2-1606 or subdivision B 6 of § 38.2-1606 shall be paid to the Department of Taxation and deposited with the State Treasurer for credit to the general fund of this Commonwealth.

D. The amount of any credit against premium taxes provided for in this section for an insurer shall be reduced by the amount of reduction in federal income taxes for any deduction claimed by the insurer for an assessment paid pursuant to this chapter.

1987, cc. 565, 655; 1991, c. 371; 1997, c. 160; 2011, c. 850; 2014, c. 154.

§ 38.2-1612. Examination and regulation of Association by Commission; annual financial report.
The Association shall be subject to examination and regulation by the Commission. The board of directors shall submit, not later than May 1 of each year, a financial report for the preceding calendar year in a form approved by the Commission.

1970, c. 766, § 38.1-769; 1986, c. 562; 1996, c. 245.

§ 38.2-1613. Exemption from payment of fees and taxes.
The Association shall be exempt from payment of all fees and all taxes levied by this Commonwealth or any of its subdivisions except taxes levied on real or personal property.

1970, c. 766, § 38.1-770; 1986, c. 562.

§ 38.2-1614. Repealed.
Repealed by Acts 1993, c. 679.

§ 38.2-1615. No liability for action taken in good faith.
There shall be no liability on the part of and no cause of action shall arise against any member insurer, the Association or its agents or employees, the board of directors, or the Commission or its representatives for any action taken or statement made by them in good faith in the performance of their

powers and duties under this chapter. The Association's board of directors shall not incur any civil liability for any statements made in good faith under this provision.

1970, c. 766, § 38.1-772; 1986, c. 562.

§ 38.2-1616. Stay of proceedings against insolvent insurer; setting aside judgment, etc.; access to records.

A. All proceedings in which the insolvent insurer is a party or is obligated to defend a party in any court in this Commonwealth shall be stayed for up to six months and such additional time thereafter as may be determined by the court from the date the insolvency is determined or an ancillary proceeding is instituted in the Commonwealth, whichever is later, to permit proper defense by the Association of all pending causes of action. For any covered claims arising from a judgment under any decision, verdict or finding based on the default of the insolvent insurer or its failure to defend an insured, the Association either on its own behalf or on behalf of the insured may apply to have the judgment, order, decision, verdict or finding set aside by the same court or administrator that made the judgment, order, decision, verdict or finding and shall be permitted to defend against the claim on the merits.

B. The liquidator, receiver, or statutory successor of an insolvent insurer covered by this chapter shall permit access by the board or its authorized representatives to such of the insolvent insurer's records which are necessary for the board in carrying out its functions under this chapter with regard to covered claims. In addition, the liquidator, receiver or statutory successor shall provide the board or its representative with copies of such records upon the request by the board and at the expense of the board.

1970, c. 766, § 38.1-773; 1986, c. 562; 1987, c. 529.

§ 38.2-1617. Termination of operation of Association; expiration of chapter.

A. The Commission shall by order terminate the operation of the Association for any class of insurance covered by this chapter with respect to which it has found, after hearing, that there is in effect a statutory or voluntary plan which:

1. Is a permanent plan that is adequately funded or for which adequate funding is provided; and

2. Extends or will extend to the policyholders and residents of this Commonwealth protection and benefits with respect to insolvent insurers not substantially less favorable and effective to those policyholders and residents than the protection and benefits provided with respect to the classes of insurance under this chapter.

B. The Commission shall, by the same order, authorize discontinuance of future payments by insurers to the Association regarding the same classes of insurance. However, the assessments and payments shall continue, as necessary, to pay (i) covered claims of insurers determined to be insolvent prior to the order and (ii) the related expenses not covered by any other plan.

C. In the event the operation of the Association is terminated for all other classes of insurance within its scope, the Association shall, as soon as possible, distribute the balance of moneys and assets

remaining. Distribution shall be made after the Association has settled all prior insurer insolvencies not covered by any other plan, including their related expenses. The distribution shall be made to the insurers that are then writing in this Commonwealth policies of the classes of insurance covered by this chapter and that had made payments to the Association. Distribution shall be made using a pro rata method based upon the aggregate of the payments made by the respective insurers during the five years immediately preceding the date of the order. Upon completion of the distribution for all of the classes of insurance covered by this chapter, this chapter shall be deemed to have expired.

1970, c. 766, § 38.1-774; 1986, c. 562.

Article 2 - ADDITIONAL FUNDS PAID TO ASSOCIATION

§ 38.2-1618. Purpose and applicability of article.

The purpose of this article is to provide directions and guidelines for the control and use of funds provided pursuant to § 38.2-225, obtained through secured borrowings made pursuant to subdivision B 7 of § 38.2-1606, or obtained from sources of funds not specified in Article 1 (§ 38.2-1600 et seq.) of this chapter.

1986, c. 562; 1998, c. 230.

§ 38.2-1619. Safety fund.

The Association shall maintain a separate asset account to be known as the safety fund. The safety fund shall be used to assist the Association in meeting the objectives specified in § 38.2-1600.

1986, c. 562.

§ 38.2-1620. Financing the safety fund, maximum amount, distribution of excess.

A. The safety fund, at the discretion of the Commission, shall receive penalty payments levied against member insurers made pursuant to subsection B of § 38.2-225 or any other payments approved by the Commission. Such payments shall include funds borrowed under the provisions of subdivision B 7 of § 38.2-1606 in the event of a natural disaster in order to provide for the prompt payment of covered claims and expenses related thereto.

B. The Commission may approve the payment of funds to the Association provided the balance in the safety fund account does not exceed two percent of the total of all member insurers' net direct written premiums for classes of insurance covered by the accounts specified in § 38.2-1604.

C. Except as provided in subsection D of this section, investment income earned on assets held in the safety fund shall be credited to the safety fund.

D. In the event the safety fund balance exceeds three percent of the net written premium for all classes of insurance covered by the accounts specified in § 38.2-1604, at the discretion of the Commission the difference shall be paid to the state treasury to the credit of the Literary Fund or shall be subject to subsection F of § 38.2-1622.

E. In the event the fund is dissolved, remaining assets in the safety fund will be distributed to the state treasury to the credit of the Literary Fund.

1986, c. 562; 1998, c. 230.

§ 38.2-1621. Investment of safety fund.

The assets held in the safety fund may be invested in securities set forth in § 38.2-1415.

1986, c. 562; 1998, c. 230.

§ 38.2-1622. Use of safety fund, repayment, etc.

A. The purpose of the safety fund is to provide for the payment of covered claims in the event the assessment limit specified in subdivision A 3 of § 38.2-1606 is reached.

B. In the event the assets in the safety fund are needed to pay covered claims, these assets shall be loaned to the respective account specified in § 38.2-1604. This loan shall be the general obligation of the Association.

C. Assets in the safety fund derived from borrowed moneys obtained under the provisions of subdivision B 7 of § 38.2-1606 shall be lent to an account at the rate of interest the Association is paying the lender providing such moneys. Interest on any other loan shall be compounded quarterly and be based upon the average ninety-day treasury bill rate for the most recently completed calendar quarter as published in the Federal Reserve Bulletin. This rate will be updated quarterly in order to conform with the market rates of interest.

D. Loans shall be repaid by levying assessments pursuant to subdivision A 3 of § 38.2-1606 against the members for the account on whose behalf the loan was negotiated. Unless otherwise approved by the Commission, the loan shall be repaid within six months of its issuance. This assessment in conjunction with any other assessments levied, shall not exceed the limit specified in subdivision A 3 of § 38.2-1606.

E. Subject to the approval of the Commission, assets in the safety fund may be loaned to any account specified in § 38.2-1604 even though the maximum assessment in subdivision A 3 of § 38.2-1606 has not been levied if the directors of the Association determine that this action will minimize the cost to the Association in paying covered claims.

F. Excess assets in the safety fund set forth in subsection D of § 38.2-1620 may be used to pay the Association's covered claims without the members incurring a liability to repay the safety fund.

1986, c. 562; 1998, c. 230.

§ 38.2-1623. Association as a fiduciary.

In handling the assets of the safety fund, the Association shall be deemed a fiduciary for the Commonwealth.

1986, c. 562.

Chapter 17 - Virginia Life, Accident and Sickness Insurance Guaranty Association

Article 1 - ESTABLISHMENT AND OPERATION OF THE ASSOCIATION

§ 38.2-1700. Purpose and applicability of chapter.

A. The purpose of this chapter is to protect, subject to certain limitations, the persons specified in subsection B against failure in the performance of contractual obligations, under life, accident and sickness insurance, and annuity policies, plans, or contracts specified in subsection C because of the impairment or insolvency of the member insurer that issued the policies, plans, or contracts. This chapter shall be construed to effect this purpose. To provide this protection, an association of member insurers is created to pay benefits and to continue coverage as limited by this chapter, and members of the Association are subject to assessments to provide funds to carry out the purpose of this chapter.

B. This chapter shall provide coverage for the policies and contracts specified in subsection C as follows:

1. This chapter shall provide coverage, for the policies and contracts specified in subsection C, to persons who, regardless of where they reside, except for nonresident certificate holders under group policies or contracts, are the beneficiaries, assignees, or payees, including health care providers rendering services covered under accident and sickness insurance policies or certificates, of the persons covered under subdivision B 2.

2. This chapter shall provide coverage, for the policies and contracts specified in subsection C, to persons who are owners of or certificate holders or enrollees under the policies or contracts, other than unallocated annuity contracts and structured settlement annuities, and in each case who:

a. Are residents; or

b. Are not residents and (i) the member insurer that issued the policies or contracts is domiciled in the Commonwealth, (ii) the states in which the persons reside have associations similar to the Association, and (iii) the persons are not eligible for coverage by an association in any other state due to the fact that the insurer or health maintenance organization was not licensed in the state at the time specified in the state's guaranty association law.

3. For unallocated annuity contracts specified in subsection C, subdivisions B 1 and B 2 shall not apply, and this chapter, except as provided in subdivisions B 5 and B 6, shall provide coverage to persons who are the owners of the unallocated annuity contracts if the contracts are issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in the Commonwealth.

4. For structured settlement annuities specified in subsection C, subdivision B 1 and B 2 shall not apply and this chapter, except as provided in subdivisions B 5 and B 6, shall provide coverage to a

person who is a payee under a structured settlement annuity, or beneficiary of a payee if the payee is deceased, if the payee:

a. Is a resident, regardless of where the contract owner resides; or

b. Is not a resident and both (i) the contract owner of the structured settlement annuity is (a) a resident or (b) not a resident but the insurer that issued the structured settlement annuity is domiciled in the Commonwealth and the state in which the contract owner resides has an association similar to the Association; and (ii) neither the payee or beneficiary, nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides.

5. This chapter shall not provide coverage to:

a. A person who is a payee, or beneficiary, of a contract owner resident of the Commonwealth if the payee, or beneficiary, is afforded any coverage by the association of another state; or

b. A person covered under subdivision B 3 if any coverage is provided by the association of another state to the person.

6. This chapter is intended to provide coverage to a person who is a resident of the Commonwealth and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this chapter is provided coverage under the laws of any other state, the person shall not be provided coverage under this chapter. In determining the application of the provisions of this subdivision in situations where a person could be covered by the association of more than one state, whether as an owner, payee, enrollee, beneficiary, or assignee, this chapter shall be construed in conjunction with other state laws to result in coverage by only one association.

C. This chapter shall:

1. Provide coverage to the persons specified in subsection B for policies or contracts of direct, nongroup life insurance, accident and sickness insurance, which for the purposes of this chapter includes health maintenance organization subscriber contracts and certificates, or annuities, and supplemental contracts to any of these, for certificates under direct group policies and contracts, and for unallocated annuity contracts issued by member insurers, in each case except as limited by this chapter. Annuity contracts and certificates under group annuity contracts include guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement annuities, and any immediate or deferred annuity contracts. This chapter shall apply also to dental benefit contracts entered into with a dental plan organization as provided in Chapter 61 (§ 38.2-6100 et seq.).

2. Except as otherwise provided in subdivision 3, not provide coverage for:

a. A portion of a policy or contract not guaranteed by a member insurer or under which the risk is borne by the policy or contract owner;

b. A policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract;

c. A portion of a policy or contract to the extent that the rate of interest on which it is based, or the interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value:

(1) Averaged over the period of four years prior to the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier, exceeds the rate of interest determined by subtracting two percentage points from Moody's Corporate Bond Yield Average averaged for that same four-year period or for such lesser period if the policy or contract was issued less than four years before the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier; and

(2) On and after the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier, exceeds the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently available;

d. A portion of a policy or contract issued to a plan or program of an employer, association, or other person to provide life, health, or annuity benefits to its employees, members, or others, to the extent that the plan or program is self-funded or uninsured, including but not limited to benefits payable by an employer, association, or other person under:

(1) A multiple employer welfare arrangement as defined in 29 U.S.C. § 1144;

(2) A minimum premium group insurance plan;

(3) A stop-loss agreement described in subsection B of § 38.2-109; or

(4) An administrative services only contract;

e. A portion of a policy or contract to the extent that it provides for:

(1) Dividends or experience rating credits;

(2) Voting rights; or

(3) Payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;

f. A policy or contract issued in the Commonwealth by a member insurer at a time when its license to issue the policy or contract in the Commonwealth had been suspended, revoked, not renewed, or voluntarily withdrawn;

g. An unallocated annuity contract issued to or in connection with a benefit plan protected under the federal Pension Benefit Guaranty Corporation, regardless of whether the federal Pension Benefit Guaranty Corporation has yet become liable to make any payments with respect to the benefit plan;

h. A portion of an unallocated annuity contract that is not issued to or in connection with a specific employee, union, or association of natural persons benefit plan;

i. A portion of a policy or contract to the extent that the assessments required by § 38.2-1705 with respect to the policy or contract are preempted by federal or state law;

j. An obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, certificate holder, contract owner, or policy owner, including:

(1) Claims based on marketing materials;

(2) Claims based on side letters, riders, or other documents that were issued by the member insurer without meeting applicable policy or contract form filing or approval requirements;

(3) Misrepresentations of or regarding policy or contract benefits;

(4) Extra-contractual claims; or

(5) A claim for penalties or consequential or incidental damages;

k. A contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer;

l. A portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this subdivision, the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture;

m. A policy or contract providing any hospital, medical, prescription drug, or other health care benefits pursuant to Part C or Part D of Subchapter XVIII, Chapter 7 of Title 42 of the United States Code (known as Medicare Parts C and D); Subchapter XIX, Chapter 7 of Title 42 of the United States Code (known as Medicaid); § 32.1-352 (known as FAMIS); or any regulations issued pursuant thereto; or

n. A charitable gift annuity as defined in § 38.2-106.1.

3. The exclusion from coverage referenced in subdivision 2 c shall not apply to any portion of a policy or contract, including a rider, that provides long-term care or any other accident and sickness insurance benefits.

D. The benefits that the Association may become obligated to cover shall in no event exceed the lesser of:

1. The contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or

2. With respect to:

a. One life, regardless of the number of policies or contracts:

(1) $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;

(2) For accident and sickness insurance benefits, (i) $100,000 for coverage not defined as disability income insurance, health benefit plans, or long-term care insurance including any net cash surrender and net cash withdrawal values; (ii) $300,000 for disability income insurance and $300,000 for long-term care insurance; and (iii) $500,000 for health benefit plans; and

(3) $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;

b. Each individual participating in a benefit plan established under Section 401, 403(b) or 457 of the U.S. Internal Revenue Code who (i) selected an investment option that includes investment in unallocated annuity contracts and (ii) is covered by such an unallocated annuity contract, including the beneficiaries of each such individual if deceased, in the aggregate, $250,000 in present value of annuity benefits, including net cash surrender and net cash withdrawal values;

c. Each payee of a structured settlement annuity (or beneficiary or beneficiaries of the payee if deceased), $250,000 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any; and

d. One plan sponsor whose plans own directly or in trust one or more unallocated annuity contracts part or all of any of which is not included in subdivision 2 b, $5 million in benefits, irrespective of the number of contracts with respect to the plan sponsor. However, in the case where one or more unallocated annuity contracts are covered contracts under this chapter and are owned by a trust or other entity for the benefit or two or more plan sponsors, coverage shall be afforded by the Association if the largest interest in the trust or entity owning the contract or contracts is held by a plan sponsor whose principal place of business is in the Commonwealth and in no event shall the Association be obligated to cover more than $5 million in benefits with respect to all such unallocated contracts.

e. In no event shall the Association be obligated to cover (i) more than an aggregate of $350,000 in benefits with respect to any one life under subdivisions D 2 a, b, and c except with respect to benefits for health benefit plans under subdivision D 2 a (2), in which case the aggregate liability of the Association shall not exceed $500,000 with respect to any one individual, or (ii) with respect to one owner of multiple nongroup policies of life insurance, whether the policy or contract owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers,

employees, or other persons, more than $5 million in benefits, regardless of the number of policies and contracts held by the owner.

f. The limitations set forth in this subsection are limitations on the benefits for which the Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the Association's obligations under this chapter may be met by the use of assets attributable to covered policies or reimbursed to the Association pursuant to its subrogation and assignment rights.

g. For purposes of this chapter, benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which such rider relates.

E. In performing its obligations to provide coverage under § 38.2-1704, the Association shall not be required to guarantee, assume, reinsure, reissue, or perform, or cause to be guaranteed, assumed, reinsured, reissued, or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that the Association has determined, with the concurrence of the Commission, do not materially affect the economic values or economic benefits of the covered policy or contract.

1976, c. 330, § 38.1-482.18; 1986, c. 562; 1988, c. 178; 1991, c. 340; 1992, c. 299; 2000, c. 206; 2004, c. 668; 2010, c. 510; 2018, c. 706.

§ 38.2-1701. Definitions.

As used in this chapter:

"Account" means any one of the two accounts created under § 38.2-1702.

"Association" means the Virginia Life, Accident and Sickness Insurance Guaranty Association created under § 38.2-1702.

"Authorized assessment" or the term "authorized" when used in the context of assessments means that a resolution by the board of directors has been passed whereby an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed.

"Benefit plan" means a specific employee, union, or association of natural persons benefit plan.

"Called assessment" or the term "called" when used in the context of assessments means that a notice has been issued by the Association to member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the Association to member insurers.

"Contractual obligation" means an obligation under a policy or contract or certificate under a group policy or contract, or portion thereof for which coverage is provided under § 38.2-1700.

"Covered contract" or "covered policy" means a policy or contract or portion of a policy or contract for which coverage is provided under § 38.2-1700.

"Extra-contractual claims" shall include, for example, claims relating to bad faith in the payment of claims, punitive damages, or attorney fees and costs.

"Health benefit plan" means any hospital or medical expense policy or certificate, or health maintenance organization subscriber contract or any other similar health contract. "Health benefit plan" does not include:

1. Accident only insurance;

2. Credit insurance;

3. Dental only insurance;

4. Vision only insurance;

5. Medicare Supplement insurance;

6. Benefits for long-term care, home health care, community-based care, or any combination thereof;

7. Disability income insurance;

8. Coverage for on-site medical clinics; or

9. Specified disease, hospital confinement indemnity, or limited benefit health insurance if the types of coverage do not provide coordination of benefits and are provided under separate policies or certificates.

"Impaired insurer" means a member insurer considered by the Commission to be potentially unable to fulfill its contractual obligations.

"Insolvent insurer" means a member insurer that is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

"Member insurer" means an insurer or health maintenance organization licensed to transact in the Commonwealth any class of insurance or health maintenance organization business to which this chapter applies under § 38.2-1700, including an insurer or health maintenance organization whose license to transact the business of insurance in the Commonwealth has been suspended, revoked, not renewed, or voluntarily withdrawn, but does not include cooperative nonprofit life benefit companies, mutual assessment life, accident and sickness insurance companies, burial societies, fraternal benefit societies, dental and optometric services plans, and health services plans not subject to this chapter pursuant to § 38.2-4213.

"Moody's Corporate Bond Yield Average" means the Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto.

"Owner" of a policy or contract or "policyholder," "policy owner," and "contract owner" means the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise

vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the member insurer. The terms "owner," "contract owner," "policyholder," and "policy owner" do not include persons with a mere beneficial interest in a policy or contract.

"Plan sponsor" means (i) the employer, in the case of a benefit plan established or maintained by a single employer; (ii) the employee organization in the case of a benefit plan established or maintained by an employee organization; or (iii) in the case of a benefit plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan.

"Premiums" means amounts or considerations, by whatever name called, received on covered policies or contracts, less any returned premiums, considerations, and deposits and less dividends and experience credits. "Premiums" does not include amounts or considerations received for policies or contracts or for the portions of policies or contracts for which coverage is not provided under subsection C of § 38.2-1700 except that assessable premium shall not be reduced on account of subdivision C 2 of § 38.2-1700 relating to interest limitations and subdivision D 2 of § 38.2-1700 relating to limitations with respect to one individual, one participant, and one policy or contract owner. "Premiums" shall not include (i) premiums for coverage in excess of $5 million on an unallocated annuity contract covered under subdivisions D 2 d, e, and f of § 38.2-1700 or (ii) with respect to multiple nongroup policies of life insurance owned by one owner, whether the policy or contract owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees or other persons, premiums for coverage in excess of $5 million with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

"Principal place of business" of a plan sponsor or a person other than a natural person means the single state in which the natural persons who establish policy for the direction, control, and coordination of the operations of the entity as a whole primarily exercise that function, determined by the Association in its reasonable judgment by considering the following factors: (i) the state in which the primary executive and administrative headquarters of the entity is located; (ii) the state in which the principal office of the chief executive officer of the entity is located; (iii) the state in which the board of directors (or similar governing person or persons) of the entity conducts the majority of its meetings; (iv) the state from which the management of the overall operations of the entity is directed; and in the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using these factors. However, in the case of a plan sponsor, if more than 50 percent of the participants in the benefit plan are employed in a single state, that state shall be deemed to be the principal place of business of the plan sponsor. The principal place of business of a plan sponsor described in clause (iii) of the definition of plan sponsor in this section shall be deemed to be the principal place of business of the association, committee, joint board of trustees, or other similar group of

representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, shall be deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question.

"Receivership court" means the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation, or liquidation of the member insurer.

"Resident" means a person to whom a contractual obligation is owed and who resides in the Commonwealth on the date a member insurer becomes an impaired insurer or a court order is entered that determines a member insurer to be an insolvent insurer. A person may be a resident of only one state, which in the case of a person other than a natural person shall be its principal place of business. Citizens of the United States that are either (i) residents of foreign countries, or (ii) residents of United States possessions, territories, or protectorates that do not have an association similar to the Association, shall be deemed residents of the state of domicile of the member insurer that issued the policies or contracts.

"Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury or sickness suffered by the plaintiff or other claimant.

"Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health, or annuity policy or contract.

"Unallocated annuity contract" means an annuity contract or group annuity certificate that is not issued to and owned by an individual or a trust created by an individual for the benefit of one or more individuals, except to the extent of any annuity benefits guaranteed to an individual or such a trust by an insurer under the contract or certificate.

1976, c. 330, § 38.1-482.19; 1980, c. 186; 1986, c. 562; 2010, c. 510; 2015, c. 710; 2018, c. 706.

§ 38.2-1702. Association; creation; memberships; accounts; supervision.

A. The Association is a nonprofit legal entity known as the Virginia Life, Accident and Sickness Insurance Guaranty Association, created by former § 38.1-482.20. All member insurers shall be and remain members of the Association as a condition of their license to transact the business of insurance or the business of a health maintenance organization in the Commonwealth. The Association shall perform its functions under the plan of operation established and approved under § 38.2-1706 and shall exercise its powers through a board of directors established under § 38.2-1703. For purposes of administration and assessment, the Association shall maintain two accounts: (i) the accident and sickness insurance account; and (ii) the life insurance and annuity account, which includes the following subaccounts: (a) the life insurance account, (b) the annuity account, which shall include unallocated annuity contracts covered under subdivision D 2 b of § 38.2-1700, but shall otherwise exclude unallocated annuities, and (c) the unallocated annuity account, which shall consist of contracts covered under subdivisions D 2 d, e, and f of § 38.2-1700, but shall otherwise exclude unallocated annuities.

B. The Association shall come under the immediate supervision of the Commission and shall be subject to the applicable provisions of the insurance laws of the Commonwealth. Meetings or records of the Association may be opened to the public upon majority vote of the board of directors of the Association.

1976, c. 330, § 38.1-482.20; 1980, c. 186; 1986, c. 562; 2010, c. 510; 2018, c. 706.

§ 38.2-1703. Board of directors of Association.

A. The board of directors of the Association shall consist of not less than nine nor more than 13 member insurers serving terms as established in the plan of operation. The members of the board shall be selected by member insurers subject to the approval of the Commission. Vacancies on the board shall be filled for the remainder of the term by a majority vote of the remaining board members, subject to the approval of the Commission.

B. In approving selections the Commission shall consider, among other things, whether all member insurers are fairly represented.

C. Members of the board may be reimbursed from the assets of the Association for expenses incurred by them as members of the board of directors but members of the board shall not be otherwise compensated by the Association for their services.

1976, c. 330, § 38.1-482.21; 1986, c. 562; 2010, c. 510; 2018, cc. 258, 306, 706.

§ 38.2-1704. Powers and duties of Association.

In addition to the powers and duties enumerated in other sections of this chapter:

A. If the member insurer is an impaired insurer, the Association may, in its discretion and subject to any conditions imposed by the Association that do not impair the contractual obligations of the impaired insurer and that are approved by the Commission:

1. Guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued, or reinsured, any or all of the policies or contracts of the impaired insurer; and

2. Provide moneys, pledges, loans, notes, guarantees or other means as are proper to effectuate subdivision 1 and assure payment of the contractual obligations of the impaired insurer pending action under that subdivision.

B. If the member insurer is an insolvent insurer, the Association shall, in its discretion and subject to the approval of the Commission, either:

1. a. Guarantee, assume, reissue, or reinsure or cause to be guaranteed, assumed, reissued, or reinsured the covered policies of the insolvent insurer or assure payment of the contractual obligations of the insolvent insurer; and

b. Provide moneys, pledges, notes, guarantees, or other means reasonably necessary to discharge its duties; or

2. Provide benefits and coverages in accordance with the following provisions:

a. With respect to policies and contracts, assure payment of benefits that would have been payable under the policies or contracts of the insolvent insurer, for claims incurred:

(1) With respect to group policies and contracts, not later than the earlier of the next renewal date under those policies or contracts or 45 days, but in no event less than 30 days, after the date on which the Association becomes obligated with respect to the policies and contracts;

(2) With respect to nongroup policies, contracts, and annuities, not later than the earlier of the next renewal date, if any, under the policies or contracts or one year, but in no event less than 30 days, from the date on which the Association becomes obligated with respect to the policies or contracts;

b. Make diligent efforts to provide all known insureds, enrollees, or annuitants (for nongroup policies and contracts), or group policy or contract owners with respect to group policies and contracts, 30 days' notice of the termination, pursuant to subdivision 2 a, of the benefits provided;

c. With respect to nongroup policies and contracts covered by the Association, make available to each known insured, enrollee, or annuitant, or owner if other than the insured, enrollee, or annuitant, and with respect to an individual formerly an insured, enrollee, or annuitant under a group policy or contract who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of subdivision 2 d, if the insureds, enrollees, or annuitants had a right under law or the terminated policy or annuity to convert coverage to individual coverage or to continue an individual policy, contract, or annuity in force until a specified age or for a specified time, during which the insurer or health maintenance organization had no right unilaterally to make changes in any provision of the policy, contract, or annuity or had a right only to make changes in premium by class;

d. In providing the substitute coverage required under subdivision 2 c, the Association may offer either to reissue the terminated coverage or to issue an alternative policy or contract at actuarially justified rates, subject to the prior approval of the Commission. Alternative or reissued policies shall be offered without requiring evidence of insurability, and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy or contract. The Association may reinsure any alternative or reissued policy or contract;

e. Alternative policies or contracts adopted by the Association shall be subject to the approval of the Commission. The Association may adopt alternative policies or contracts of various types for future issuance without regard to any particular impairment or insolvency. Alternative policies or contracts shall contain at least the minimum statutory provisions required in the Commonwealth and provide benefits that shall not be unreasonable in relation to the premium charged. The Association shall set the premium in accordance with a table of rates that it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but shall not reflect any changes in the health of the insured after the original policy or contract was last underwritten. Any alternative policy or contract issued by the Association shall provide coverage of a type similar to that of the policy or contract issued by the impaired or insolvent insurer, as determined by the Association;

f. If the Association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy or contract, the premium shall be actuarially justified and set by the Association in accordance with the amount of insurance or coverage provided and the age and class of risk, subject to approval of the Commission;

g. The Association's obligations with respect to coverage under any policy or contract of the impaired or insolvent insurer or under any reissued or alternative policy or contract shall cease on the date the coverage or policy or contract is replaced by another similar policy or contract by the policy or contract owner, the insured, the enrollee, or the Association; and

h. When proceeding under subdivision B 2 with respect to a policy or contract carrying guaranteed minimum interest rates, the Association shall assure the payment or crediting of a rate of interest consistent with subdivision C 2 c of § 38.2-1700.

C. Nonpayment of premiums within 31 days after the date required under the terms of any guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage shall terminate the Association's obligations under the policy or contract or coverage under this chapter with respect to the policy, contract, or coverage, except with respect to any claims incurred or any net cash surrender value that may be due in accordance with the provisions of this chapter.

D. Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the Association. If the liquidator of an insolvent insurer requests, the Association shall provide a report to the liquidator regarding such premium collected by the Association. The Association shall be liable for unearned premiums due to policy or contract owners arising after the entry of the order.

E. The protection provided by this chapter shall not apply where the Commission has determined that the foreign or alien insurer's domiciliary jurisdiction or state of entry provides substantially similar protection by statute or regulation for residents of the Commonwealth.

F. In carrying out its duties under subsection B, the Association may:

1. Subject to approval by the Commission, impose permanent policy contract liens in connection with a guarantee, assumption, or reinsurance agreement, if the Association finds that the amounts that can be assessed under this chapter are less than the amounts needed to assure full and prompt performance of the Association's duties under this chapter, or that economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens to be in the public interest; and

2. Subject to approval by the Commission, impose temporary moratoriums or liens on payments of cash values and policy loans or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan values. In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payment of cash values or policy loans, or on any other right to withdraw funds held in conjunction

with policies or contracts, out of the assets of the impaired or insolvent insurer, the Association may defer the payment of cash values, policy loans, or other rights by the Association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the Association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

G. A deposit in the Commonwealth, held pursuant to law or required by the Commission for the benefit of creditors, including policy or contract owners, not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of a member insurer domiciled in the Commonwealth or in a reciprocal state, pursuant to Article 7 (§ 38.2-1045 et seq.) of Chapter 10 shall be promptly paid to the Association. The Association shall be entitled to retain a portion of any amount so paid to it equal to the percentage determined by dividing the aggregate amount of policy or contract owners' claims related to that insolvency for which the Association has provided statutory benefits by the aggregate amount of all policy or contract owners' claims in the Commonwealth related to that insolvency and shall remit to the domiciliary receiver the amount so paid to the Association less the amount retained pursuant to this subsection. Any amount so paid to the Association and retained by it shall be treated as a distribution of estate assets pursuant to applicable state receivership law dealing with early access disbursements.

H. If the Association fails to act within a reasonable period of time with respect to an insolvent insurer, as provided in subsection B, the Commission shall have the powers and duties of the Association under this chapter with respect to the insolvent insurer.

I. The Association may render assistance and advice to the Commission, upon the Commission's request, concerning rehabilitation, payment of claims, continuation of coverage, or the performance of other contractual obligations of an impaired or insolvent insurer.

J. The Association shall have standing to appear or intervene before the Commission or any court or agency in the Commonwealth with jurisdiction over an impaired or insolvent insurer concerning which the Association is or may become obligated under this chapter or with jurisdiction over any person or property against which the Association may have rights through subrogation or otherwise. Standing shall extend to all matters germane to the powers and duties of the Association, including proposals for reinsuring, reissuing, modifying, or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The Association shall also have the right to appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the Association is or may become obligated or with jurisdiction over any person or property against whom the Association may have rights through subrogation or otherwise.

K. 1. Any person receiving benefits under this chapter shall be deemed to have assigned the rights under, and any causes of action against any person for losses arising under, resulting from, or otherwise relating to, the covered policy or contract to the Association to the extent of the benefits

received because of this chapter, whether the benefits are payments of or on account of contractual obligations, continuation of coverage, or provision of substitute or alternative policies, contracts, or coverages. The Association may require an assignment to it of such rights and causes of action by any enrollee, payee, policy or contract owner, beneficiary, insured, or annuitant as a condition precedent to the receipt of any right or benefits conferred by this chapter upon the person.

2. The subrogation rights of the Association under this subsection shall have the same priority against the assets of the insolvent insurer as that possessed by the person entitled to receive benefits under this chapter.

3. In addition to the rights provided by subdivisions K 1 and K 2, the Association shall have all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary, enrollee, or payee of a policy or contract with respect to the policy or contract, including, in the case of a structured settlement annuity, any rights of the owner, beneficiary, or payee of the annuity, to the extent of benefits received pursuant to this chapter, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment therefor, excepting any such person responsible solely by reason of serving as an assignee in respect of a qualified assignment under § 130 of the Internal Revenue Code.

4. If subdivisions K 1, 2, and 3 are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the Association with respect to the related covered obligations shall be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies or contracts, or portion thereof, covered by the Association.

5. If the Association has provided benefits with respect to a covered obligation and a person recovers amounts to which the Association has rights as described in subdivisions K 1 through K 4, the person shall pay to the Association the portion of the recovery attributable to the policies or contracts, or portion thereof, covered by the Association.

L. In addition to the rights and powers granted to it elsewhere in this chapter, the Association may:

1. Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this chapter;

2. Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under § 38.2-1705 and to settle any claims or potential claims against it;

3. Borrow money to effect the purposes of this chapter. Any notes or other evidence of indebtedness of the Association not in default shall be Category 1 investments, as defined in § 38.2-1401, for domestic member insurers;

4. Employ or retain such persons as are necessary or appropriate to handle the financial transactions of the Association, and to perform other functions as become necessary or proper under this chapter;

5. Negotiate and contract with any liquidator, rehabilitator, conservator, or ancillary receiver to carry out the powers and duties of the Association;

6. Take such legal action as may be necessary or appropriate to avoid or recover payment of improper claims;

7. Exercise, for the purposes of this chapter and to the extent approved by the Commission, the powers of a domestic life insurer, accident and sickness insurer, or health maintenance organization, but in no case may the Association issue policies or contracts other than those issued to perform its obligations under this chapter;

8. Organize itself as a corporation or in other legal form permitted by the laws of the Commonwealth;

9. Request information from a person seeking coverage from the Association in order to aid the Association in determining its obligations under this chapter with respect to the person, and the person shall promptly comply with the request;

10. In accordance with the terms and conditions of the policy or contract, file for actuarially justified rate or premium increases for any policy or contract for which it provides coverage under this chapter; and

11. Take other necessary or appropriate action to discharge its duties and obligations under this chapter or to exercise its powers under this chapter.

M. The Association may join an organization of one or more other state associations of similar purposes, to further the purposes and administer the powers and duties of the Association.

N. 1. a. At any time within 180 days of the date of the order of liquidation, the Association may elect to succeed to the rights and obligations of the ceding member insurer that relate to policies, contracts, or annuities covered, in whole or in part, by the Association, in each case under any one or more reinsurance contracts entered into by the insolvent insurer and its reinsurers and selected by the Association. Any such assumption shall be effective as of the date of the order of liquidation. The election shall be effected by the Association or any agent of the Association on the Association's behalf sending written notice, return receipt requested, to the affected reinsurers.

b. To facilitate the earliest practicable decision about whether to assume any of the contracts of reinsurance, and in order to protect the financial position of the estate, the receiver and each reinsurer of the ceding member insurer shall make available upon request to the Association or to any agent of the Association on the Association's behalf as soon as possible after commencement of formal delinquency proceedings (i) copies of in-force contracts of reinsurance and all related files and records relevant to the determination of whether such contracts should be assumed and (ii) notices of any defaults under the reinsurance contracts or any known event or condition which with the passage of time could become a default under the reinsurance contracts.

c. The following shall apply to reinsurance contracts so assumed by the Association:

(1) The Association shall be responsible for all unpaid premiums due under the reinsurance contracts for periods both before and after the date of the order of liquidation, and shall be responsible for the performance of all other obligations to be performed after the date of the order of liquidation, in each case which relate to policies, contracts, or annuities covered, in whole or in part, by the Association. The Association may charge policies, contracts, or annuities covered in part by the Association, through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the Association and shall provide notice and an accounting of these charges to the liquidator;

(2) The Association shall be entitled to any amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods after the date of the order of liquidation and that relate to policies, contracts, or annuities covered, in whole or in part, by the Association, provided that, upon receipt of any such amounts, the Association shall be obliged to pay to the beneficiary, under the policy, contract, or annuity on account of which the amounts were paid, a portion of the amount equal to the lesser of (i) the amount received by the Association and (ii) the excess of the amount received by the Association over the amount equal to the benefits paid by the Association on account of the policy, contract, or annuity less the retention of the insurer applicable to the loss or event;

(3) Within 30 days following the Association's election (the election date), the Association and each reinsurer under contracts assumed by the Association shall calculate the net balance due to or from the Association under each reinsurance contract as of the election date with respect to policies, contracts, or annuities covered, in whole or in part, by the Association, which calculation shall give full credit to all items paid by either the member insurer or its receiver or the reinsurer prior to the election date. The reinsurer shall pay the receiver any amounts due for losses or events prior to the date of the order of liquidation, subject to any set-off for premiums unpaid for periods prior to the date, and the Association or reinsurer shall pay any remaining balance due the other, in each case within five days of the completion of the aforementioned calculation. Any disputes over the amounts due to either the Association or the reinsurer shall be resolved by arbitration pursuant to the terms of the affected reinsurance contract or, if the contract contains no arbitration clause, as otherwise provided by law. If the receiver has received any amounts due the Association pursuant to subdivision N 1 c (2), the receiver shall remit the same to the Association as promptly as practicable; and

(4) If the Association or receiver, on the Association's behalf, within 60 days of the election date, pays the unpaid premiums due for periods both before and after the election date that relate to policies, contracts, or annuities covered, in whole or in part, by the Association, the reinsurer shall not be entitled to terminate the reinsurance contracts for failure to pay premium insofar as the reinsurance contracts related to policies, contracts, or annuities covered, in whole or in part, by the Association, and shall not be entitled to set off any unpaid amounts due under other contracts, or unpaid amounts due from parties other than the Association, against amounts due the Association.

2. During the period from the date of the order of liquidation until the election date (or, if the election date does not occur, until 180 days after the date of the order of liquidation),

a. Neither the Association nor the reinsurer shall have any rights or obligations under reinsurance contracts that the Association has the right to assume under subdivision N 1, whether for periods prior to or after the date of the order of liquidation; and the reinsurer, the receiver, and the Association shall, to the extent practicable, provide each other data and records reasonably requested;

b. Provided that once the Association has elected to assume a reinsurance contract, the parties' rights and obligations shall be governed by subdivision N 1.

3. If the Association does not elect to assume a reinsurance contract by the election date pursuant to subdivision N 1, the Association shall have no rights or obligations, in each case for periods both before and after the date of the order of liquidation, with respect to the reinsurance contract.

4. When policies, contracts, or annuities, or covered obligations with respect thereto, are transferred to an assuming insurer, reinsurance on the policies, contracts, or annuities may also be transferred by the Association, in the case of contracts assumed under subdivision N 1, subject to the following:

a. Unless the reinsurer and the assuming insurer agree otherwise, the reinsurance contract transferred shall not cover any new policies of insurance, contracts, or annuities in addition to those transferred;

b. The obligations described in subdivision N 1 shall no longer apply with respect to matters arising after the effective date of the transfer; and

c. Notice shall be given in writing, return receipt requested, by the transferring party to the affected reinsurer not less than 30 days prior to the effective date of the transfer.

5. The provisions of this subsection shall supersede the provisions of any Commonwealth law or of any affected reinsurance contract that provides for or requires any payment of reinsurance proceeds, on account of losses or events that occur in periods after the date of the order of liquidation, to the receiver of the insolvent insurer or any other person. The receiver shall remain entitled to any amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods prior to the date of the order of liquidation, subject to applicable setoff provisions.

6. Except as otherwise provided in this section, nothing in this subsection shall alter or modify the terms and conditions of any reinsurance contract. Nothing in this section shall abrogate or limit any rights of any reinsurer to claim that it is entitled to rescind a reinsurance contract. Nothing in this section shall give a policy holder, contract owner, enrollee, certificate holder, or beneficiary an independent cause of action against a reinsurer that is not otherwise set forth in the reinsurance contract. Nothing in this section shall limit or affect the Association's rights as a creditor of the estate against the assets of the estate. Nothing in this section shall apply to reinsurance agreements covering property or casualty risks.

O. The board of directors of the Association shall have discretion and may exercise good faith business judgment to determine the means by which the Association is to provide the benefits of this chapter in an economical and efficient manner.

P. Where the Association has arranged or offered to provide the benefits of this chapter to a covered person under a plan or arrangement that fulfills the Association's obligations under this chapter, the person shall not be entitled to benefits from the Association in addition to or other than those provided under the plan or arrangement.

Q. Venue in a suit against the Association arising under this chapter shall be in the circuit court of the city or county in which the Association has its principal place of business except that any suit to which the Commission is a party shall be brought before the Commission. The Association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising under this chapter.

R. In carrying out its duties in connection with guaranteeing, assuming, reissuing, or reinsuring policies or contracts under subsection A or B, the Association may issue substitute coverage for a policy or contract that provides an interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with the following provisions:

1. In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for (i) a fixed interest rate, (ii) payment of dividends with minimum guarantees, or (iii) a different method for calculating interest or changes in value;

2. There is no requirement for evidence of insurability, waiting period, or other exclusion that would not have applied under the replaced policy or contract; and

3. The alternative policy or contract is similar to the replaced policy or contract in all other material terms.

1976, c. 330, § 38.1-482.22; 1986, c. 562; 1991, c. 340; 1993, c. 142; 2007, c. 482; 2010, c. 510; 2018, c. 706.

§ 38.2-1705. Assessments.

A. For the purpose of providing the funds necessary to carry out the powers and duties of the Association, the board of directors shall assess the member insurers, separately for each account, at such time and for any amounts as the board finds necessary. Assessments shall be due not less than 30 days after prior written notice has been given to the member insurers. Late payments shall accrue interest from the due date compounded quarterly, based upon the average 90-day treasury bill rate for the most recently completed calendar quarter as published in the Federal Reserve Bulletin and shall be subject to a minimum charge of $50.

B. There shall be two classes of assessments, as follows:

1. Class A assessments shall be authorized and called for the purpose of meeting administrative and legal costs and other expenses. Class A assessments may be authorized and called whether or not related to a particular impaired or insolvent insurer.

2. Class B assessments shall be authorized and called to the extent necessary to carry out the powers and duties of the Association under § 38.2-1704 with regard to an impaired or an insolvent insurer.

C. 1. The amount of any Class A assessment shall be determined by the board and may be authorized and called for current member insurers on a pro rata or non-pro rata basis. If pro rata, the board may provide that it be credited against future Class B assessments. The amount of a Class B assessment, except for assessments related to long-term care insurance, shall be allocated for assessment purposes between the accounts and among the subaccounts of the life insurance and annuity account, pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances. The amount of the Class B assessment for long-term care insurance written by the impaired or insolvent insurer shall be allocated according to a methodology included in the plan of operation and approved by the Commission. The methodology shall provide for 50 percent of the assessment to be allocated to accident and sickness member insurers and 50 percent to be allocated to life and annuity member insurers.

2. In determining the shares that shall be allocated to the life insurance and annuity account pursuant to the methodology in subdivision C 1, the guaranty association shall use the following formula: =(0.50 - Life and annuity member insurers' share of Accident and Sickness Account) / (Life and annuity member insurers' share of Life Insurance and Annuity Account - Life and annuity member insurers' share of Accident and Sickness Account).

3. For the purposes of the methodology in subdivision C 1 and the formula in subdivision C 2 only, "life and annuity member insurer" means a member insurer for which (i) the sum of its assessable life insurance premiums and annuity premiums is greater than or equal to (ii) its assessable accident and sickness insurance premiums, which shall include its assessable health maintenance organization premiums but shall exclude its assessable premiums written for disability income and long-term care insurance. For purposes of this definition, assessable premiums shall be measured within the state. An "accident and sickness member insurer" means any member insurer not defined as a "life and annuity member insurer."

4. Class B assessments against member insurers for each account and subaccount shall be in the proportion that the premiums received on business in the Commonwealth by each assessed member insurer on policies or contracts covered by each account and subaccount for the three most recent calendar years for which information is available preceding the year in which the member insurer became insolvent or, in the case of an assessment with respect to an impaired insurer, the three most recent calendar years for which information is available preceding the year in which the insurer became impaired, bear to such premiums received on business in the Commonwealth for those calendar years by all assessed member insurers.

5. Assessments for funds to meet the requirements of the Association with respect to an impaired or insolvent insurer shall not be authorized or called until necessary to implement the purposes of this

chapter. Classification of assessments under subsection B and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The Association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within 180 days after the assessment is authorized.

D. The Association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. Once the conditions that caused a deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the Association.

E. 1. a. Subject to the provisions of subdivision E 1 b, the total of all assessments authorized by the Association with respect to a member insurer for each subaccount of the life insurance and annuity account and for the accident and sickness account shall not in any one calendar year exceed two percent of that member insurer's average annual premiums received in the Commonwealth on the policies and contracts covered by the subaccount or account during the three calendar years preceding the year in which the member insurer became an impaired or insolvent insurer.

b. If two or more assessments are authorized in one calendar year with respect to member insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation referenced in subdivision E 1 a shall be equal and limited to the higher of the three-year average annual premiums for the applicable subaccount or account as calculated pursuant to this section.

c. If the maximum assessment, together with the other assets of the Association in an account, does not provide in one year in that account an amount sufficient to carry out the responsibilities of the Association, the necessary additional funds shall be assessed as soon thereafter as permitted by this chapter.

2. The board may provide in the plan of operation a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

3. If the maximum assessment for a subaccount of the life and annuity account in one year does not provide an amount sufficient to carry out the responsibilities of the Association, then pursuant to subdivision C 2, the board shall access the other subaccounts of the life and annuity account for the necessary additional amount, subject to the maximum stated in subdivision E 1.

F. If the Board of Directors of the Association determines that it has surplus funds on hand with respect to an insolvency, the Association shall, in accordance with the process set forth in the certificate of

contribution for adjusting or cancelling the unamortized portion of the member insurer's certificate of contribution in the event of a reimbursement of assessment payments, use such surplus funds to reimburse member insurers for assessment costs not otherwise amortized and offset pursuant to § 38.2-1709 and pay the remaining surplus to the Department of Taxation, for deposit with the State Treasurer for credit to the general fund of the Commonwealth. Within 90 days of making payment of surplus funds to the Department of Taxation for deposit with the State Treasurer, the Association shall notify its member insurers of such payment. If any member insurer contends that it is entitled to any portion of the surplus refunded to the Commonwealth in order to recover assessment costs not otherwise amortized and offset pursuant to § 38.2-1709, then the member insurer may present evidence of such entitlement to the Department of Taxation. If the Department of Taxation determines that the member insurer is entitled to a portion of the surplus funds in order to recover assessment costs not otherwise amortized and offset pursuant to § 38.2-1709, then the State Treasurer shall pay to the member insurer the sum that the Department of Taxation determines that the member insurer is entitled to receive. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the Association and for future losses and claims. For purposes of this subsection, "surplus funds" includes funds that the Association obtains by way of distributions or recoveries from receivers and third parties as reimbursement for its costs in connection with insolvencies and impairments in excess of reasonable amounts retained in an account to provide funds for the continuing expenses of the Association and for future losses and claims.

G. It shall be proper for any member insurer, in determining its premium rates and policy owner dividends as to any kind of insurance or health maintenance organization business within the scope of this chapter, to consider the amount reasonably necessary to meet its assessment obligations under this chapter.

H. The Association shall issue to each member insurer paying an assessment under this chapter, other than a Class A assessment, a certificate of contribution, in a form prescribed by the Commission, for the amount of the assessment so paid excluding interest penalties. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the member insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the Commission may approve.

I. 1. A member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the Association. The payment shall be available to meet Association obligations during the pendency of the protest or any subsequent appeal. Payment shall be accompanied by a statement in writing that the payment is made under protest and setting forth a brief statement of the grounds for the protest.

2. Within 60 days following the payment of an assessment under protest by a member insurer, the Association shall notify the member insurer in writing of its determination with respect to the protest unless the Association notifies the member insurer that additional time is required to resolve the issues raised by the protest.

3. Within 30 days after a final decision has been made, the Association shall notify the protesting member insurer in writing of that final decision. Within 60 days of receipt of notice of the final decision, the protesting member insurer may appeal that final action to the Commission.

4. In the alternative to rendering a final decision with respect to a protest based on a question regarding the assessment base, the Association may refer the protest to the Commission for a final decision, with or without a recommendation from the Association.

5. If the protest or appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member insurer. Interest on a refund due a protesting member insurer shall be paid at the rate actually earned by the Association.

J. The Association may request information of member insurers in order to aid in the exercise of its power under this section and member insurers shall promptly comply with a request.

1976, c. 330, § 38.1-482.23; 1980, c. 186; 1986, c. 562; 1992, c. 299; 2010, c. 510; 2011, c. 682; 2014, c. 154; 2018, c. 706.

§ 38.2-1706. Plan of operation.

A. 1. The Association's plan of operation approved under former § 38.1-482.24 shall remain in effect until modified in accordance with this subsection. The Association shall from time to time submit to the Commission any amendments to the plan of operation necessary or suitable to assure the fair, reasonable, and equitable administration of the Association. Any amendments to the plan of operation shall become effective upon the Commission's written approval or unless they have not been disapproved within 60 days.

2. If at any time the Association fails to submit suitable amendments to the plan, the Commission shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this chapter. The rules shall continue in force until modified by the Commission or superseded by an amended plan submitted by the Association and approved by the Commission.

B. All member insurers shall comply with the plan of operation.

C. The plan of operation shall, in addition to requirements enumerated elsewhere in this chapter:

1. Establish procedures for handling assets of the Association;

2. Establish the amount and method of reimbursing members of the board of directors under § 38.2-1703;

3. Establish regular places and times for meetings, including telephone conference calls, of the board of directors;

4. Establish procedures for records to be kept of all financial transactions of the Association, its agents, and the board of directors;

5. Establish the procedures whereby selections for the board of directors will be made and submitted to the Commission;

6. Establish any additional procedures for assessments under § 38.2-1705;

7. Establish a plan for equitable distribution of refunds to member insurers;

8. Contain additional provisions necessary or proper for the execution of the powers and duties of the Association;

9. Establish procedures whereby a director may be removed for cause, including in the case where a member insurer director becomes an impaired or insolvent insurer; and

10. Require the board of directors to establish a policy and procedures for addressing conflicts of interests.

D. The plan of operation may provide that any or all powers and duties of the Association, except those under subdivision L 3 of § 38.2-1704 and § 38.2-1705, are delegated to a corporation, association, or other organization that performs or will perform functions similar to those of this Association, or its equivalent, in two or more states. Such a corporation, association, or organization shall be reimbursed for any payments made on behalf of the Association and shall be paid for its performance of any function of the Association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the Commission, and may be made only to a corporation, association, or organization that extends protection not substantially less favorable and effective than that provided by this chapter.

1976, c. 330, § 38.1-482.24; 1986, c. 562; 2010, c. 510; 2018, c. 706.

§ 38.2-1707. Duties and powers of the Commission.

A. In addition to the duties and powers enumerated elsewhere in this chapter, the Commission shall:

1. Upon request of the board of directors, provide the Association with a statement of the premiums in the appropriate states for each member insurer;

2. When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time. Notice to the impaired insurer shall constitute notice to its shareholders, if any. The failure of the impaired insurer to promptly comply with this demand shall not excuse the Association from the performance of its powers and duties under this chapter; and

3. Be appointed as the liquidator or rehabilitator in any liquidation or rehabilitation proceeding involving a domestic member insurer. If a foreign or alien member insurer is subject to a liquidation proceeding in its domiciliary jurisdiction or state of entry, the Commission shall be appointed conservator.

B. The Commission may suspend or revoke, after notice and hearing, the license to transact business in the Commonwealth of any member insurer that fails to pay an assessment when due or fails to

comply with the plan of operation. As an alternative the Commission may levy a forfeiture on any member insurer that fails to pay an assessment when due. The forfeiture shall not exceed five percent of the unpaid assessment per month, but no forfeiture shall be less than $100 per month.

C. Any action of the board of directors or the Association may be appealed to the Commission by any member insurer if the appeal is taken within 30 days of the action being appealed. Any final action or order of the Commission shall be subject to judicial review in accordance with the provisions of §§ 12.1-39 through 12.1-41.

D. The liquidator, rehabilitator, or conservator of any impaired or insolvent insurer may notify all interested persons of the effect of this chapter.

1976, c. 330, § 38.1-482.25; 1986, c. 562; 2010, c. 510; 2018, c. 706.

§ 38.2-1708. Detection and prevention of insolvencies.

A. To aid in the detection and prevention of member insurer insolvencies, the Commission shall have the duty to:

1. Notify the insurance departments of all of the other states within 30 days following the action taken or the date the action occurs, when the Commission takes any of the following actions against a member insurer:

a. Revocation of license;

b. Suspension of license; or

c. Enters a formal order that the member insurer restrict its premium writing, obtain additional contributions to surplus, withdraw from the Commonwealth, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of policy owners, contract owners, certificate holders, or creditors;

2. Report to the board of directors when the Commission has taken any of the actions set forth in subdivision 1 or has received a report from any other insurance department indicating that any such action has been taken in another state. The report to the board of directors shall contain all significant details of the action taken or the report received from another insurance department;

3. Report to the board of directors when the Commission has reasonable cause to believe from an examination, whether completed or in process, of any member insurer that the member insurer may be an impaired or insolvent insurer; and

4. Furnish to the board of directors the National Association of Insurance Commissioners (NAIC) Insurance Regulatory Information System (IRIS) ratios and listings of companies not included in the ratios developed by the NAIC, and the board may use the information contained therein in carrying out its duties and responsibilities under this section. The report and the information contained therein shall be kept confidential by the board of directors until such time as made public by the Commission or other lawful authority.

B. The Commission may seek the advice and recommendations of the board of directors concerning any matter affecting its duties and responsibilities regarding the financial condition of member insurers and insurers or health maintenance organizations seeking admission to transact business in the Commonwealth.

C. The board of directors may, upon majority vote, make reports and recommendations to the Commission upon any matter germane to the solvency, liquidation, rehabilitation or conservation of any member insurer or germane to the solvency of any insurer or health maintenance organization seeking to transact business in the Commonwealth. These reports and recommendations shall not be considered public documents.

D. The board of directors, upon majority vote, may notify the Commission of any information indicating a member insurer may be an impaired or insolvent insurer.

E. The board of directors, upon majority vote, may make recommendations to the Commission for the detection and prevention of member insurer insolvencies.

1976, c. 330, § 38.1-482.26; 1986, c. 562; 2010, c. 510; 2018, c. 706.

§ 38.2-1709. Tax write-offs of certificates of contributions.

A. A member insurer shall have at its option the right to show a certificate of contribution as an asset in the form approved by the Commission pursuant to subsection H of § 38.2-1705 at the original face amount for the calendar year of issuance. Such amount shall be amortized over the 10 calendar years following the year the contribution was paid in amounts each equal to 10 percent of the amount of the contribution.

B. The member insurer may offset the amount of the certificate amortized in a calendar year as provided in subsection A. This amount shall be deducted from the premium tax liability incurred on business transacted in the Commonwealth for that year. However, the Association shall diligently pursue all rights available to it to recover its expenditures made in the fulfillment of its responsibilities under this chapter. If the Commission determines after a hearing that the Association is not diligently pursuing available measures of recovery, the Commission shall notify the Department and contributing member insurers will not be able to offset amounts amortized during the period that the Commission determines that the Association has not been diligently pursuing available measures of recovery.

C. Any sums for which a certificate of contribution has been issued that have been (i) amortized by contributing insurers and offset against premium taxes as provided in subsection B and (ii) subsequently refunded pursuant to subsection F of § 38.2-1705 shall be paid to the Department of Taxation and deposited with the State Treasurer for credit to the general fund of the Commonwealth.

D. The amount of any credit against premium taxes provided for in this section for a member insurer shall be reduced by the amount of reduction in federal income taxes for any deduction claimed by the member insurer for an assessment paid pursuant to this chapter.

E. A member insurer that is exempt from taxes referenced in subsection A may recoup its assessments by a surcharge on its premiums in a sum reasonably calculated to recoup the assessments over a reasonable period of time, as approved by the Commission. Amounts recouped shall not be considered premiums for any other purpose, including the computation of gross premium tax, the loss ratio, or agent commission. If a member insurer collects excess surcharges, the member insurer shall remit the excess amount to the Association, and the excess amount shall be applied to reduce future assessments in the appropriate account.

1976, c. 330, § 38.1-482.27; 1986, c. 562; 1987, cc. 565, 655; 1991, c. 371; 1997, c. 160; 2010, c. 510; 2011, c. 850; 2018, c. 706.

§ 38.2-1710. Miscellaneous provisions.

A. Nothing in this chapter shall be construed to reduce the liability for unpaid assessments of the insureds on an impaired or insolvent insurer operating under a plan with assessment liability.

B. Records shall be kept of all meetings of the board of directors to discuss the activities of the Association in carrying out its powers and duties under § 38.2-1704. The records of the Association with respect to an impaired or insolvent insurer shall not be disclosed prior to the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer, except (i) upon the termination of the impairment or insolvency of the member insurer or (ii) upon the order of a court of competent jurisdiction. Nothing in this subsection shall limit the duty of the Association to render a report of its activities under § 38.2-1711.

C. For the purpose of carrying out its obligations under this chapter, the Association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies and contracts reduced by any amounts to which the Association is entitled as subrogee pursuant to subsection K of § 38.2-1704. Assets of the impaired or insolvent insurer attributable to covered policies and contracts shall be used to continue all covered policies and contracts and pay all contractual obligations of the impaired or insolvent insurer as required by this chapter. "Assets attributable to covered policies and contracts" means that proportion of the assets which the reserves that should have been established for these policies and contracts bear to the reserves that should have been established for all insurance policies, contracts, and health benefit plans written by the impaired or insolvent insurer.

D. As a creditor of the impaired or insolvent insurer as established in subsection C and consistent with subsection B of § 38.2-1509, the Association and other similar associations shall be entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations under this chapter. If the liquidator has not, within 120 days of a final determination of insolvency of a member insurer by the receivership court, made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, then the Asso-

ciation shall be entitled to make application to the receivership court for approval of its own proposal to disburse these assets.

E. 1. Prior to the termination of any liquidation, rehabilitation, or conservation proceeding, the court, in making an equitable distribution of the ownership rights of the insolvent insurer, may take into consideration the contributions of the respective parties, including the Association, the shareholders, contract owners, certificate holders, enrollees, and policy and contract owners of the insolvent insurer, and any other party with a legitimate interest. In this determination, consideration shall be given to the welfare of the policy owners, contract owners, certificate holders, and enrollees of the continuing or successor member insurer.

2. No distribution to any stockholders, if any, of an impaired or insolvent insurer shall be made until and unless the total amount of valid claims of the Association with interest thereon for funds expended in carrying out its powers and duties under § 38.2-1704 with respect to the member insurer have been fully recovered by the Association.

F. 1. If an order for liquidation or rehabilitation of a member insurer domiciled in the Commonwealth has been entered, the receiver appointed under that order shall have a right to recover on behalf of the member insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the member insurer on its capital stock, made at any time during the five years preceding the petition for liquidation or rehabilitation, subject to the limitations of subdivisions 2 through 4.

2. No such distribution shall be recoverable if the member insurer shows that when paid the distribution was lawful and reasonable, and that the member insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the member insurer to fulfill its contractual obligations.

3. Any person who was an affiliate that controlled the member insurer at the time the distributions were paid shall be liable up to the amount of distributions received. Any person who was an affiliate that controlled the member insurer at the time the distributions were declared shall be liable up to the amount of distributions that would have been received if they had been paid immediately. If two or more persons are liable with respect to the same distributions, they shall be jointly and severally liable.

4. The maximum amount recoverable under this subsection shall be the amount in excess of all other available assets of the insolvent insurer needed to pay (i) the contractual obligations of the insolvent insurer and (ii) the reasonable expenses of the Association incurred in connection with the performance of its duties for the insolvent insurer.

5. If any person liable under subdivision 3 is insolvent, all its affiliates that controlled it at the time the distribution was paid shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

1976, c. 330, § 38.1-482.28; 1986, c. 562; 2010, c. 510; 2018, c. 706.

§ 38.2-1711. Examination of the Association; annual report.

The Association shall be subject to examination and regulation by the Commission. The board of directors shall submit to the Commission, not later than each May 1, a financial report for the preceding calendar year in a form approved by the Commission and a report of its activities during the preceding calendar year. Upon the request of a member insurer, the Association shall provide the member insurer with a copy of the report.

1976, c. 330, § 38.1-482.29; 1986, c. 562; 2010, c. 510.

§ 38.2-1712. Tax exemptions.

The Association shall be exempt from the payment of all fees and all taxes levied by the Commonwealth or any of its subdivisions, except taxes levied on real and personal property.

1976, c. 330, § 38.1-482.30; 1986, c. 562; 2010, c. 510.

§ 38.2-1713. Immunity.

There shall be no liability on the part of, and no cause of action of any nature shall arise against, any member insurer or its agents or employees, the Association or its agents or employees, members of the board of directors, or the Commission or its representatives, for any action taken by them in the performance of their powers and duties under this chapter. This immunity shall extend to the participation in any organization of one or more other state associations of similar purposes and to any such organization and its agents or employees.

1976, c. 330, § 38.1-482.31; 1986, c. 562; 2010, c. 510.

§ 38.2-1714. Stay of proceedings; reopening default judgments.

All proceedings in which the insolvent member insurer is a party in any court in this Commonwealth shall be stayed 180 days from the date an order of liquidation, rehabilitation, or conservation is final to permit proper legal action by the Association on all matters germane to its powers and duties. The Association may apply to have the judgment under any decision, order, verdict, or finding based on default set aside by the same court that made the judgment and shall be permitted to defend against the suit on the merits.

1976, c. 330, § 38.1-482.32; 1986, c. 562; 2010, c. 510; 2018, c. 706.

§ 38.2-1715. Prohibited advertisement of Association coverage in insurance sales; notice to policy owners.

A. No person, including a member insurer, agent, or affiliate of a member insurer, shall make, publish, disseminate, circulate, or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in any newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station or television station, or in any other way, any advertisement, announcement, or statement, written or oral, that uses the existence of the Association of the Commonwealth for the purpose of sales, solicitation, or inducement to purchase any form of insurance or other coverage covered by this chapter. This sub-

section shall not apply to the Association or any other entity that does not sell or solicit insurance or coverage by a health maintenance organization.

B. The Association shall prepare a summary document describing the general purposes and current limitations of this chapter and that complies with subsection C. This document shall be submitted to the Commission for approval. At the expiration of the sixtieth day after the date on which the Commission approves the document, a member insurer may not deliver a policy or contract to a policy owner, contract owner, certificate holder, or enrollee unless the summary document is delivered to the policy owner, contract owner, certificate holder, or enrollee at the time of delivery of the policy or contract. The document shall be posted on the Association's website and shall also be available upon request by a policy owner, contract owner, certificate holder, or enrollee. The distribution, delivery, or contents or interpretation of this document does not guarantee that either the policy or the contract or the policy owner, contract owner, certificate holder, or enrollee is covered in the event of the impairment or insolvency of a member insurer. The summary document shall be revised by the Association as amendments to the chapter may require. Failure to receive this document does not give the policy owner, contract owner, certificate owner, certificate holder, enrollee, or insured any greater rights than those stated in this chapter.

C. The document prepared under subsection B shall contain a clear and conspicuous disclaimer on its face. The Commission shall establish the form and content of the disclaimer. The disclaimer shall:

1. State the name and address of the Association and the Bureau of Insurance;

2. Prominently warn the policy owner, contract owner, certificate holder, or enrollee that the Association may not cover the policy or contract or, if coverage is available, it will be subject to substantial limitations and exclusions and conditioned on continued residence in the Commonwealth;

3. State the types of policies or contracts for which guaranty funds will provide coverage;

4. State that the member insurer and its agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance or health maintenance organization coverage;

5. State that the policy owner, contract owner, certificate holder, or enrollee should not rely on coverage under the Association when selecting an insurer or health maintenance organization;

6. Explain rights available and procedures for filing a complaint to allege a violation of any provisions of this chapter; and

7. Provide other information as directed by the Commission including but not limited to, sources for information about the financial condition of insurers provided that the information is not proprietary and is subject to disclosure under the Virginia Freedom of Information Act (§ 2.2-3700 et seq.).

D. A member insurer shall retain evidence of compliance with subsection B for so long as the policy or contract for which the notice is given remains in effect.

1976, c. 330, § 38.1-482.33; 1986, c. 562; 2010, c. 510; 2011, c. 306; 2018, c. 706.

Article 2 - ADDITIONAL FUNDS PAID TO THE ASSOCIATION

§ 38.2-1716. Purpose and applicability of article.

The purpose of this article is to provide directions and guidelines for the control and use of funds provided pursuant to § 38.2-225 or any other sources of funds not specified in Article 1 (§ 38.2-1700 et seq.) of this chapter.

1986, c. 562.

§ 38.2-1717. Safety fund.

The Association shall maintain a separate asset account to be known as the safety fund for the purpose of meeting the Association's objectives as specified in § 38.2-1700.

1986, c. 562.

§ 38.2-1718. Financing the safety fund, maximum amount, distribution of excess.

A. The safety fund, at the discretion of the Commission, shall receive penalty payments levied against member insurers made pursuant to subsection B of § 38.2-225 or any other payments approved by the Commission.

B. The Commission may approve the payment of funds to the Association provided the balance in the safety fund account does not exceed two percent of the total of all member insurer's premium received in this Commonwealth for classes of insurance covered by the accounts specified in subsection A of § 38.2-1702.

C. Investment income earned on assets held in the safety fund shall be credited to the safety fund provided the balance of the safety fund does not exceed three percent of the total of all member insurer's premium received in this Commonwealth for classes of insurance covered by the accounts specified in subsection A of § 38.2-1702 unless otherwise determined by the Commission.

D. In the event the safety fund balance exceeds the amount specified in subsection C of this section, at the discretion of the Commission the difference shall be paid to the state treasury to the credit of the Literary Fund or shall be subject to subsection F of § 38.2-1720.

E. In the event the fund is dissolved, remaining assets in the safety fund will be distributed to the state treasury to the credit of the Literary Fund.

1986, c. 562.

§ 38.2-1719. Investment of safety fund.

The assets of the safety fund may be invested in securities set forth in § 38.2-1415.

1986, c. 562.

§ 38.2-1720. Use of safety fund, repayment, etc.

A. The purpose of the safety fund is to provide for the payment of covered claims in the event the assessment limit specified in subsection E of § 38.2-1705 is reached.

B. In the event the assets of the safety fund are needed to pay covered claims, these assets shall be loaned to the respective account listed in subsection A of § 38.2-1702. This loan shall be the general obligation of the Association members and shall be evidenced by an agreement approved by the Commission.

C. Interest on this loan shall be compounded quarterly and be based upon the average ninety-day treasury bill rate for the most recently completed calendar quarter as published in the Federal Reserve Bulletin. This rate will be updated quarterly in order to conform with market rates of interest.

D. This loan shall be repaid by levying assessments against the members for the account on whose behalf the loan was negotiated. Unless otherwise approved by the Commission, the loan shall be repaid within six months of its issuance. This assessment in conjunction with any other assessments levied, shall not exceed the limit specified in subsection E of § 38.2-1705.

E. Subject to the approval of the Commission assets of the safety fund may be loaned to any account in subsection A of § 38.2-1702 even though the maximum assessment in subsection E of § 38.2-1705 has not been levied if the directors of the Association determine that this action will minimize the cost to the Association in paying covered claims.

F. Excess safety fund assets set forth in subsection D of § 38.2-1718 may be used to pay the Association's covered claims without the members incurring a liability to repay the safety fund.

1986, c. 562.

§ 38.2-1721. Association as a fiduciary.

In handling the assets of the safety fund, the Association shall be deemed a fiduciary for the Commonwealth.

1986, c. 562.

Chapter 18 - INSURANCE AGENTS

Article 1 - Definitions and General Provisions

§ 38.2-1800. Definitions.

As used in this chapter:

"Agent," "insurance agent," "producer," or "insurance producer," when used without qualification, means an individual or business entity that sells, solicits, or negotiates contracts of insurance or annuity in the Commonwealth.

"Appointed agent," "appointed insurance agent," "appointed producer," or "appointed insurance producer," when used without qualification, means an individual or business entity licensed in the Commonwealth to sell, solicit, or negotiate contracts of insurance or annuity of the classes authorized within the scope of such license and who is appointed by a company licensed in the Commonwealth to sell, solicit, or negotiate on its behalf contracts of insurance of the classes authorized within the scope of such license and, if authorized by the company, may collect premiums on those contracts.

"Business entity" means a partnership, limited partnership, limited liability company, corporation, or other legal entity other than a sole proprietorship.

"Dental plan organization authority" means the authority in the Commonwealth to sell, solicit, or negotiate dental benefit contracts on behalf of dental plan organizations licensed under Chapter 61 (§ 38.2-6100 et seq.).

"Dental services authority" means the authority in the Commonwealth to sell, solicit, or negotiate dental services plan contracts on behalf of dental services plans licensed under Chapter 45 (§ 38.2-4500 et seq.).

"Filed" means received by the Commission.

"Health agent" means an agent licensed in the Commonwealth to sell, solicit, or negotiate insurance as defined in §§ 38.2-107.2, 38.2-108, and 38.2-109, and including contracts issued by insurers, health services plans, health maintenance organizations, dental services plans, optometric services plans, and dental plan organizations licensed in the Commonwealth.

"Home protection insurance authority" means the authority in the Commonwealth to sell, solicit, or negotiate home protection insurance as defined in § 38.2-129 on behalf of insurers licensed in the Commonwealth.

"Home state" means the District of Columbia and any state or territory of the United States, except Virginia, or any province of Canada, in which an insurance producer maintains such person's principal place of residence or principal place of business and is licensed by that jurisdiction to act as a resident insurance producer.

"Legal services insurance authority" means the authority in the Commonwealth to sell, solicit, or negotiate legal services insurance as defined in § 38.2-127 on behalf of insurers licensed in the Commonwealth.

"License" means a document issued by the Commission authorizing an individual or business entity to act as an insurance producer for the lines of authority specified in the document. Except as provided in § 38.2-1833, the license itself does not create any authority, actual, apparent or inherent, in the licensee to represent, commit, or bind an insurer.

"Licensed agent," "licensed insurance agent," "licensed producer," or "licensed insurance producer," when used without qualification, means an individual or business entity licensed in the Commonwealth to sell, solicit, or negotiate contracts of insurance or annuity of the classes authorized within the scope of such license.

"Life and annuities insurance agent" means an agent licensed in the Commonwealth to sell, solicit, or negotiate life insurance and annuity contracts as defined in §§ 38.2-102, 38.2-103, 38.2-104, 38.2-105.1, 38.2-106, and 38.2-107.1, respectively, and family leave insurance as defined in § 38.2-107.2, on behalf of insurers licensed in the Commonwealth.

"Limited burial insurance authority" means the authority in the Commonwealth to sell, solicit, or negotiate burial insurance society membership where the certificates of membership are used solely to fund preneed funeral contracts on any individual, on behalf of insurers licensed under Chapter 40 (§ 38.2-4000 et seq.); or to represent an association referred to in § 38.2-3318.1, limited to soliciting members of that association for association group life insurance certificates where the funds are used solely to fund preneed funeral contracts.

"Limited lines credit insurance agent" means an agent licensed in the Commonwealth whose authority is restricted to selling, soliciting, or negotiating, on behalf of insurers licensed in the Commonwealth, one or more of the following coverages to individuals through a master, corporate, group or individual policy: (i) credit life insurance and credit accident and sickness insurance, but only to the extent authorized in Chapter 37.1 (§ 38.2-3717 et seq.); (ii) credit involuntary unemployment insurance as defined in § 38.2-122.1; (iii) credit property insurance, as defined in § 38.2-122.2; (iv) mortgage accident and sickness insurance; (v) mortgage redemption insurance; (vi) mortgage guaranty insurance; and (vii) any other form of insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing that credit obligation and that the Commission specifically determines may be sold, solicited, or negotiated by those holding a limited lines credit insurance agent license. Each insurer that sells, solicits or negotiates any of the coverages set forth in this definition shall provide to each individual whose duties will include selling, soliciting or negotiating such coverages a program of instruction that may, at the discretion of the Commission, be submitted for approval by the Commission or reviewed by the Commission subsequent to its implementation.

"Limited lines life and health agent" means an individual or business entity authorized by the Commission whose license authority to sell, solicit, or negotiate is limited to the following, or any other type of authority that the Commission may deem it necessary to recognize for the purposes of complying with § 38.2-1836: dental services authority; limited burial insurance authority; mutual assessment life and health insurance authority; optometric services authority; and dental plan organization authority. Limited lines life and health insurance shall not include life insurance, health insurance, property insurance, casualty insurance, private family leave insurance, and title insurance.

"Limited lines property and casualty agent" means an individual or business entity authorized by the Commission whose license authority to sell, solicit, or negotiate is limited to the following, or any other type of authority that the Commission may deem it necessary to recognize for the purposes of complying with § 38.2-1836: home protection insurance authority; legal services insurance authority; mutual assessment property and casualty insurance authority; ocean marine insurance authority; pet accident, sickness and hospitalization insurance authority; portable electronics insurance authority; self storage insurance authority; and travel insurance. Unless otherwise defined, "limited lines property and casualty insurance" shall not include life insurance, health insurance, property insurance, casualty insurance, private family leave insurance, and title insurance.

"Mortgage accident and sickness insurance authority" means the authority in the Commonwealth to sell, solicit, or negotiate mortgage accident and sickness insurance on behalf of insurers licensed in the Commonwealth.

"Mortgage guaranty insurance authority" means the authority in the Commonwealth to sell, solicit, or negotiate mortgage guaranty insurance on behalf of insurers licensed in the Commonwealth.

"Mortgage redemption insurance authority" means the authority in the Commonwealth to sell, solicit, or negotiate mortgage redemption insurance on behalf of insurers licensed in the Commonwealth. As used in this chapter, "mortgage redemption insurance" means a nonrenewable, nonconvertible, decreasing term life insurance policy written in connection with a mortgage transaction for a period of time coinciding with the term of the mortgage. The initial sum shall not exceed the amount of the indebtedness outstanding at the time the insurance becomes effective, rounded up to the next $1,000.

"Motor vehicle rental contract enroller" means an unlicensed hourly or salaried employee of a motor vehicle rental company that is in the business of providing primarily private motor vehicles to the public under a rental agreement for a period of less than six months, and receives no direct or indirect commission from the insurer, the renter or the vehicle rental company.

"Motor vehicle rental contract insurance agent" means a person who (i) is a selling agent of a motor vehicle rental company that is in the business of providing primarily private passenger motor vehicles to the public under a rental agreement for a period of less than six months and (ii) whose license in the Commonwealth is restricted to selling, soliciting, or negotiating only the following insurance coverages, and solely in connection with and incidental to the rental contract:

1. Personal accident insurance that provides benefits in the event of accidental death or injury occurring during the rental period;

2. Liability coverage sold to the renter in excess of the rental company's obligations under § 38.2-2204, 38.2-2205, or Title 46.2, as applicable;

3. Personal effects insurance that provides coverages for the loss of or damage to the personal effects of the renter and other vehicle occupants while such personal effects are in or upon the rental vehicle during the rental period;

4. Roadside assistance and emergency sickness protection programs; and

5. Other travel-related or vehicle-related insurance coverage that a motor vehicle rental company offers in connection with and incidental to the rental of vehicles.

The term "motor vehicle rental contract insurance agent" does not include motor vehicle rental contract enrollers.

"Mutual assessment life and health insurance authority" means the authority in the Commonwealth to sell, solicit, or negotiate mutual assessment life and accident and sickness insurance on behalf of

insurers licensed under Chapter 39 (§ 38.2-3900 et seq.), but only to the extent permitted under § 38.2-3919.

"Mutual assessment property and casualty insurance authority" means the authority in the Commonwealth to sell, solicit, or negotiate mutual assessment property and casualty insurance on behalf of insurers licensed under Chapter 25 (§ 38.2-2500 et seq.), but only to the extent permitted under § 38.2-2525.

"NAIC" means the National Association of Insurance Commissioners.

"Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms or conditions of the contract, provided that the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers.

"Ocean marine insurance authority" means the authority in the Commonwealth to sell, solicit, or negotiate those classes of insurance classified in § 38.2-126, except those classes specifically classified as inland marine insurance, on behalf of insurers licensed in the Commonwealth.

"Optometric services authority" means the authority in the Commonwealth to sell, solicit, or negotiate optometric services plan contracts on behalf of optometric services plans licensed under Chapter 45 (§ 38.2-4500 et seq.).

"Personal lines agent" means an agent licensed in the Commonwealth to sell, solicit, or negotiate insurance as defined in §§ 38.2-110 through 38.2-114, 38.2-116, 38.2-117, 38.2-118, 38.2-124, 38.2-125, 38.2-126, 38.2-129, 38.2-130, and 38.2-131 for transactions involving insurance primarily for personal, family, or household needs rather than for business or professional needs.

"Pet accident, sickness and hospitalization insurance authority" means the authority in the Commonwealth to sell, solicit, or negotiate pet accident, sickness and hospitalization insurance on behalf of insurers licensed in the Commonwealth.

"Property and casualty insurance agent" means an agent licensed in the Commonwealth to sell, solicit, or negotiate both personal and commercial lines of insurance as defined in §§ 38.2-107.2, 38.2-110 through 38.2-122.2, and 38.2-124 through 38.2-134 on behalf of insurers licensed in the Commonwealth.

"Resident" means (i) an individual residing in Virginia; (ii) an individual residing outside of Virginia whose principal place of business is in Virginia, who is able to demonstrate to the satisfaction of the Commission that the laws of his home state prevent him from obtaining a resident agent license in that state, and who affirmatively chooses to qualify as and be treated as a resident of Virginia for purposes of licensing and continuing education, both in Virginia and in the state in which the individual resides, if applicable; (iii) a partnership duly formed and recorded in Virginia; (iv) a corporation incorporated and existing under the laws of Virginia; (v) a limited liability company organized and existing under the laws of Virginia; or (vi) a foreign business entity that is not licensed as a resident agent in any other

jurisdiction, and that demonstrates to the satisfaction of the Commission that its principal place of business is within the Commonwealth of Virginia.

"Restricted nonresident health agent" means a nonresident agent whose license authority in his home state does not include all of the authority granted under a health agent license in Virginia. The license issued to such agent shall authorize the agent to sell, solicit, or negotiate in Virginia, on behalf of insurers licensed in Virginia, only those kinds or classes of insurance for which the agent is authorized in his home state.

"Restricted nonresident life and annuities agent" means a nonresident agent whose license authority in his home state does not include all of the authority granted under a life and annuities agent license in Virginia. The license issued to such agent shall authorize the agent to sell, solicit, or negotiate in Virginia, on behalf of insurers licensed in Virginia, only those kinds or classes of insurance for which the agent is authorized in his home state.

"Restricted nonresident personal lines agent" means a nonresident agent whose license authority in his home state does not include all of the authority granted under a personal lines agent license in Virginia. The license issued to such agent shall authorize the agent to sell, solicit, or negotiate in Virginia, on behalf of insurers licensed in Virginia, only those kinds or classes of insurance for which the agent is authorized in his home state.

"Restricted nonresident property and casualty agent" means a nonresident agent whose license authority in his home state does not include all of the authority granted under a property and casualty agent license in Virginia. The license issued to such agent shall authorize the agent to sell, solicit, or negotiate in Virginia, on behalf of insurers licensed in Virginia, only those kinds or classes of insurance for which the agent is authorized in his home state.

"Sell" means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurer.

"Settlement agent" means a person licensed as a title insurance agent and registered with the Virginia State Bar pursuant to Chapter 10 (§ 55.1-1000 et seq.) of Title 55.1.

"Solicit" means attempting to sell insurance or asking or urging a person to apply for a particular class of insurance from one or more insurers.

"Surety bail bondsman" means a person licensed as a surety bail bondsman pursuant to Article 11 (§ 9.1-185 et seq.) of Chapter 1 of Title 9.1.

"Surplus lines broker" means a person licensed pursuant to Article 5.1 (§ 38.2-1857.1 et seq.) of this chapter, and who is thereby authorized to engage in the activities set forth in Chapter 48 (§ 38.2-4805.1 et seq.).

"Terminate" means the cancellation of the relationship between an insurance producer and the insurer, or the termination of an insurance producer's authority to transact insurance.

"Title insurance agent" means an agent licensed in the Commonwealth to sell, solicit, or negotiate title insurance, and performing all of the services set forth in § 38.2-4601.1, on behalf of title insurance companies licensed under Chapter 46 (§ 38.2-4600 et seq.).

"Uniform Application" means the current version of the NAIC Uniform Application for resident and nonresident producer licensing.

"Uniform Business Entity Application" means the current version of the NAIC Uniform Business Entity Application for resident and nonresident business entities.

"Variable contract agent" means an agent licensed in the Commonwealth to sell, solicit, or negotiate variable life insurance and variable annuity contracts on behalf of insurers licensed in the Commonwealth.

"Viatical settlement broker" means a person licensed pursuant to Chapter 60 (§ 38.2-6000 et seq.), in accordance with Article 6.1 (§ 38.2-1865.1 et seq.) of this chapter, and who is thereby authorized to engage in the activities set forth in Chapter 60 (§ 38.2-6000 et seq.).

1979, c. 513, § 38.1-327.1; 1981, c. 604; 1983, c. 480; 1984, c. 719; 1986, c. 562; 1987, cc. 520, 521; 1992, c. 586; 1994, cc. 106, 316; 1995, c. 167; 1998, cc. 16, 47, 164; 1999, cc. 86, 490, 493, 586; 2000, c. 526; 2001, c. 706; 2003, cc. 412, 717, 979; 2004, cc. 460, 668, 784; 2006, c. 410; 2011, c. 222; 2012, c. 447; 2013, cc. 203, 497; 2016, c. 250; 2022, cc. 131, 132; 2023, cc. 338, 339.

§ 38.2-1800.1. Proof of residency.

A. For purposes of this chapter, an individual shall be deemed to be a resident of this Commonwealth provided such individual (i) maintains his principal place of residence within this Commonwealth, or satisfies the requirements set forth in subsection B of § 38.2-1836; (ii) declares himself to be a Virginia resident on his federal tax return; and (iii) declares himself to be a Virginia resident for purposes of paying Virginia income tax and personal property taxes; and provided that such individual is able to document the above to the satisfaction of the Commission. The Commission may also consider other documentation furnished by the individual, including, but not limited to, a valid current Virginia driver's license or voter registration card, as additional proof of residency. An individual applying for or holding a license issued pursuant to this chapter who is unable to document his residency as set forth above shall be deemed not to be a resident of Virginia for purposes of this chapter, except that an individual residing outside of Virginia whose principal place of business is in Virginia, who is able to demonstrate to the satisfaction of the Commission that the laws of his home state prevent him from obtaining a resident agent license in that state, and who affirmatively chooses to qualify as and be treated as a resident of Virginia for purposes of licensing and continuing education, both in Virginia and in the state in which the individual resides, if applicable, may be considered a resident for purposes of issuance of a license pursuant to this chapter.

B. For purposes of this chapter, a business entity shall be deemed to be a resident of this Commonwealth provided such business entity:

1. If a domestic corporation, has filed its articles of incorporation with the clerk of the Commission, and has been issued a charter by the Commission;

2. If a domestic limited liability company, has filed its articles of organization with the clerk of the Commission, and has been issued a certificate of organization by the Commission;

3. If a domestic limited partnership, has applied for and received a certificate of limited partnership from the clerk of the Commission;

4. If a domestic partnership, has filed its partnership agreement with the clerk of the appropriate court; or

5. If a foreign business entity that is not licensed as a resident agent in any other jurisdiction, demonstrates to the satisfaction of the Commission that its principal place of business is within the Commonwealth of Virginia.

1997, c. 583; 2001, c. 706.

§ 38.2-1801. Person soliciting insurance deemed agent of insurer; prohibition against misrepresenting agency relationship.

A. A licensed agent shall be held to be the agent of the insurer that issued the insurance sold, solicited, or negotiated by such agent in any controversy between the insured or his beneficiary and the insurer. No licensed agent or any other person shall claim to be a representative of, authorized agent of, agent of, or other term implying an appointed relationship with a particular insurer unless such agent has become an appointed agent of that insurer. For the purpose of notice of claim or suit, the agent or producer of record shall be deemed to be the agent of the insurer. In the case of policies of life insurance, accident and sickness insurance, annuities and variable annuities, such notice shall be given to the insurer at its home office as shown in the policy of insurance.

B. A premium payment made by an insured to an agent, whether appointed by an insurer or not, or to a surplus lines broker, where the insurer or its appointed agent acknowledged specific insurance for a specific policy period by the issuance of a policy, written binder, or other contract of temporary insurance, whether new or renewal, shall be considered payment to the insurer, and such insurer shall be liable to the insured for (i) any covered losses under the insurance and (ii) the return to the insured of any unearned premium amount due the insured except as provided in subsection D of § 38.2-1806.

C. Except as provided in subsection D of § 38.2-1806, where premiums for the issuance of a policy or endorsement have been financed by an insurance premium finance company and payment and evidence of financing for such policy or endorsement have been received by the insurer or its appointed agent, the insurer shall be liable for the return to the insurance premium finance company of any unearned premium due the insurance premium finance company.

Code 1950, § 38.1-292; 1952, c. 317; 1979, c. 513, § 38.1-327.2; 1986, c. 562; 1987, c. 521; 1988, c. 229; 1989, c. 543; 1993, c. 145; 2001, c. 706.

§ 38.2-1802. Acting as agent for unlicensed insurer prohibited; penalties.

A. No person other than a licensed surplus lines broker shall sell, solicit, or negotiate contracts of insurance in this Commonwealth on behalf of any insurer which is not licensed to transact the business of insurance in this Commonwealth. Nothing in this section shall prohibit any person from obtaining insurance upon his own life or property from an unlicensed insurer.

B. Any person violating the provisions of this section shall be guilty upon conviction of a Class 1 misdemeanor and punished for each offense. In addition, any person violating this section shall be (i) liable on any claim against any unlicensed insurer that arises out of a contract or policy sold, solicited, or negotiated by the person or which the person assisted in selling, soliciting, or negotiating, or (ii) punished as provided in §§ 38.2-218 and 38.2-1831, or (iii) subject to both (i) and (ii).

C. Nothing in this section shall apply to the selling, soliciting, or negotiating of contracts of insurance on:

1. Vessels or craft, their cargo, freight, marine builder's risk, maritime protection and indemnity, ship repairer's legal liability, tower's liability or other risks commonly insured under ocean marine insurance policies as distinguished from inland marine insurance policies, provided that a property and casualty or limited lines property and casualty agent licensed in this Commonwealth sells, solicits, or negotiates these classes of insurance on behalf of any insurer not licensed to transact the business of insurance in this Commonwealth; or

2. The rolling stock and operating properties of railroads used in interstate commerce or of any liability or other risks incidental to their ownership, maintenance or operation.

D. A property and casualty or limited lines property and casualty agent licensed in this Commonwealth who, pursuant to the provisions of subdivision C 1, sells, solicits, or negotiates ocean marine insurance on behalf of any insurer not licensed to transact the business of insurance in this Commonwealth shall provide a notice to the insured stating that the insurance policy is to be placed with an insurer not licensed to transact the business of insurance in the Commonwealth and stating that (i) in the event of the insolvency of the insurer, there is no protection under the Virginia Property and Casualty Insurance Guaranty Association against financial loss to claimants or policyholders because of the insolvency of an unlicensed insurer, and (ii) the insured may not be protected under the insurance laws of this Commonwealth. The notice required by this subsection shall be in a form prescribed by the Commission and shall be signed and dated by the agent and the insured. The signatures required by this subsection may be in electronic form. The agent shall keep a copy of the notice for at least three years after the effective date of the policy to which the notice pertains. A copy of the notice shall be given to the insured prior to placement of the insurance.

Code 1950, § 38.1-281; 1952, c. 317; 1956, c. 173; 1979, c. 513, § 38.1-327.3; 1982, c. 264; 1983, c. 480; 1986, c. 562; 1987, cc. 519, 521; 2001, c. 706.

§ 38.2-1803. Repealed.

Repealed by Acts 2001, c. 706, cl. 2, effective September 1, 2002.

§ 38.2-1804. Blank forms.

No agent shall sign or allow an applicant or insured to sign any incomplete or blank form pertaining to insurance in this Commonwealth.

Code 1950, § 38.1-288; 1952, c. 317; 1979, c. 513, § 38.1-327.5; 1986, c. 562; 2001, c. 706.

§ 38.2-1805. Acceptance by insurance agents of premiums in arrears; how advance premiums recorded.

A. No agent of a home service insurer shall accept, and no insurer or licensed agent shall knowingly permit an agent to accept, payment of premiums in arrears on any policy of life insurance or accident and sickness insurance on which the premiums are collected at least monthly that has lapsed and that the insured seeks to reinstate, unless the payment (i) at least equals the total of all premiums in arrears and (ii) entitles the policyholder to make immediate application for reinstatement of the policy. As used in this chapter, "home service insurer" means an insurer selling industrial or ordinary life insurance or accident and sickness insurance on a debit, where the premiums are payable at least monthly directly by the owner of the policy or a person representing the owner to a representative of the insurer.

B. Every advance premium paid to an agent on a life insurance policy or accident and sickness insurance policy on which the premiums are collected at least monthly shall be recorded in the receipt book of the insured and in the record book of the agent in exactly the same manner as current premiums are recorded. However, the failure to do so shall not invalidate the policy.

Code 1950, § 38.1-293; 1952, c. 317; 1979, c. 513, § 38.1-327.6; 1986, c. 562; 1987, c. 521; 1990, c. 464; 2001, c. 706.

§ 38.2-1806. Interest with respect to credit extended or money lent for premiums on certain policies.

A. Any agent licensed in this Commonwealth to sell, solicit or negotiate property and casualty insurance, mutual assessment property and casualty insurance, or ocean marine insurance may charge interest on credit extended by the agent to the holder of any fire, casualty, surety or marine insurance policy, written or being serviced by or through such agent, for the premium due on such policy. The rate of interest shall not exceed one and one-half percent per month of the unpaid balance. However, the extension of credit or the making of the loan shall not be in conflict with the contract between the agent and the insurer that issues the policy.

B. A licensed insurance agent extending credit as authorized in this section shall not be required to comply with the provisions of Chapter 47 (§ 38.2-4700 et seq.) of this title with respect to the licensing of premium finance companies.

C. Notwithstanding the provisions of §§ 38.2-2114 and 38.2-2212, if any insured fails to discharge any of his obligations to a licensed insurance agent when due in connection with the payment of any premium for a policy of insurance, that agent may request in writing that the insurer cancel such policy for nonpayment of premium. Within ten business days of the receipt of such written request, which shall also state the amount owed the agent by the policyholder, the insurer shall deliver or mail a

written notice of cancellation to the named insured at the address shown in the policy and to any mortgagee or lienholder. This notice shall state the date on which the cancellation shall become effective. That date shall be established by giving at least the number of days notice prior to cancellation that are required by statute or the terms of the policy. Except for statutory requirements and contractual obligations, there shall be no liability on the part of the insurer for improper cancellation under this section if the insurer (i) in good faith relies upon the request of the agent and (ii) gives notice of cancellation in compliance with the provisions of this section.

D. The insurance agent shall have a lien on any return premium for the policy to the extent of the amount owed by the policyholder. Within thirty calendar days of the mailing of the notice of cancellation, the insurer shall forward that amount to the agent and shall forward the remainder, if any, of the return premium to the policyholder.

Code 1950, § 38.1-293.1; 1970, c. 370; 1979, c. 513, § 38.1-327.7; 1980, c. 581; 1985, c. 33; 1986, c. 562; 1987, c. 521; 2001, c. 706.

§ 38.2-1807. Repealed.

Repealed by Acts 2020, c. 222, cl. 1.

§ 38.2-1808. All agreements to be expressed in contract.

No agent shall make any contract of insurance or agreement with respect to the insurance that is not plainly expressed in the policy or contract issued.

Code 1950, § 38.1-294; 1952, c. 317; 1979, c. 513, § 38.1-327.8; 1986, c. 562; 1987, c. 521.

§ 38.2-1809. Power of Commission to investigate affairs of persons engaged in insurance business; penalties for refusal to permit investigation.

A. The Commission shall have power to examine and investigate the business affairs of any person engaged or alleged to be engaged in the business of insurance in this Commonwealth, including all agents, to determine whether the person has engaged or is engaging in any violation of this title. The Commission shall have the right to examine all records relating to the writing or alleged writing of insurance by any such person in this Commonwealth to determine whether the person is now or has been violating any of the provisions of this title. Any licensee under this title, or any person purporting to be a licensee under this title, or any person whose actions have led any person to believe that he is a licensee under this title, who refuses to permit the Commission or any of its employees or agents, including employees of the Bureau of Insurance, to make an examination or who fails or refuses to comply with the provisions of this section may, after notice and an opportunity to be heard, be subject to any of the penalties relating to licensees under this title, as provided in this title, including the denial, suspension or revocation of his license.

B. Except as otherwise provided in this title, every licensee shall retain all of his records relative to insurance transactions for the three previous calendar years except that records of premium quotations which are not accepted by the insured or prospective insured need not be kept. These records

shall be made available promptly upon request for examination by the Commission or its employees without notice during normal business hours.

Code 1950, § 38.1-295.1; 1968, c. 238; 1979, c. 513, § 38.1-327.9; 1985, c. 3; 1986, c. 562; 1987, c. 521; 1990, c. 464; 1991, c. 417; 2001, c. 706.

§ 38.2-1810. Report of acts deemed larceny under § 18.2-111; privileged communications; attorney for the Commonwealth to be informed.

A. Whenever any insurer licensed to transact the business of insurance in this Commonwealth knows or has reasonable cause to believe that any licensee under this title has committed any act of larceny as prescribed in § 18.2-111 with respect to any money, bill, note, check, order, draft or other property either belonging to the insurer or received by the licensee on behalf of the insurer, it shall be the duty of the insurer within sixty calendar days after acquiring the knowledge to file with the Commission a complete statement of the relevant facts and circumstances. Each statement shall be a privileged communication, and when made and filed shall not subject the insurer, or any individual representative of it that is making or filing the statement, to any liability whatsoever.

B. Whenever any insurer licensed to transact the business of title insurance in this Commonwealth knows or has reasonable cause to believe that any title insurance agent appointed by such insurer has committed any act of larceny as prescribed in § 18.2-111 with respect to any money, bill, note, check, order, draft or other property either belonging to the insured or prospective insured or received by the agent on behalf of the insured or prospective insured related to that agent's provision of escrow, closing or settlement services as defined in § 55.1-1000, it shall be the duty of the insurer within sixty calendar days after acquiring such knowledge to file with the Commission a complete statement of the relevant facts and circumstances. Each statement shall be a privileged communication, and when made and filed shall not subject the insurer, or any individual representative of it that is making or filing the statement, to any liability whatsoever.

C. The Commission shall inform the attorney for the Commonwealth of the appropriate county or city of each statement filed pursuant to subsection A or B of this section.

1962, c. 263, § 38.1-165.1; 1986, c. 562; 1987, c. 521; 2000, c. 549; 2001, c. 706.

§ 38.2-1811. Repealed.

Repealed by Acts 1991, c. 620.

§ 38.2-1812. Payment and sharing of commissions.

A. No insurer shall pay directly or indirectly any commission or other valuable consideration to any person for services as an agent or a surplus lines broker within this Commonwealth unless the person is then a duly appointed agent of such insurer and, at the time of the transaction out of which arose the right to such commission or other valuable consideration, held a valid license as an agent, or valid license as a surplus lines broker, for the class of insurance involved.

B. No person other than a duly licensed and appointed agent or a surplus lines broker may accept any such commission or other valuable consideration unless such person, at the time of the transaction

out of which arose the right to such commission or other valuable consideration, held a valid license as an agent or surplus lines broker for the class of insurance involved.

C. An agent of a home service insurer who is assigned a debit may receive, and the insurer may pay, commissions on business written on the debit prior to the agent's becoming licensed and appointed, provided that the insurance was sold by a duly licensed and appointed agent, and further provided that the agent receiving the commission is duly licensed and, if appropriate, appointed on the day such commissions are paid to and received by him.

D. This provision shall not prevent the payment or receipt of renewal or other deferred commissions or compensation to or by any person if the person was duly licensed and appointed, where the appointment was necessary, at the time of the transactions out of which arose the right to such renewals or deferred commissions or compensation.

E. This provision shall not prevent the payment of commissions to a trade name which has been filed with the Bureau of Insurance pursuant to subsection E of § 38.2-1822.

F. Except as provided in subdivision B 8 of § 38.2-1821.1, no agent or surplus lines broker shall directly or indirectly share his commissions or other compensation received or to be received by him on account of a transaction under his license with any person not also then licensed under this chapter, for the class of insurance involved in the transactions. No agent or surplus lines broker not then licensed and qualified for the same class of insurance shall receive any commission or other compensation. This provision shall not affect payment of the regular salaries due employees of the licensee.

G. Notwithstanding any contrary provision of law, each insurer shall accept and honor each request by a policyholder for a change of insurance agent of record, which change shall be effective on the date of the next renewal of the policy, unless the policyholder withdraws the request in writing, provided that the change of insurance agent of record shall not be effective unless the proposed new insurance agent of record is a duly appointed agent of the insurer. Prior to the effective date of the change, the insurer shall provide written notice of the change to the current insurance agent of record. The new insurance agent of record shall be paid all commissions payable on the policy effective not later than the next renewal date of the policy following the policyholder's requested change, excluding any commissions or other compensation payable under an insurer's retirement or deferred compensation plan with the insurance agent. A request for a change of insurance agent of record shall be in writing and shall include (a) the policyholder's name and address; (b) the insurer's name and address; (c) the policy number; (d) the name and address of the new insurance agent of record; (e) the date of the request; (f) the signature of the policyholder; and (g) the signature of acceptance by the new insurance agent. This subsection shall not require an insurer to appoint an insurance agent of record, alter an insurer's existing contract with an insurance agent that provides for direct compensation in lieu of commission, or require the payment of full commissions to a new insurance agent where the original writing insurance agent or current insurance agent continues to have responsibility for processing and

matters relating to the policyholder. For the purposes of this subsection, "insurance agent" and "insurance agent of record" shall mean only a limited lines property and casualty agent, a property and casualty insurance agent, a personal lines agent, a restricted nonresident property and casualty agent, or a restricted nonresident personal lines agent, as such terms are defined in § 38.2-1800. The provisions of this subsection shall not apply to insurers who provide a process that (i) permits the insured to change the insurance agent of record under terms that are at least as favorable to the insured as the provisions of this subsection and (ii) equitably allocates commissions between the current and new insurance agents.

1979, c. 513, § 38.1-327.11; 1986, c. 562; 1987, c. 521; 1999, c. 97; 2001, c. 706; 2002, c. 323.

§ 38.2-1812.1. Placement of insurance for public bodies.

No insurance agent may provide or offer to provide, directly or indirectly, insurance products to a public body while concurrently and on its behalf (i) evaluating proposals from other insurance agents and (ii) recommending the placement of insurance.

1996, c. 989.

§ 38.2-1812.2. Administrative charges in excess of premium prohibited; exceptions.

A. Notwithstanding the provisions of § 38.2-310 and Article 4 (§ 38.2-1837 et seq.) of this chapter, no agent shall charge, or demand or receive from, an applicant for insurance or a policyholder any consideration in return for rendering services associated with a contract of insurance, when the consideration is in addition to the premium for such contract, unless:

1. The applicant or policyholder consents in writing before any services are rendered. Consent shall be provided on a form that includes the applicant's or policyholder's signature, the duration of services and amount of fees to be charged, the services for which the fees are charged, and a statement that the agent is entitled to receive a commission from the insurer for selling, soliciting, or negotiating the insurance; and

2. A schedule of fees and documentation for services rendered is maintained in the agent's office and is made available to applicants or policyholders upon request.

B. This section shall not apply to charges for services described in subsection C of § 38.2-4608 when provided by title insurance agents.

C. This section shall apply to new and renewal policies issued or renewed on or after July 1, 1999.

1999, c. 2; 2001, c. 706.

§ 38.2-1813. Reporting and accounting for premiums.

A. All premiums, return premiums, or other funds received in any manner by an agent or a surplus lines broker shall be held in a fiduciary capacity and shall be accounted for by such agent or surplus lines broker. The agent or surplus lines broker shall, in the ordinary course of business, pay the funds to the insured or his assignee, insurer, insurance premium finance company or agent entitled to the payment.

B. With the exception of premium funds made payable to insurers or insureds for remittance and funds referred to in subsection D of this section, on and after January 1, 1993, all funds referred to in subsection A of this section shall be maintained in a fiduciary account separate from all other business and personal funds. Funds deposited into the separate fiduciary account may not be commingled or combined with other funds except for the purpose of advancing premiums, establishing reserves for the payment of return premiums, or establishing funds to maintain a minimum balance or to guarantee the adequacy of the account. The agent or surplus lines broker shall maintain an accurate record and itemization of the funds deposited into this account. The commission portion of any premiums deposited to this separate account may be withdrawn at the discretion of the agent or surplus lines broker.

C. For the purposes of this section, the separate fiduciary account of a licensed business entity shall be considered the fiduciary account of an individual agent or surplus lines broker acting on behalf of the licensed business entity.

D. This section shall not require any agent who is a duly appointed agent of an insurer and who has a written contractual relationship with such insurer which includes provisions regarding remittance of funds to maintain a separate fiduciary account for the funds. Such funds shall be held separately from any personal or nonbusiness funds and shall be reasonably ascertainable from the books of accounts and records of the agent.

1979, c. 513, § 38.1-327.12; 1986, c. 562; 1992, c. 49; 1993, c. 145; 2001, c. 706.

Article 2 - QUALIFICATIONS OF PROPERTY AND CASUALTY INSURANCE AGENTS, PERSONAL LINES AGENTS, TITLE INSURANCE AGENTS, LIFE AND ANNUITIES AGENTS, AND HEALTH AGENTS

§ 38.2-1814. License required of resident property and casualty insurance agent and resident personal lines agent.

A. No individual who is a resident of this Commonwealth shall obtain a license as a property and casualty insurance agent or as a personal lines agent from the Commission unless he has passed an examination in a form and manner prescribed by the Commission.

B. An individual may obtain a license as a limited lines credit insurance agent, a limited lines property and casualty agent, a motor vehicle rental contract insurance agent, or any other type of license of restricted authority that the Commission may deem it necessary to recognize for the purpose of complying with § 38.2-1836 without taking such examination.

1979, c. 513, § 38.1-327.15; 1985, c. 616; 1986, cc. 364, 562; 1987, c. 521; 1989, c. 435; 1994, c. 106; 1995, c. 167; 1998, cc. 16, 47, 164; 1999, cc. 490, 586; 2001, c. 706.

§ 38.2-1814.1. License required of resident title insurance agent.

A. No individual who is a resident of the Commonwealth shall obtain a license as a title insurance agent from the Commission unless he has passed an examination in a form and manner prescribed by the Commission. Before registering to take an examination for a license as a title insurance agent,

each applicant shall have completed, within the period specified in subsection B, a pre-licensing education course of 16 hours of instruction. The pre-licensing education course may be comprised of or include any form of classroom education or distance education in accordance with an examination content outline approved by the Commission. The applicant shall submit proof of completion of the pre-licensing education course in a form acceptable to the Commission. The proof of completion of the pre-licensing education course shall be:

1. Signed by the applicant affirming that the applicant completed a course for which the requisite number of classroom or distance education hours were completed. An applicant who is found to have submitted a materially false proof of course completion shall be deemed to have committed a knowing and willful violation of this section and be subject to the penalties as set forth in § 38.2-218. Upon receipt of acceptable proof that an applicant submitted a materially false proof of course completion, the Commission may administratively terminate any license issued based upon such submission; and

2. Signed by the individual who acted as the instructor for the course, who shall certify that the requisite number of the classroom or distance education hours were completed by the applicant. An instructor who is found to have submitted a materially false certification that an applicant completed the requisite number of classroom or distance education hours shall be deemed to have committed a knowing and willful violation of this section and be subject to the penalties as set forth in § 38.2-218. If the instructor is also a licensed insurance agent or insurance consultant, the Commission may also impose on the instructor the penalties set forth in § 38.2-1831 or 38.2-1843, as applicable.

As used in this subsection:

"Classroom education" means actual hours in a classroom environment with an instructor. Instructors shall have the right to consider an applicant to have met the classroom hour requirement if the applicant was present for not less than 95 percent of the required hours.

"Distance education" means instruction delivered or presented by or under the general supervision of an instructor using a medium other than a classroom setting. "Distance education" shall not include self-study or correspondence courses.

B. An applicant's satisfaction of the education requirement established by subsection A shall be valid only for the one-year period following the date he satisfied the education requirement. However, the Commission may waive this time limit in individual circumstances in accordance with criteria prescribed by the Commission.

C. Officers or employees who are not agents of a title insurance company shall be exempt from the provisions of this section.

D. Agents who, as of January 1, 1987, were authorized agents of title insurance companies licensed to transact title insurance in this Commonwealth shall be exempt from the requirements of subsections A and B of this section.

1986, c. 364, § 38.1-327.15:1; 1987, c. 521; 1988, c. 187; 1989, c. 435; 2001, c. 706; 2008, c. 250; 2023, c. 577.

§ 38.2-1815. License required of resident life and annuities agent.

A. No individual who is a resident of the Commonwealth shall obtain a license as a life and annuities agent from the Commission unless the individual has passed an examination in a form and manner prescribed by the Commission. The Commission annually shall review whether the examination's pass rate is consistent with the 2013 NAIC State Licensing Handbook, or any successor publication adopted by the NAIC.

B. An individual may obtain a license as a limited lines credit insurance agent, a limited lines life and health agent, a motor vehicle rental contract insurance agent, or any other type of license of restricted authority that the Commission may deem it necessary to recognize for the purposes of complying with § 38.2-1836 without taking such examination.

C. No individual who is a resident of the Commonwealth shall obtain a license as a variable contract agent unless the individual currently holds a life and annuities license, and no individual, whether resident or nonresident, shall obtain a license as a variable contract agent unless the individual has passed the Financial Industry Regulatory Authority examination or examinations prescribed by the Commission or such other examination prescribed by the Commission.

1979, c. 513, § 38.1-327.24; 1982, c. 223; 1983, cc. 160, 185; 1985, c. 616; 1986, c. 562; 1987, c. 521; 1993, c. 695; 1998, c. 47; 1999, c. 86; 2001, c. 706; 2010, c. 281; 2012, c. 413; 2020, c. 223.

§ 38.2-1815.1. License required of resident health agent.

A. No individual who is a resident of this Commonwealth shall obtain a license as a health agent from the Commission unless he has passed an examination in a form and manner prescribed by the Commission.

B. An individual may obtain a license as a limited lines credit insurance agent, a limited lines life and health agent, a motor vehicle rental contract insurance agent, or any other type of license of restricted authority that the Commission may deem it necessary to recognize for the purposes of complying with § 38.2-1836 without taking such examination.

2001, c. 706.

§ 38.2-1816. Repealed.

Repealed by Acts 2001, c. 706, cl. 2, effective September 1, 2002.

§ 38.2-1817. Examination for license; fee required; when fee forfeited.

A. Examinations for licenses shall be conducted at least monthly at the times and places the Commission prescribes. Each applicant shall pass the examination prescribed by the Commission unless otherwise exempted.

B. If a resident individual applicant fails three times to pass the examination, the applicant shall be required to wait 30 calendar days before the applicant may retake the examination.

C. Each applicant for an examination shall make application in the form and containing the information the Commission prescribes.

D. Each applicant shall, at the time of applying to take the examination, pay such fee as may be prescribed by the Commission and in a manner prescribed by the Commission. The prescribed examination fee shall not be less than $20 nor more than $100. The examination fee shall be nonrefundable.

E. If the applicant fails to take the examination within 90 calendar days from the date his registration for the examination is accepted, the examination fee shall be forfeited and the registration shall be considered withdrawn.

F. If the applicant fails to obtain the appropriate license from the Commission within 183 calendar days from the date he passes the examination, the examination grade shall be considered invalid and the examination fee and application processing fee shall be forfeited. Such applicant shall be required to reapply for the examination and to satisfy any appropriate prelicensing requirements.

G. An individual who applies for a resident insurance agent's license in the Commonwealth who was previously licensed for the same lines of authority in the individual's home state shall not be required to complete any prelicensing examination. This exemption is only available if the individual is currently licensed in the applicant's home state, or if the application is received within 90 calendar days of the cancellation of the applicant's previous license in the applicant's home state, and if the applicant's home state issues a certification that, at the time of cancellation, the applicant was in good standing in that state or the state's Producer Database records, maintained by the NAIC, its affiliates or subsidiaries, indicate that the producer is or was licensed in good standing for the line of authority requested.

1979, c. 513, § 38.1-327.17; 1985, c. 616; 1986, c. 562; 1987, c. 521; 1989, c. 435; 1990, c. 464; 1999, c. 86; 2001, c. 706; 2018, c. 131.

§ 38.2-1818. Individual moving from another state or Canadian province.

A. An individual holding a nonresident Virginia agent license who has moved into this Commonwealth from another state or a province of Canada shall submit the application and pay the license processing fee required by § 38.2-1819 and in accordance with the requirements set forth in § 38.2-1836. Agents with active nonresident Virginia agent licenses may continue to operate under their nonresident licenses for up to ninety calendar days while applying for resident Virginia agent's licenses. Appointments made under such nonresident licenses shall remain in effect during the ninety-calendar-day period, unless terminated for other reasons. Appointments held by an agent under a nonresident Virginia agent license shall automatically be converted to resident agent appointments if the agent obtains an equivalent resident Virginia agent license during the ninety-calendar-day period. If an agent fails to obtain such resident license by the end of the ninety-calendar-day period, the equivalent nonresident license and all associated appointments under that license shall terminate at the end of the ninety-calendar-day period.

B. An individual licensed as an insurance producer in another state or province of Canada, but not holding a nonresident Virginia agent license, who moves to this Commonwealth shall submit the application to become a resident licensee and shall pay the license processing fee required by § 38.2-1819 and in accordance with the requirements of § 38.2-1836 within ninety calendar days of establishing legal residence in this Commonwealth. No prelicensing examination shall be required of that individual to obtain any line of authority previously held in the prior state except where the Commission determines otherwise by regulation. After establishing legal residence in this Commonwealth and prior to obtaining a license as a resident agent, the individual shall be prohibited from selling, soliciting, or negotiating insurance in this Commonwealth. An individual who fails to submit the application and license processing fee within ninety calendar days of establishing legal residence in this Commonwealth shall be required to satisfy all resident agent prelicensing requirements in order to be issued a license.

1979, c. 513, § 38.1-327.19; 1980, c. 743; 1986, c. 562; 1987, c. 521; 1997, c. 583; 2001, c. 706.

Article 3 - Licensing and Appointment of Agents

§ 38.2-1819. Application for license; fee required; fingerprints.

A. Each applicant for a license shall make application to the Commission, in the form and containing the information the Commission prescribes. Each applicant shall, at the time of applying for a license, pay a nonrefundable application processing fee in an amount and in a manner prescribed by the Commission. The prescribed application processing fee shall not be less than $10 nor more than $20 per line of authority. The fee shall be collected by the Commission and paid directly into the state treasury and credited to the fund for the maintenance of the Bureau of Insurance as provided in subsection B of § 38.2-400.

B. Each individual who is a resident of the Commonwealth shall, at the time of applying for a new license, be fingerprinted in a form and manner prescribed by the Commission and shall provide personal descriptive information to be forwarded along with the applicant's fingerprints through the Central Criminal Records Exchange to the Federal Bureau of Investigation for the purpose of obtaining criminal history record information regarding such applicant. The results of the state and national records search shall be forwarded to the Commissioner or the Commissioner's designee, who shall be an employee of the Commission. The cost of fingerprinting and the criminal history record check shall be paid by the applicant. If an applicant's application for a license is denied, the Commission shall provide a copy of the information obtained from the Central Criminal Records Exchange to the applicant upon request. The information provided to the Commission shall not be disseminated except as provided in this subsection.

C. No resident license requiring an examination shall be issued by the Commission later than 183 calendar days from the date the applicant satisfies the prelicensing examination requirements set forth in § 38.2-1817. Applicants failing to satisfy this requirement shall be required to satisfy all prelicensing requirements, including the examination, again before applying.

D. Except where prohibited by state or federal law, by submitting an application for license, the applicant shall be deemed to have appointed the clerk of the Commission as the agent for service of process on the applicant in any action or proceeding arising in the Commonwealth out of or in connection with the exercise of the license. Such appointment of the clerk of the Commission as agent for service of process shall be irrevocable during the period within which a cause of action against the applicant may arise out of transactions with respect to subjects of insurance in the Commonwealth. Service of process on the clerk of the Commission shall conform to the provisions of Chapter 8 (§ 38.2-800 et seq.).

1979, c. 513, § 38.1-327.20; 1986, c. 562; 1987, c. 521; 1989, c. 435; 1994, c. 316; 2001, c. 706; 2019, c. 675.

§ 38.2-1820. Issuance of license.

A. Each applicant who is at least 18 years of age and who has satisfied the Commission that he is of good character, has a good reputation for honesty, and has complied with the other requirements of this article is entitled to and shall receive a license in the form the Commission prescribes.

B. A business entity acting as an insurance producer is required to obtain an insurance producer license. Application shall be made using the Uniform Business Entity Application, or such other application acceptable to the Commission. Before approving the application, the Commission shall find that:

1. The business entity has paid the nonrefundable application processing fee set forth in § 38.2-1819; and

2. The business entity has designated an employee, officer, director, manager, member, or partner to serve as the licensed producer responsible for the business entity's compliance with the insurance laws, rules, and regulations of the Commonwealth. However, with respect to a business entity applying for a limited lines license pursuant to Article 8 (§ 38.2-1875 et seq.) or 8.1 (§ 38.2-1881 et seq.), the licensed producer designated by the vendor or lessor is not required to be an employee, officer, director, manager, member, or partner of the vendor or lessor.

C. The Commission may require any documents reasonably necessary to verify the information contained in an application.

1979, c. 513, § 38.1-327.21; 1985, c. 616; 1986, c. 562; 2001, c. 706; 2008, c. 213; 2016, c. 552; 2018, c. 131; 2019, c. 675.

§ 38.2-1821. Revocation, etc., of license revokes appointment.

If the Commission refuses to grant or revokes or suspends a license, any appointment of such licensee shall likewise be revoked or suspended. No individual whose license is revoked shall be issued another license without first complying with all requirements of this article.

1979, c. 513, § 38.1-327.22; 1985, c. 616; 1986, c. 562; 1987, c. 521.

§ 38.2-1821.1. Exceptions to licensing.

A. Nothing in this article shall be construed to require an insurer to obtain an insurance producer license. As used in this section, the term "insurer" does not include an insurer's officers, directors, employees, subsidiaries or affiliates.

B. A license as an insurance producer shall not be required of the following:

1. An officer, director or employee of an insurer or of an insurance producer, provided that the officer, director or employee does not receive any direct or indirect commission on policies written or sold to insure risks residing, located or to be performed in this Commonwealth and:

a. The officer, director or employee's activities are executive, administrative, managerial, clerical or a combination of these, and are only indirectly related to the sale, solicitation or negotiation of insurance; or

b. The officer, director or employee's function relates to underwriting, loss control, inspection or the processing, adjusting, investigating or settling of a claim on a contract of insurance; or

c. The officer, director or employee is acting in the capacity of a special agent or agency supervisor assisting insurance producers where the person's activities are limited to providing technical advice and assistance to licensed insurance producers and do not include the sale, solicitation or negotiation of insurance;

2. A person who (i) secures and furnishes information for the purpose of group life insurance, group property and casualty insurance, group annuities, group or blanket accident and health insurance; (ii) secures and furnishes information for the purpose of enrolling individuals under plans, issuing certificates under plans or otherwise assisting in administering plans; or (iii) performs administrative services related to mass marketed property and casualty insurance. As used in this section, "administrative services" does not include the selling, soliciting, or negotiating of insurance where no direct or indirect commission is paid to the person for the service;

3. An employer or association or its officers, directors, employees, or the trustees of an employee trust plan, to the extent that the employers, officers, employees, directors or trustees are engaged in the administration or operation of a program of employee benefits for the employer's or association's own employees or the employees of its subsidiaries or affiliates, which program involves the use of insurance issued by an insurer, as long as the employers, associations, officers, directors, employees or trustees are not in any manner compensated, directly or indirectly, by the company issuing the contracts;

4. Employees of insurers or organizations employed by insurers who are engaging in the inspection, rating or classification of risks, or in the supervision of the training of insurance producers and who are not individually engaged in the sale, solicitation or negotiation of insurance;

5. A person whose activities in this Commonwealth are limited to advertising without the intent to solicit insurance in this Commonwealth through communications in printed publications or other forms of electronic mass media whose distribution is not limited to residents of the Commonwealth, provided

that the person does not sell, solicit or negotiate insurance that would insure risks residing, located or to be performed in this Commonwealth;

6. A person who is not a resident of this Commonwealth who sells, solicits or negotiates a contract of insurance for commercial property and casualty risks to an insured with risks located in more than one state insured under that contract, provided that that person is otherwise licensed as an insurance producer to sell, solicit or negotiate that insurance in the state where the insured maintains its principal place of business and the contract of insurance insures risks located in that state;

7. A salaried, full-time employee who counsels or advises his employer relative to the insurance interests of the employer or of the subsidiaries or business affiliates of the employer provided that the employee does not sell, solicit or negotiate insurance or receive direct or indirect commission; or

8. Any person who refers a customer who seeks to purchase any insurance product to a licensed agent and receives compensation for the referral of a customer, provided that:

a. The referral does not include a discussion of specific insurance policy terms and conditions;

b. The compensation is in the form of a one-time nominal fee of a fixed dollar amount for each referral; and

c. The compensation does not depend on whether the referral results in the purchase of insurance by the customer.

2001, c. 706.

§ 38.2-1822. License required of individual and business entity agents; individual acting for business entity licensee.

A. No person shall act, and no insurer or licensed agent shall knowingly permit a person to act, in this Commonwealth as an agent of an insurer licensed to transact the business of insurance in this Commonwealth without first obtaining a license in a manner and in a form prescribed by the Commission. As used in this section, "act as an agent" means selling, soliciting, or negotiating contracts of insurance or annuity on behalf of an insurer licensed in this Commonwealth or receiving or sharing, directly or indirectly, any commission or other valuable consideration arising from the sale, solicitation, or negotiation of any such contract, or both. No person shall submit business to any joint underwriting association or any plan established under this title for the equitable distribution of risks among insurers unless the person holds a valid license to transact the class of insurance involved.

B. No individual shall act as an agent on behalf of a business entity in the transaction of insurance unless he is licensed as an agent and appointed, if appointment is required by statute. No individual whose license has been revoked by the Commission, or voluntarily surrendered in lieu of a hearing before the Commission, shall directly or indirectly own and operate, control, or be employed in any manner by an insurance agent or agency during the time period in which the individual is unlicensed unless otherwise authorized by the Commission.

C. No business entity may act as an agent in this Commonwealth unless licensed and appointed, if appointment is required by statute. The existence of the business entity shall be recorded pursuant to law. The Commission may require proof of the foregoing before issuing a license to the business entity.

D. For a nonresident business entity, a certification by the insurance department of the business entity's home state satisfying the requirements of subsection A of § 38.2-1836 shall be deemed to satisfy the foregoing requirements.

E. In addition to the requirements of §§ 59.1-69 and 59.1-70, any individual or business entity conducting the business of insurance in this Commonwealth under an assumed or fictitious name shall notify the Bureau of Insurance either at the time the application for a license to do business is filed or within 30 calendar days from the date the assumed or fictitious name is adopted, setting forth the name under which such business is to be conducted.

F. When the business of insurance is no longer conducted under an assumed or fictitious name, notification to the Bureau of Insurance is required within 30 calendar days from the date of cessation of use of such assumed or fictitious name.

G. Notwithstanding any other provision in this chapter, no license shall be required of a person whose employment responsibilities include enrolling individuals under a group insurance policy, provided that such person receives no commission or other valuable consideration for such enrollments, and that such compensation is in no manner contingent upon the number of individuals enrolled or the amount of premium generated by such enrollments. As used in this subsection "enrolling individuals" means the process of informing individuals of the availability of coverages, calculating the insurance charge, assisting with completion of the enrollment application, preparing and delivering the certificate of insurance, answering questions regarding the coverages, and assisting the individual in making an informed decision whether or not enrollment under the group insurance plan is to be elected.

Code 1950, § 38.1-302; 1952, c. 317; 1956, c. 172; 1979, c. 513, § 38.1-327.33; 1980, c. 581; 1981, c. 604; 1985, c. 616; 1986, c. 562; 1987, c. 521; 1989, c. 435; 1991, c. 88; 1994, c. 316; 1997, c. 583; 1999, c. 586; 2001, c. 706; 2002, c. 456; 2008, c. 213; 2013, c. 212.

§ 38.2-1823. Penalty for acting for insurer, joint underwriting association, etc., when not licensed.
Any person submitting business, in violation of § 38.2-1822, while the person is not a holder of a valid agent's license to transact the class of insurance involved shall be penalized a sum equal to the first year commission for the placement of that business and in addition shall be subject to the penalties prescribed in §§ 38.2-218 and 38.2-1831.

1979, c. 513, § 38.1-327.34; 1981, c. 604; 1985, c. 616; 1986, c. 562; 1987, c. 521.

§ 38.2-1824. Kinds of agents' licenses and appointments issued.
A. 1. The Commission shall issue the following kinds of agents' licenses and appointments under this chapter: Life and annuities insurance agent; health agent; property and casualty insurance agent; personal lines agent; limited lines credit insurance agent; limited lines life and health insurance agent;

limited lines property and casualty insurance agent; motor vehicle rental contract insurance agent; restricted nonresident life and annuities insurance agent; restricted nonresident health agent; restricted nonresident property and casualty insurance agent; restricted nonresident personal lines agent; public adjuster; surplus lines broker; title insurance agent; variable contract agent; and viatical settlement broker. For the purposes of nonresident reciprocal licensing as provided in § 38.2-1836, the Commission may issue a license for any other limited line of insurance that the Commission may deem it necessary to recognize.

2. The Commission shall permit insurers, within each insurer's authority, to make the following kinds of appointments: life and health insurance, property and casualty insurance, and title insurance. The appointed agent's authority is limited to that provided by his license and may not be expanded by his appointment or by his contractual agreement with an insurer.

B. The licenses of all individuals and business entities who on August 31, 2002, hold limited licenses to write accident and sickness insurance, or automobile insurance, or casualty insurance, or fidelity and surety bonds, or fire insurance, or life insurance and annuities, shall have such licenses automatically converted to the nearest equivalent license type provided in subsection A and shall henceforth be subject to all prelicensing, renewal, and continuing education requirements applicable to such new license type.

Code 1950, § 38.1-306; 1952, c. 317; 1979, c. 513, § 38.1-327.35; 1986, c. 562; 1987, c. 521; 1988, c. 32; 1991, c. 620; 1994, c. 106; 1995, c. 167; 1998, cc. 16, 47, 164; 1999, cc. 86, 490, 586; 2001, c. 706; 2003, c. 979; 2004, c. 460; 2012, cc. 734, 735; 2019, c. 675.

§ 38.2-1825. Duration and termination of licenses and appointments.

A. A license issued to:

1. An individual agent shall authorize him to act as an agent until the license is otherwise terminated, suspended or revoked.

2. A business entity shall authorize such business entity to act as an agent until the license is otherwise terminated, suspended, or revoked. The dissolution or discontinuance of a partnership, whether by intent or by operation of law, shall automatically terminate all licenses issued to such partnership. The Bureau shall automatically terminate all insurance licenses within 90 calendar days of receiving notification from the clerk of the Commission that the certificate of organization or charter of a domestic limited liability company or corporation, respectively, whether by intent or by operation of law, has been terminated or that the certificate of registration or certificate of authority of a foreign limited liability company or corporation, respectively, has been revoked.

B. The license issued to a resident variable contract agent pursuant to this chapter shall terminate immediately upon the termination of the licensee's life and annuities insurance agent license, and may not be applied for again until the person has been issued a new life and annuities insurance agent license.

C. The license issued to a resident surplus lines broker pursuant to this title shall terminate immediately upon the termination of the licensee's property and casualty insurance agent license, and may not be applied for again until the person has been issued a new property and casualty insurance agent license.

D. Immediately upon termination of a settlement agent's last appointment under his title insurance agent license, the Bureau shall terminate the settlement agent's registration and the person shall not be permitted to act as a settlement agent under his title insurance agent's license until a new appointment has taken effect.

E. An appointment issued to an agent by an insurer, unless terminated, suspended or revoked, shall authorize the appointee to act as an agent for that insurer and to be compensated therefor notwithstanding the provisions of §§ 38.2-1812 and 38.2-1823.

F. A business entity licensed as a producer shall designate within 30 calendar days a new licensed producer responsible for the business entity's compliance with the insurance laws, rules, and regulations of the Commonwealth pursuant to subdivision B 2 of § 38.2-1820 following the removal, for any reason, of the previous designated licensed producer.

Code 1950, § 38.1-305; 1952, c. 317; 1978, c. 4; 1979, c. 513, § 38.1-327.36; 1981, c. 604; 1984, c. 549; 1985, c. 616; 1986, c. 562; 1987, c. 521; 1997, c. 583; 2001, c. 706; 2007, c. 703; 2010, c. 281; 2016, cc. 552, 619.

§ 38.2-1825.1. Renewal application and fee; compliance with continuing education requirements; reinstatement; waiver.

A. Beginning January 1, 2021, each individual agent shall submit biennially to the Commission a renewal application in a form and manner prescribed by the Commission, along with a nonrefundable renewal application processing fee prescribed by the Commission, for the renewal of the license. Licenses shall be renewed biennially based on the agent's month and year of birth. The license for an agent born in an even-numbered year shall expire at the end of the agent's birth month in even-numbered years. The license for an agent born in an odd-numbered year shall expire at the end of the agent's birth month in odd-numbered years. Any license for which the renewal application and nonrefundable renewal application processing fee have been received by the Commission and all other applicable licensing and renewal provisions in this chapter have been met shall, unless the license has been terminated, suspended, or revoked, be renewed for a two-year period. Any license for which the renewal application and nonrefundable renewal application processing fee have not been received by the Commission in the manner prescribed by the Commission shall automatically be terminated.

B. Each individual agent who is not exempt under § 38.2-1871 shall submit to the Virginia Insurance Continuing Education Board or its administrator proof of compliance with the continuing education requirements set forth in Article 7 (§ 38.2-1866 et seq.) on a biennial basis in conjunction with the

agent's license renewal. The agent's license shall not be renewed if the agent has failed to satisfy the applicable continuing education requirements.

C. On or before May 1, 2021, and biennially thereafter, each business entity shall submit to the Commission a renewal application, along with a nonrefundable renewal application processing fee prescribed by the Commission, for the renewal of the license. Any license for which the renewal application and nonrefundable renewal application processing fee have been received by the Commission and all other applicable licensing and renewal provisions in this chapter have been met shall, unless the license has been terminated, suspended, or revoked, be renewed for a two-year period. Any license for which the renewal application and nonrefundable renewal application processing fee have not been received by the Commission shall automatically be terminated.

D. The nonrefundable renewal application processing fee shall be paid in a manner and in an amount prescribed by the Commission. The prescribed nonrefundable renewal application processing fee shall not be less than $10 nor more than $20 per line of authority. All fees shall be collected by the Commission and paid directly into the state treasury and credited to the fund for the maintenance of the Bureau of Insurance as provided in subsection B of § 38.2-400.

E. An individual agent whose license terminates due to failure to renew may, within 12 months from the renewal date, reinstate the same license without the necessity of passing a prelicensing written examination by:

1. Submitting a renewal application;

2. Submitting a nonrefundable reinstatement processing fee equivalent to double the nonrefundable renewal application processing fee; and

3. Satisfying the relevant continuing education requirements.

F. A licensed agent who is unable to comply with the license renewal requirements due to military service or another extenuating circumstance such as a long-term illness or incapacity may request a waiver of those requirements. Requests for waivers of renewal requirements shall be made in a form and manner prescribed by the Commission. Agents seeking a waiver of renewal requirements shall submit all documentation specified by the Commission so as to be received by the Commission no later than the last day of the renewal period. After the renewal period, agents who have failed to complete the renewal waiver requirements may request a waiver from the reinstatement requirements set forth in subdivisions E 1 and 2 within the 12-month reinstatement period. The Commission shall approve or disapprove the waiver request within 30 calendar days of receipt thereof and shall provide written notice of its decision to the applicant for waiver within five calendar days of rendering its decision. Any waiver granted pursuant to this section shall be valid only for the renewal period or reinstatement period for which the waiver request was made.

2019, c. 675.

§ 38.2-1826. Requirement to report to Commission.

A. Each licensed agent shall report within 30 calendar days to the Commission, and to every insurer for which he is appointed any change in his residence address, email address, or name.

B. Each licensed agent convicted of a felony shall report within 30 calendar days to the Commission the facts and circumstances regarding the criminal conviction.

C. Each licensed agent shall report to the Commission within 30 calendar days of the final disposition of the matter any administrative action taken against him in another jurisdiction or by another governmental agency in the Commonwealth. Such report shall include a copy of the order, consent to order or other relevant legal documents.

D. The license authority of any licensed resident agent shall terminate immediately when such agent has moved his residence from the Commonwealth, whether or not the Commission has been notified of such move.

E. Each business entity acting as an insurance producer shall report within 30 calendar days to the Commission the removal, for any reason, of the designated licensed producer responsible for the business entity's compliance with the insurance laws, rules, and regulations of the Commonwealth pursuant to subdivision B 2 of § 38.2-1820, along with the name of the new designated licensed producer.

1979, c. 513, § 38.1-327.37; 1986, c. 562; 1987, c. 521; 1999, c. 59; 2001, c. 706; 2016, c. 552; 2019, c. 675.

§ 38.2-1827. Appointment may include one or more classes of insurance.

Except as otherwise provided in this title, an appointment of a licensed agent authorizes that person to sell, solicit, or negotiate any one or more of the classes of insurance (i) for which the agent is licensed in this Commonwealth and (ii) for which the appointing insurer is also licensed in this Commonwealth. However, an agent holding a license that includes both life and health and property and casualty authorities shall be required to obtain both a life and health and a property and casualty appointment if the agent intends to sell, solicit, or negotiate both types of insurance, and an insurer shall be required to appoint any such agent for both life and health and property and casualty if the insurer intends to authorize the agent to sell, solicit, or negotiate both types of insurance on its behalf.

Code 1950, § 38.1-303; 1952, c. 317; 1979, c. 513, § 38.1-327.38; 1986, c. 562; 1987, c. 521; 2001, c. 706.

§ 38.2-1828. Selling accident and sickness insurance.

Any individual or business entity who desires to sell, solicit, or negotiate accident and sickness insurance as defined in § 38.2-109 shall obtain a health agent's license. However, this requirement does not apply to individuals or business entities eligible for limited licenses pursuant to § 38.2-1815.1, or those agents selling, soliciting or negotiating medical, hospital, surgical, funeral or weekly indemnity benefits as a part of a policy of motor vehicle or aircraft insurance.

1979, c. 513, § 38.1-327.39; 1985, c. 616; 1986, c. 562; 1987, c. 521; 2001, c. 706.

§ 38.2-1829. Repealed.

Repealed by Acts 2001, c. 706, cl. 2, effective September 1, 2002.

§ 38.2-1830. Temporary licenses and appointments; when issued.

A. Temporary individual licenses providing for life and health insurance authority or property and casualty insurance authority shall be issued by the Commission in the following circumstances:

1. Upon the death of an agent, to his personal representative, surviving spouse, employee, child or next of kin;

2. Upon the inability of an agent to act because of sickness, injury or mental incapacity, to his spouse, child, next of kin, employee or legal representative;

3. Upon the sale of the agent's business, to any person employed in the business. In the event no person is available and suitable for licensing and appointment, the Commission may license and appoint any other suitable person; or

4. To an applicant who is to be an appointed agent of a home service insurer, and who will be assigned a debit and will actually collect the premiums on insurance contracts during the period of such temporary license.

B. Before any temporary license is issued, the applicant shall file with the Commission an application in the form and containing the information the Commission prescribes.

C. No examination shall be required of the applicant; however, no license shall be issued until the Commission is satisfied that the applicant is trustworthy and competent to be licensed.

D. Only one temporary life and health license and one temporary property and casualty license may be issued to any individual during his lifetime, and each such temporary license shall be valid for a period of 180 calendar days.

E. Appointments made by insurers of agents holding temporary licenses shall expire upon the expiration of the temporary license, unless the agent has obtained prior to expiration of the temporary license, a permanent license of the same type, in which event the appointment shall remain in effect subject to the provisions of § 38.2-1825.

F. An individual holding a temporary license shall not be prevented from securing a license by meeting the applicable requirements for the license, nor shall a temporary license be required before an individual may obtain a license.

G. The Commission, in its sole discretion and for good cause shown, may renew licenses granted under this section.

Code 1950, § 38.1-310; 1952, c. 317; 1979, c. 513, § 38.1-327.42; 1986, c. 562; 1987, c. 521; 1989, c. 435; 2001, c. 706.

§ 38.2-1831. Grounds for placing on probation, refusal to issue or renew, revocation, or suspension of license.

The Commission may, in addition to or in lieu of a penalty imposed under § 38.2-218, place on probation, suspend, revoke or refuse to issue or renew any person's license for any one or more of the following causes:

1. Providing materially incorrect, misleading, incomplete or untrue information in the license application or any other document filed with the Commission;

2. Violating any insurance laws, or violating any regulation, subpoena or order of the Commission or of another state's insurance regulatory authority;

3. Obtaining or attempting to obtain a license through misrepresentation or fraud;

4. Engaging in the practice of rebating;

5. Engaging in twisting or any form thereof, where "twisting" means inducing an insured to terminate an existing policy and purchase a new policy through misrepresentation;

6. Improperly withholding, misappropriating or converting any moneys or properties received in the course of doing insurance business;

7. Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance;

8. Having admitted or been found to have committed any insurance unfair trade practice or fraud;

9. Having been convicted of a felony;

10. Using fraudulent, coercive, or dishonest practices, or demonstrating incompetence, or untrustworthiness in the conduct of business in this Commonwealth or elsewhere, or demonstrating financial irresponsibility in the handling of applicant, policyholder, agency, or insurance company funds;

11. Having an insurance producer license, or its equivalent, denied, suspended or revoked in any other state, province, district or territory;

12. Forging another's name to an application for insurance or to any document related to an insurance transaction;

13. Improperly using notes or any other reference material to complete an examination for an insurance license;

14. Knowingly accepting insurance business from an individual who is not licensed;

15. Failing to comply with an administrative or court order imposing a child support obligation; or

16. Failing to pay state income tax or comply with any administrative or court order directing payment of state income tax.

Code 1950, § 38.1-311; 1952, c. 317; 1970, c. 656; 1979, c. 513, § 38.1-327.43; 1986, c. 562; 1987, c. 521; 1996, c. 10; 2001, c. 706.

§ 38.2-1832. Refusal to issue and revocation of license; hearing; new application.

A. If the Commission believes that any applicant for a license is not of good character or does not have a good reputation for honesty, it may refuse to issue the license, subject to the right of the applicant to demand a hearing on the application. Except as provided in § 38.2-1042, the Commission shall not revoke or suspend an existing license until the licensee is given an opportunity to be heard before the Commission. If the Commission refuses to issue a new license or proposes to revoke or suspend an existing license, it shall give the applicant or licensee at least ten calendar days' notice in writing of the time and place of the hearing if a hearing is requested. The notice shall contain a statement of the objections to the issuance of the license, or the reason for its proposed revocation or suspension, as the case may be. The notice may be given to the applicant or licensee by registered or certified mail, sent to the last known address of record pursuant to § 38.2-1826, or the last known business address if the address of record is incorrect, or in any other lawful manner the Commission prescribes. The Commission may summon witnesses to testify with respect to the applicant or licensee, and the applicant or licensee may introduce evidence in his or its behalf. No applicant to whom a license is refused after a hearing, nor any licensee whose license is revoked, shall again apply for a license until after the expiration of a period of five years from the date of the Commission's order, or such other period of time as the Commission prescribes in its order.

B. The license of a business entity may be suspended, revoked or refused if the Commission finds, after notice and an opportunity to be heard, that a violation by an individual licensee acting at the direction of, on behalf of, or with the permission of the business entity was known to be a violation by one or more of the partners, officers or managers acting on behalf of the business entity, and the violation was neither reported to the Commission nor corrective action taken.

C. In addition to or in lieu of any applicable denial, suspension or revocation of a license, a person may, after notice and an opportunity to be heard, be subject to a penalty pursuant to § 38.2-218.

D. The Commission shall retain the authority to enforce the provisions of and impose any penalty or remedy authorized by this title against any person who is under investigation for or charged with a violation of this title, even if the person's license or registration has been surrendered, terminated, suspended, revoked, or has lapsed by operation of law.

Code 1950, § 38.1-312; 1952, c. 317; 1979, c. 513, § 38.1-327.44; 1981, c. 604; 1985, c. 616; 1986, c. 562; 1987, c. 521; 2001, c. 706.

§ 38.2-1833. Appointments of agents.

A. Subject to the requirement of § 38.2-1801, every licensed agent may sell policies and solicit applications for insurance for any one or more of the classes of insurance for which he is licensed on behalf of an insurer (i) also licensed in this Commonwealth for those classes of insurance and (ii) by which the licensed agent has not yet been validly appointed, subject to the following requirements:

1. The insurer shall, within 30 calendar days of the date of execution of the first insurance application or policy submitted by a licensed but not yet appointed agent, either reject such application or policy or file with the Commission a notice of appointment in a form acceptable to the Commission. The

Commission shall provide a means whereby an insurer may elect to appoint an agent to represent all or some of the insurers within the insurer's holding company system or group by the submission of a single notice of appointment for each appointment type applicable.

2. The insurer shall provide to the licensed agent, within the same 30-day period, a verification that the notice of appointment has been filed with the Commission.

3. Upon receipt of the notice of appointment, the Commission shall verify that the agent holds a valid license and that the notice has been properly completed and submitted. The Commission shall notify the appointing insurer if the appointment of the agent is invalid within five business days of its receipt of the appointment notice, and the insurer shall notify the agent in writing of the invalid appointment within five business days of receiving such notice from the Commission. Any agent who sells or solicits insurance on behalf of the insurer after being notified of an invalid appointment shall be in violation of this section and shall be subject to penalties as prescribed in §§ 38.2-218 and 38.2-1831.

4. An agent whose appointment by an insurer has been terminated by the insurer shall be prohibited from selling or soliciting applications or policies on behalf of that insurer unless and until reappointed by the insurer. Any such selling or solicitation on behalf of that insurer subsequent to such appointment termination and prior to such reappointment shall constitute a violation of this section by the agent and shall subject the agent to penalties as prescribed in §§ 38.2-218 and 38.2-1831.

B. Each agent's appointment record shall be public information and shall be available for public inspection during normal business hours of the Commission. The Commission may charge a reasonable fee to cover the costs incurred in providing this information.

C. Each insurer shall pay a nonrefundable appointment processing fee, in an amount prescribed by the Commission, for each appointment notification submitted by the insurer to the Commission.

D. The prescribed appointment fee shall not be less than $7 nor more than $25.

E. Such fees shall be billed to the insurer by the Commission on a quarterly basis and shall be due and payable on August 10 for the quarter ending June 30, on November 10 for the quarter ending September 30, on February 10 for the quarter ending December 31, and on May 10 for the quarter ending March 31. In the event that a due date falls on a weekend or holiday, payment shall be due on the first business day following such due date.

F. Such quarterly billing shall include all appointment notifications submitted by the insurer during the immediately preceding quarter, regardless of the current status of any such appointments.

G. All appointment processing fees collected by the Commission, as well as penalties collected pursuant to subsection H, shall be paid directly into the state treasury and placed to the credit of the fund for the maintenance of the Bureau of Insurance as provided in subsection B of § 38.2-400.

H. Upon the failure of the insurer to pay amounts due under this section by the date due, the Commission:

1. Shall impose a penalty of $50 per day for each day between the date due and the date full payment is received by the Commission. The appointment fees described above shall not be considered paid in full unless and until the penalty described herein has been received by the Commission; and

2. May, in addition to the penalty imposed above, administratively terminate the appointment of each agent on whose behalf the appointment processing fee, including any penalty imposed pursuant to this section, was not received by the Commission by the date due and after the insurer has been given due notice and an opportunity to submit the overdue payment.

1985, c. 616, § 38.1-327.44:1; 1986, c. 562; 1987, c. 521; 1988, c. 302; 1994, c. 316; 2001, c. 706; 2003, c. 871; 2008, c. 357.

§ 38.2-1834. Duration of appointment; annual renewal of agent's appointment.

A. A valid appointment of an agent shall authorize the agent to act for the insurer during the time for which the appointing insurer is licensed to do business in this Commonwealth, unless such appointment is otherwise terminated, suspended, or revoked. No later than 10 calendar days after notice of the termination, suspension or revocation of an appointment has been sent to the agent or agency, the agent or agency shall immediately cease selling or soliciting on behalf of such insurer.

B. Prior to August 10 of each year, or the first business day thereafter if August 10 falls on a weekend or holiday, every insurer shall remit in a manner prescribed by the Commission a renewal appointment fee, for each appointment for which notice of appointment termination was not received by the Commission on or before the preceding June 30, in an amount prescribed by the Commission, which shall be collected by the Commission and, along with any penalties collected pursuant to subsection C, paid directly into the state treasury and credited to the fund for the maintenance of the Bureau of Insurance as provided in subsection B of § 38.2-400.

C. Upon the failure of the insurer to pay amounts due under this section by the date due, the Commission:

1. Shall impose a penalty of $50 per day for each calendar day between the date due and the date full payment is received by the Commission. The renewal appointment fees described above shall not be considered paid in full unless and until the penalty described herein has been received by the Commission; and

2. May, in addition to the penalty imposed above, administratively terminate the appointment of each agent on whose behalf the appointment renewal fee, including any penalty imposed pursuant to this section, was not received by the Commission by the date due and after the insurer has been given due notice and an opportunity to submit the overdue payment.

D. Except as provided in § 38.2-1834.1, upon the termination of the appointment of an agent by an insurer, the insurer shall notify the agent of such termination within five calendar days and the Commission, except as provided in subsection B of this section, within 30 calendar days in a manner

acceptable to the Commission, whereupon termination of the agent's appointment to represent the insurer shall be recorded by the Commission.

E. Any license in effect on January 1, 1986, shall be deemed to be an appointment for the unexpired term of that license. Certificates of qualifications issued prior to January 1, 1986, shall be deemed to be the license required by this chapter.

F. An appointment of an agent holding a restricted or limited license shall authorize such agent to sell, solicit, or negotiate only those classes of insurance specifically included in such agent's license authority.

1985, c. 616, § 38.1-327.44:2; 1986, c. 562; 1987, c. 521; 1988, c. 32; 1994, c. 316; 2001, c. 706; 2003, c. 871.

§ 38.2-1834.1. Notification to Commission of termination; notice to agent; immunities; confidentiality; penalties.

A. An insurer or authorized representative of the insurer that terminates the appointment, employment, contract or other insurance business relationship with an agent or other licensee under this chapter shall notify the Commission within thirty calendar days following the effective date of the termination, using a format prescribed by the Commission, if the reason for termination is one of the reasons set forth in § 38.2-1831 or the insurer has knowledge the agent was found by a court, government body, or legally authorized self-regulatory organization authorized by law to have engaged in any of the activities in § 38.2-1356, 38.2-1363, 38.2-1831 or 38.2-1843. The propriety of any such termination for cause shall be certified in writing by an officer or authorized representative of the insurer or agent terminating the relationship. Upon the written request of the Commission, the insurer shall provide additional information, documents, records or other data pertaining to the termination or activity of the agent or other licensee.

B. The insurer or the authorized representative of the insurer shall promptly notify the Commission in a format acceptable to the Commission if, upon further review or investigation, the insurer discovers additional information that would have been reportable to the Commission in accordance with subsection A had the insurer then known of its existence.

C. 1. Within fifteen calendar days after making the notification required by subsections A and B, the insurer shall mail a copy of the notification to the agent at his last known address pursuant to the insurer's records. If the agent is terminated for cause for any of the reasons listed in § 38.2-1831, the insurer shall provide a copy of the notification to the agent at his last known address by certified mail, return receipt requested, postage prepaid or by overnight delivery using a nationally recognized carrier.

2. Within thirty calendar days after the agent has received the original or additional notification, the agent may file written comments concerning the substance of the notification with the Commission in the form and manner required by the Commission. The agent shall, by the same means, simultaneously send a copy of the comments to the reporting insurer, and the comments shall become a

part of the Commission's file and accompany every copy of a report distributed or disclosed for any reason about the agent as permitted under subsection D.

D. 1. In the absence of actual malice, an insurer, the authorized representative of the insurer, a producer, the Commission, authorized representatives of the Commission, the NAIC, its affiliates or subsidiaries, or state, federal, and international law-enforcement authorities shall not be subject to civil liability, and a civil cause of action of any nature shall not arise against these entities or their respective agents or employees, as a result of any statement or information required by or provided pursuant to this section or any information relating to any statement that may be requested in writing by the Commission, from an insurer or agent, or a statement by a terminating insurer or agent to an insurer or agent limited solely and exclusively to whether a termination for cause under subsection A was reported to the Commission, provided that the propriety of any termination for cause under subsection A is certified in writing, pursuant to subsection A of this section, by an officer or authorized representative of the insurer or agent terminating the relationship.

2. In any action brought against a person that may have immunity under subdivision 1 for making any statement required by this section or providing any information relating to any statement that may be requested by the Commission, the party bringing the action shall plead specifically in any allegation that subdivision 1 does not apply because the person making the statement or providing the information did so with actual malice.

3. Subdivision 1 or 2 shall not abrogate or modify any existing statutory or common law privileges or immunities.

E. 1. Any documents, materials or other information in the control or possession of the Commission that is furnished by an insurer, agent or an employee thereof acting on behalf of the insurer or agent, or obtained by the Commission in an investigation pursuant to this chapter shall be confidential by law and privileged, shall not be subject to inspection or review by the general public, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the Commission is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the Commission's duties.

2. Neither the Commission nor any person who received documents, materials or other information while acting under the authority of the Commission shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subdivision 1.

3. In order to assist in the performance of the Commission's duties under this chapter, the Commission:

a. May share documents, material or other information, including the confidential and privileged documents, materials or information subject to subdivision 1, with other state, federal, and international regulatory agencies, with the NAIC, its affiliates or subsidiaries, and with local, state, federal, and inter-

national law-enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material or other information.

b. May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the NAIC, its affiliates or subsidiaries and from regulatory and law-enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information.

4. No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the Commission under this section or as a result of sharing as authorized in subdivision 3.

5. Nothing in this chapter shall prohibit the Commission from releasing final, adjudicated actions including for cause terminations that are open to public inspection pursuant to Chapter 4 (§ 12.1-18 et seq.) of Title 12.1 to a database or other clearinghouse service maintained by the NAIC, its affiliates or subsidiaries of the NAIC.

F. An insurer, the authorized representative of the insurer, or agent that fails to report as required under the provisions of this section or that is found to have reported with actual malice by a court of competent jurisdiction may, after notice and an opportunity to be heard, have its license or certificate of authority suspended or revoked and may be fined in accordance with Chapter 2 (§ 38.2-200 et seq.) of this title.

2001, c. 706; 2002, c. 296; 2008, c. 303.

§ 38.2-1835. Failure to appoint.

Any insurer that accepts applications from an unlicensed agent or does not appoint a licensed agent pursuant to the provisions of § 38.2-1833 shall be penalized as provided in §§ 38.2-218 and 38.2-1040.

1985, c. 616, § 38.1-327.44:3; 1986, c. 562; 1987, c. 521.

§ 38.2-1836. Licensing nonresidents; reciprocal agreements with other states and Canadian provinces.

A. An individual or business entity who is not a resident as defined in § 38.2-1800, but who is a resident of another state or territory of the United States or a province of Canada shall receive a nonresident agent license if:

1. The applicant presents proof in a form acceptable to the Commission that the applicant is currently licensed as a resident and in good standing in his home state;

2. The applicant has submitted the proper request for licensure and has paid the fees required by § 38.2-1819;

3. The applicant has submitted or transmitted to the Commission the application for licensure that the person submitted to his home state, or in lieu of the same, a completed Uniform Application; and

4. The person's home state issues nonresident agent licenses to residents of this Commonwealth on the same basis.

B. For the purposes of this chapter, any individual whose place of residence and place of business are in a city or town located partly within the Commonwealth and partly within another state may be considered as meeting the requirements as a resident of this Commonwealth, provided the other state has established by law or regulation similar requirements as to residence of such individuals.

C. The Commission may enter into a reciprocal agreement with an appropriate official of any other state, territory or province of Canada if such an agreement is required in order for a Virginia resident to be similarly licensed as a nonresident in that state, territory or province. No applicant for a nonresident agent license shall be permitted to obtain such a license unless such agent's home state will grant a similar license to a resident of this Commonwealth.

D. The Commission may verify the agent's licensing status through the Producer Database maintained by the NAIC, its affiliates or subsidiaries.

E. A nonresident agent who moves from one state or province to another state shall file a change of address and provide a certification from the new home state within thirty calendar days of the change of legal residence. No fee or license application is required.

F. Notwithstanding any other provision of this chapter, a person licensed as a limited lines credit insurance or other type of limited lines agent in his home state shall receive a nonresident limited lines agent license, pursuant to subsection A of this section, granting the same scope of authority as is granted under the license issued by the agent's home state. A person holding an unrestricted license from his home state in which the authority of the license is less than the total authority prescribed in the associated major lines pursuant §§ 38.2-1814 through 38.2-1815.1 shall be issued a restricted nonresident license providing authority equivalent to that held by the agent in his home state.

G. Any licenses and appointments issued to nonresidents pursuant to this section shall be terminated at any time that the nonresident's equivalent authority in his home state is terminated, suspended, or revoked.

Code 1950, § 38.1-301.9; 1956, c. 541; 1979, c. 513, § 38.1-327.45; 1980, c. 743; 1981, c. 604; 1986, c. 562; 1987, c. 521; 1988, c. 335; 1989, c. 435; 1990, c. 464; 2001, c. 706; 2008, c. 213.

§ 38.2-1836.1. Authority of Commission to delegate certain functions.

In order to assist in the performance of its duties, the Commission may contract with nongovernmental entities, including the NAIC or any affiliates or subsidiaries that the NAIC oversees, to perform any ministerial functions, including licensing examination administration, the collection of fees related to producer licensing and appointments, and such other functions as the Commission may deem appropriate.

2001, c. 706.

Article 4 - LICENSING OF INSURANCE CONSULTANTS

§ 38.2-1837. Definitions.

As used in this article:

"Insurance consultant" means any individual or business entity who acts as an independent contractor in relation to his client and for a fee or compensation, other than from an insurer or agent or surplus lines broker, advises or offers or purports to advise, as to life and health or property and casualty insurance, any person actively or prospectively insured. "Insurance consultant" shall not include:

1. Any licensed attorney acting in his professional capacity;

2. A trust officer of a bank acting in the normal course of his employment;

3. Any actuary or certified public accountant who consults during the normal course of his business; and

4. Any person employed as a risk manager and who consults for his employer only.

"Life and health insurance consultant" means an insurance consultant whose services are limited to insurance as defined in §§ 38.2-102 through 38.2-109 or health services as provided for in Chapters 42 (§ 38.2-4200 et seq.) and 43 (§ 38.2-4300 et seq.) of this title.

"Property and casualty insurance consultant" means an insurance consultant whose services are limited to insurance as defined in §§ 38.2-110 through 38.2-122 and 38.2-124 through 38.2-134.

1985, c. 3, § 38.1-327.62; 1986, c. 562; 1987, cc. 521, 678; 1992, c. 574; 2001, c. 706.

§ 38.2-1838. License required of consultants; fingerprinting.

A. No person, unless he holds an appropriate license shall:

1. Represent to members of the public that he provides planning or consulting services beyond those within the normal scope of activities of a licensed insurance agent; or

2. Except as provided in § 38.2-1812.2, charge or receive, directly or indirectly, a fee or other compensation for insurance advice, other than commissions received in such person's capacity as a licensed insurance agent or surplus lines broker resulting from selling, soliciting, or negotiating insurance or health care services as allowed by his license.

B. Each individual applying for an insurance consultant's license shall apply to the Commission in a form acceptable to the Commission, and shall provide satisfactory evidence of having met the following requirements:

1. To be licensed as a property and casualty insurance consultant the applicant must pass, within 183 calendar days prior to the date of application for such license, the property and casualty examination as required in § 38.2-1817, except that an applicant who, at the time of such application holds an act-

ive property and casualty insurance agent license, shall be exempt from the examination requirements;

2. To be licensed as a life and health insurance consultant, the applicant must pass, within 183 calendar days prior to the date of application for such license, both the life and annuities and the health examinations as required in § 38.2-1817, except that an applicant who, at the time of such application holds both an active life and annuities license and an active health agent license, shall be exempt from the examination requirements;

3. Each individual applicant for an insurance consultant license shall, at the time of applying for a new license, be fingerprinted in a form and manner prescribed by the Commission and shall provide personal descriptive information to be forwarded along with the applicant's fingerprints through the Central Criminal Records Exchange to the Federal Bureau of Investigation for the purpose of obtaining criminal history record information regarding such applicant. The results of the state and national records search shall be forwarded to the Commissioner or the Commissioner's designee, who shall be an employee of the Commission. The cost of fingerprinting and the criminal history record check shall be paid by the applicant. If an applicant's application for a license is denied, the Commission shall provide a copy of the information obtained from the Central Criminal Records Exchange to the applicant upon request. The information provided to the Commission shall not be disseminated except as provided in this subsection; and

4. Except where prohibited by state or federal law, by submitting an application for license, the applicant shall be deemed to have appointed the clerk of the Commission as the agent for service of process on the applicant in any action or proceeding arising in the Commonwealth out of or in connection with the exercise of the license. Such appointment of the clerk of the Commission as agent for service of process shall be irrevocable during the period within which a cause of action against the applicant may arise out of transactions with respect to subjects of insurance in the Commonwealth. Service of process on the clerk of the Commission shall conform to the provisions of Chapter 8 (§ 38.2-800 et seq.).

C. Any individual who acts as an insurance consultant as an officer, director, principal or employee of a business entity shall be required to hold an appropriate individual license as an insurance consultant.

D. A business entity acting as an insurance consultant is required to obtain an insurance consultant license. Application shall be made in a form and manner acceptable to the Commission. Before approving the application, the Commission shall find that:

1. The business entity has paid the fee set forth in this section; and

2. The business entity has designated an employee, officer, director, manager, member, or partner to serve as the licensed producer responsible for the business entity's compliance with the insurance laws, rules and regulations of the Commonwealth.

E. The Commission may require any documents reasonably necessary to verify the information contained in an application.

F. Each applicant for an insurance consultant's license shall, at the time of applying for a license, pay a nonrefundable application processing fee in an amount and in a manner prescribed by the Commission.

1985, c. 3, § 38.1-327.63; 1986, c. 562; 1987, c. 678; 1992, c. 574; 1997, c. 583; 2001, c. 706; 2008, c. 213; 2016, c. 552; 2018, c. 131; 2019, c. 675.

§ 38.2-1839. Contract required; placement of insurance for public bodies.

A. A licensed insurance consultant that does not sell, solicit or negotiate insurance as part of his services shall enter into a written contract with his client prior to any act as a consultant in this Commonwealth. A licensed insurance consultant that does sell, solicit or negotiate insurance in this Commonwealth as part of his services shall enter into a written contract with his client prior to the purchase of any insurance by that client. The contract shall include, without limitation, the amount and basis of any consulting fee and the duration of employment. If the insurance consultant may also receive commissions, incentives, bonuses, overrides, or any other form of remuneration either directly or indirectly as a result of his services for selling, soliciting, or negotiating insurance as a part of his services in addition to a consulting fee, unless otherwise prohibited, such information shall be disclosed in the contract.

B. No insurance consultant may provide or offer to provide, directly or indirectly, insurance products to a public body while concurrently and on its behalf (i) evaluating proposals from other insurance agents and (ii) recommending the placement of insurance.

1985, c. 3, § 38.1-327.64; 1986, c. 562; 1987, cc. 521, 678; 1996, c. 989; 2001, c. 706; 2003, c. 621; 2007, c. 449.

§ 38.2-1840. Renewal application and fee; compliance with continuing education requirements; reinstatement; waiver.

A. Beginning January 1, 2021, each insurance consultant shall submit biennially to the Commission a renewal application in a form and manner prescribed by the Commission, along with a nonrefundable renewal application processing fee prescribed by the Commission, for the renewal of the license. Licenses shall be renewed biennially based on the insurance consultant's month and year of birth. The license for a consultant born in an even-numbered year shall expire at the end of the consultant's birth month in even-numbered years. The license for a consultant born in an odd-numbered year shall expire at the end of the consultant's birth month in odd-numbered years. Any consultant license for which the renewal application and nonrefundable renewal application processing fee have been received by the Commission and all other applicable licensing and renewal provisions in this chapter have been met shall, unless the license has been terminated, suspended, or revoked, be renewed for a two-year period. Any consultant license for which the renewal application and nonrefundable

renewal application processing fee have not been received by the Commission shall automatically be terminated.

B. Each individual insurance consultant who is not exempt under § 38.2-1871 shall submit to the Virginia Insurance Continuing Education Board or its administrator proof of compliance with the continuing education requirements set forth in Article 7 (§ 38.2-1866 et seq.) on a biennial basis in conjunction with the insurance consultant's license renewal. The insurance consultant's license shall not be renewed if the agent has failed to satisfy the applicable continuing education requirements.

C. On or before May 1, 2021, and biennially thereafter, each business entity licensed as a consultant shall submit to the Commission a renewal application, along with a nonrefundable renewal application processing fee prescribed by the Commission, for the renewal of the license. Any consultant license for which the renewal application and nonrefundable renewal application processing fee have been received by the Commission and all other applicable licensing and renewal provisions in this chapter have been met shall, unless the license has been terminated, suspended, or revoked, be renewed for a two-year period. Any consultant license for which the renewal application and nonrefundable renewal application processing fee have not been received by the Commission shall automatically be terminated.

D. The nonrefundable renewal processing fee shall be paid in a manner and in an amount prescribed by the Commission. All fees shall be collected by the Commission and paid directly into the state treasury and credited to the fund for the maintenance of the Bureau of Insurance as provided in subsection B of § 38.2-400.

E. An individual insurance consultant whose license terminates due to failure to renew may, within 12 months from the renewal date, reinstate the same license without the necessity of passing a written examination by:

1. Submitting a renewal application;

2. Submitting a nonrefundable reinstatement processing fee equivalent to double the nonrefundable renewal application processing fee; and

3. Satisfying the relevant continuing education requirements.

F. An individual insurance consultant who is unable to comply with the license renewal requirements due to military service or another extenuating circumstance such as a long-term illness or incapacity may request a waiver of those requirements. Requests for waivers of renewal requirements shall be made in a form and manner prescribed by the Commission. Insurance consultants seeking a waiver of renewal requirements shall submit all documentation specified by the Commission so as to be received by the Commission no later than the last day of the renewal period. After the renewal period, insurance consultants who have failed to complete the renewal waiver requirements may request a waiver from the reinstatement requirements set forth in subdivisions E 1 and 2 within the 12-month reinstatement period. The Commission shall approve or disapprove the waiver request within 30

calendar days of receipt thereof, and shall provide written notice of its decision to the applicant for waiver within five calendar days of rendering its decision. Any waiver granted pursuant to this section shall be valid only for the renewal period or reinstatement period for which the waiver request was made.

1985, c. 3, § 38.1-327.65; 1986, c. 562; 1987, cc. 521, 678; 1994, c. 316; 1999, c. 44; 2001, c. 706; 2019, c. 675.

§ 38.2-1841. Termination, suspension, or revocation of license.

A. A license issued to an individual insurance consultant shall authorize him to act as an insurance consultant until his license is otherwise terminated, suspended, or revoked.

B. A license issued to a business entity shall authorize such business entity to act as an insurance consultant until such license is otherwise terminated, suspended, or revoked. The dissolution or discontinuance of a partnership, whether by intent or by operation of law, shall automatically terminate the insurance consultant's license issued to such partnership. The Bureau shall automatically terminate all insurance consultant licenses within 90 calendar days of receiving notification from the clerk of the Commission that the certificate of organization or charter of a domestic limited liability company or corporation respectively, whether by intent or by operation of law, has been terminated or that the certificate of registration or certificate of authority of a foreign limited liability company or corporation, respectively, has been revoked.

C. The termination of a consultant as an insurance agent pursuant to subsection A of § 38.2-1825 shall not result in the termination of the consultant's license, provided that the renewal application and nonrefundable renewal application processing fee prescribed in § 38.2-1840 continues to be paid, the consultant license continues to be renewed as required by § 38.2-1840, and the license is not otherwise revoked, suspended, or terminated.

D. The license authority of any business entity licensed as a consultant shall terminate immediately if the designated licensed producer responsible for the business entity's compliance with the insurance laws, rules, and regulations of the Commonwealth pursuant to subdivision D 2 of § 38.2-1838 is removed for any reason and a new responsible producer has not been designated and the Commission notified within 30 calendar days of such removal and of the new designated responsible producer.

1985, c. 3, § 38.1-327.66; 1986, c. 562; 1987, cc. 521, 678; 1992, c. 574; 1997, c. 583; 1999, c. 44; 2001, c. 706; 2016, c. 552; 2019, c. 675.

§ 38.2-1842. Requirement to report to Commission.

A. Each licensed insurance consultant shall report within 30 calendar days to the Commission any change in his residence address, email address, or name.

B. In addition to the requirements of §§ 59.1-69 and 59.1-70, any individual or business entity licensed as an insurance consultant in the Commonwealth and operating under an assumed or fictitious name shall notify the Commission, at the earlier of the time the application for an insurance consultant

license is filed or within 30 calendar days from the date the assumed or fictitious name is adopted, setting forth the name under which the insurance consultant intends to operate in Virginia. The Commission shall also be notified within 30 calendar days from the date of cessation of the use of such assumed or fictitious name.

C. Each licensed insurance consultant convicted of a felony shall report within 30 calendar days to the Commission the facts and circumstances regarding the criminal conviction.

D. Each licensed insurance consultant shall report to the Commission within 30 calendar days of the final disposition of the matter any administrative action taken against him in another jurisdiction or by another governmental agency in the Commonwealth. Such report shall include a copy of the order, consent to order or other relevant legal documents.

E. The license authority of any licensed resident insurance consultant shall terminate immediately when such insurance consultant has moved his residence from the Commonwealth, whether or not the Commission has been notified of such move.

1985, c. 3, § 38.1-327.67; 1986, c. 562; 1987, cc. 521, 678; 1999, c. 59; 2001, c. 706; 2019, c. 675.

§ 38.2-1843. Grounds for placing on probation, refusal to issue or renew, revocation or suspension of license.

The Commission may, in addition to or in lieu of a penalty imposed under § 38.2-218, place on probation, suspend, revoke or refuse to issue or renew any person's license for any one or more of the following causes:

1. Providing materially incorrect, misleading, incomplete or untrue information in the license application or any other document filed with the Commission;

2. Violating any insurance laws, or violating any regulation, subpoena or order of the Commission or of another state's insurance regulatory authority;

3. Obtaining or attempting to obtain a license through misrepresentation or fraud;

4. Improperly withholding, misappropriating or converting any moneys or properties received in the course of doing insurance consulting business;

5. Engaging in twisting or any form thereof, where "twisting" means inducing an insured to terminate an existing policy and purchase a new policy through misrepresentation;

6. Engaging in the practice of rebating;

7. Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance;

8. Having admitted or been found to have committed any insurance unfair trade practice or fraud, including reducing the fee or compensation provided for in § 38.2-1837 for the purpose of inducing a client or potential client to purchase a policy;

9. Having been convicted of a felony;

10. Using fraudulent, coercive, or dishonest practices, or demonstrating incompetence, or untrustworthiness in the conduct of business in this Commonwealth or elsewhere, or demonstrating financial irresponsibility in the handling of applicant, policyholder, agency, or insurance company funds;

11. Having an insurance producer or consultant license, or its equivalent, denied, suspended or revoked in any other state, province, district or territory;

12. Forging another's name to an application for insurance or to any document related to an insurance transaction;

13. Improperly using notes or any other reference material to complete an examination for an insurance license;

14. Knowingly accepting insurance business from an individual who is not licensed;

15. Failing to comply with an administrative or court order imposing a child support obligation; or

16. Failing to pay state income tax or comply with any administrative or court order directing payment of state income tax.

1985, c. 3, § 38.1-327.68; 1986, c. 562; 1987, cc. 521, 678; 1996, c. 10; 2001, c. 706.

§ 38.2-1844. Refusal to issue and revocation of license; hearing; new application.

A. If the Commission is of the opinion that any applicant for an insurance consultant's license is not of good character or does not have a good reputation for honesty, it may refuse to issue the license, subject to the right of the applicant to demand a hearing on the application. The Commission shall not revoke or suspend an existing license until the licensee is given an opportunity to be heard before the Commission. If the Commission refuses to issue a new license or proposes to revoke or suspend an existing license, it shall give the applicant or licensee at least ten calendar days' notice in writing of the time and place of the hearing, if a hearing is requested. The notice shall contain a statement of the objections to the issuance of the license, or the reason for its proposed revocation or suspension as the case may be. The notice may be given to the applicant or licensee by registered or certified mail, sent to the last known address of record pursuant to § 38.2-1842, or the last known business address if the address of record is incorrect, or in any other lawful manner the Commission prescribes. The Commission may summon witnesses to testify with respect to the applicant or licensee, and the applicant or licensee may introduce evidence in his or its behalf. No applicant to whom a license is refused after a hearing, nor any licensee whose license is revoked, shall again apply for a license until after the expiration of a period of five years from the date of the Commission's order, or such other period of time as the Commission prescribes in its order.

B. The license of a business entity may be suspended, revoked or refused if the Commission finds, after notice and an opportunity to be heard, that a violation by an individual licensee acting at the direction of, on behalf of, or with the permission of the business entity was known to be a violation by one or more of the partners, officers or managers acting on behalf of the business entity, and the violation was neither reported to the Commission nor corrective action taken.

C. In addition to or in lieu of any applicable denial, suspension or revocation of a license, a person may, after notice and an opportunity to be heard, be subject to a penalty pursuant to § 38.2-218.

D. The Commission shall retain the authority to enforce the provisions of and impose any penalty or remedy authorized by this title against any person who is under investigation for or charged with a violation of this title, even if the person's license or registration has been surrendered, terminated, suspended, revoked, or has lapsed by operation of law.

1985, c. 3, § 38.1-327.69; 1986, c. 562; 1987, cc. 521, 678; 2001, c. 706.

§ 38.2-1845. Licensing nonresidents; reciprocal agreements with other states and Canadian provinces.

A. An individual or business entity who is not a resident as defined in § 38.2-1800, but who is a resident of another state, territory, or province of Canada, shall receive a nonresident insurance consultant license if:

1. The applicant presents proof in a form acceptable to the Commission that the applicant is currently licensed or otherwise authorized as a resident insurance consultant and is in good standing in his home state;

2. The applicant has submitted the proper application for licensure or a copy of the application for licensure submitted to his home state, and has paid the fees required by § 38.2-1838; and

3. The applicant's home state issues nonresident insurance consultant licenses to residents of this Commonwealth on the same basis, or will permit a resident of this Commonwealth to act as a consultant in such state without requiring a license.

B. For the purposes of this chapter, any individual whose place of residence and place of business are in a city or town located partly within the Commonwealth and partly within another state may be considered as meeting the requirements as a resident of this Commonwealth, provided the other state has established by law or regulation similar requirements as to residence of such individuals.

C. The Commission may enter into a reciprocal agreement with an appropriate official of any other state or province of Canada if such an agreement is required in order for a Virginia resident to be similarly licensed as a nonresident in that state or province.

D. The Commission may verify the insurance consultant's licensing status through the Producer Database maintained by the NAIC, its affiliates or subsidiaries.

E. A nonresident insurance consultant who moves from one state or province to another state or province shall file a change of address and provide a certification from the new home state or province within thirty calendar days of the change of legal residence. No fee or license application is required.

F. Any licenses issued to nonresidents pursuant to this section shall be terminated at any time that the nonresident's equivalent authority in his home state is terminated, suspended, or revoked.

1985, c. 3, § 38.1-327.70; 1986, c. 562; 1987, cc. 521, 678; 1988, c. 335; 2001, c. 706; 2008, c. 213.

Article 4.1 - Licensing of Public Adjusters

§ 38.2-1845.1. Definitions.

As used in this article:

"Catastrophic disaster" means an event where the President of the United States or the Governor of the Commonwealth has declared a state of emergency.

"Home state" means the District of Columbia and any state or territory of the United States, except Virginia, or any province of Canada, in which a public adjuster maintains such person's principal place of residence or principal place of business and is licensed by that jurisdiction to act as a resident public adjuster.

"License" means a document issued by the Commission authorizing an individual or business entity to act as a public adjuster. The license itself does not create any authority, actual, apparent, or inherent, in the licensee to represent, commit, or bind an insurer.

"Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of public adjusting concerning any of the substantive benefits, terms, or conditions of the contract.

"Proof of compliance" means all documents, forms, and fees specified by the Commission for filing proof of completion of Commission-approved continuing education courses for the appropriate number of hours and for the appropriate content.

"Public adjuster" means an individual or business entity who receives, either directly or indirectly, a salary, fee, commission, or other compensation for engaging in public adjusting.

"Public adjusting" means soliciting, investigating, negotiating, adjusting, or providing advice to an insured in relation to first party claims arising under insurance contracts that insure the real or personal property of an insured for the purpose of effecting the settlement of a claim on behalf of the insured. Public adjusting includes advertising or representing oneself as a public adjuster; however, public adjusting does not include acting in any manner in relation to liability claims for personal injury or property damage, other third-party claims, or uninsured or underinsured bodily injury liability claims. A licensed insurance agent who only provides advice to an insured in relation to first party claims arising under insurance contracts sold, solicited, or negotiated by the agent that insure the real or personal property of an insured shall not be deemed to be engaged in public adjusting.

"Received by the Commission" means delivered into the possession of the Commission or its administrator at the business address of the Commission's administrator.

"Soliciting" means attempting to persuade or asking or urging an insured to enter into a public adjusting contract by describing the terms of the contract, including any fees or commissions, and offering to negotiate a claim of loss on behalf of the insured.

2012, cc. 734, 735; 2019, c. 627.

§ 38.2-1845.2. License required of resident public adjusters.

A. No person shall engage in the business of public adjusting without first applying for and obtaining a license from the Commission, except as provided in § 38.2-1845.3.

B. Each individual applicant for a public adjuster license who is at least 18 years of age, who has satisfied the Commission that he (i) is of good character; (ii) has a reputation for honesty; (iii) has not committed any act that is a ground for the Commission to refuse to issue, deny, suspend, or revoke a public adjuster license as set forth in § 38.2-1845.10; and (iv) has complied successfully with the other requirements of this article is entitled to and shall receive a license under this chapter in the form and manner prescribed by the Commission. The Commission may require, for resident licensing, proof of residency as described in subsection B of § 38.2-1800.1.

C. Each individual applicant for a public adjuster license shall apply to the Commission in the form and manner prescribed by the Commission and shall provide satisfactory evidence of having met the following requirements:

1. Each applicant shall pass, within 183 calendar days prior to the date of application for such license, the public adjuster examination as required by the Commission pursuant to and in accordance with the requirements set forth in § 38.2-1845.4.

2. Each applicant for a public adjuster license shall submit a nonrefundable application processing fee in an amount and in a manner prescribed by the Commission at the time of initial application for such license. The fee shall be collected by the Commission and paid directly into the state treasury and credited to the fund for the maintenance of the Bureau of Insurance as provided in subsection B of § 38.2-400.

3. Prior to issuance of a license, each applicant shall attest that the applicant has, and thereafter shall keep in force for as long as the license remains in effect, a bond in favor of the Commonwealth in the amount of $50,000 with corporate sureties licensed by the Commission, on a form prescribed by the Commission. The bond shall be conditioned that the public adjuster will conduct business under the license in accordance with the laws of the Commonwealth. The bond shall not be terminated unless at least 60 calendar days' prior written notice of the termination is filed with the Commission. If, prior to the expiration date of the bond, the licensed public adjuster fails to file with the Commission a certification or attestation that a new bond satisfying the requirements of this section has been put into effect, the public adjuster license shall terminate, and the licensee shall be required to satisfy any and all prelicensing requirements in order to apply for a new public adjuster license. The Commission may ask for a copy of the bond or other evidence of financial responsibility at any time.

4. Each individual applicant for a public adjuster license shall, at the time of applying for a new license, be fingerprinted in a form and manner prescribed by the Commission and shall provide personal descriptive information to be forwarded along with the applicant's fingerprints through the Central Criminal Records Exchange to the Federal Bureau of Investigation for the purpose of obtaining criminal history record information regarding such applicant. The results of the state and national

records search shall be forwarded to the Commissioner or the Commissioner's designee, who shall be an employee of the Commission. The cost of fingerprinting and the criminal history record check shall be paid by the applicant. If an applicant's application for a license is denied, the Commission shall provide a copy of the information obtained from the Central Criminal Records Exchange to the applicant upon request. The information provided to the Commission shall not be disseminated except as provided in this subsection.

D. Except where prohibited by state or federal law, by submitting an application for license, the applicant shall be deemed to have appointed the Clerk of the Commission as the agent for service of process on the applicant in any action or proceeding arising in the Commonwealth out of or in connection with the exercise of the license. Such appointment of the Clerk of the Commission as agent for service of process shall be irrevocable during the period within which a cause of action against the applicant may arise out of transactions with respect to subjects of insurance in the Commonwealth. Service of process on the Clerk of the Commission shall conform to the provisions of Chapter 8 (§ 38.2-800 et seq.).

E. Any individual who acts as a public adjuster and who is also an officer, director, principal, or employee of a business entity acting as a public adjuster in the Commonwealth shall be required to hold an appropriate individual license as a public adjuster in the Commonwealth.

F. A business entity acting as a public adjuster is required to obtain a public adjuster license. Application shall be made in a form and manner acceptable to the Commission. Before approving the application, the Commission shall find that:

1. The business entity has paid the fee prescribed by the Commission;

2. The business entity has demonstrated proof of residency pursuant to subsection B of § 38.2-1800.1; and

3. The business entity has designated an individual employee, officer, director, manager, member, or partner licensed in Virginia as a public adjuster to be responsible for the business entity's compliance with the laws, rules, and regulations of the Commonwealth applicable to public adjusters.

G. Prior to issuance of a license, each entity shall attest that the entity has, and thereafter shall keep in force for as long as the license remains in effect, a bond in favor of the Commonwealth in the amount of $50,000 with corporate sureties licensed by the Commission, on a form prescribed by the Commission. The bond shall be conditioned that the public adjuster will conduct business under the license in accordance with the laws of the Commonwealth. The bond shall not be terminated unless at least 60 calendar days' prior written notice of the termination is filed with the Commission. If, prior to the expiration date of the bond, the licensed public adjuster fails to file with the Commission a certification or attestation that a new bond satisfying the requirements of this section has been put into effect, the public adjuster license shall terminate, and the entity shall be required to satisfy any and all prelicensing requirements in order to apply for a new public adjuster license. The Commission may ask for a copy of the bond or other evidence of financial responsibility at any time.

H. The Commission may require any documents reasonably necessary to verify the information contained in an application.

2012, cc. 734, 735; 2016, c. 552; 2018, c. 131; 2019, c. 675; 2020, c. 225.

§ 38.2-1845.3. Exemptions from article.

This article shall not apply to (i) an adjuster for or an agent or employee of an insurer or group of insurers under common control or ownership that, as a representative of the insurer or group, adjusts losses or damages under policies issued by the insurer or group; (ii) an adjuster who acts as an independent contractor for one or more insurers; (iii) any attorney licensed in the Commonwealth; (iv) a person employed only for the purpose of obtaining facts surrounding a loss or furnishing technical assistance to a licensed public adjuster, including photographers, estimators, private investigators, engineers, and handwriting experts; (v) employees of a motor vehicle repair facility that prepare repair estimates; or (vi) any person who settles subrogation claims between insurers.

2012, cc. 734, 735.

§ 38.2-1845.4. Examinations.

A. Examinations for licenses shall be conducted at least monthly at the times and places prescribed by the Commission. Each applicant shall be required to pass the examination prescribed by the Commission as a condition for licensure unless otherwise exempted.

B. If the applicant fails to take the examination within 90 calendar days from the date his registration for the examination is accepted, the examination fee shall be forfeited, and the registration shall be considered withdrawn.

C. If the applicant fails to obtain the appropriate license from the Commission within 183 calendar days from the date he passes the examination, the examination grade shall be considered invalid, and the examination fee and application processing fee shall be forfeited. Such applicant shall be required to reapply for the examination and to satisfy all appropriate prelicensing requirements.

D. An individual who applies for a resident public adjuster's license in the Commonwealth who was previously licensed as a public adjuster in the individual's home state shall not be required to complete any prelicensing examination. This exemption is only available if the individual is currently licensed in the applicant's home state or if the application is received within 90 calendar days of the cancellation of the applicant's previous license in the applicant's home state and if the applicant's home state issues a certification that, at the time of cancellation, the applicant was in good standing in that state or the state's Producer Database records, maintained by the NAIC, its affiliates, or subsidiaries, indicate that the public adjuster is or was licensed in good standing in that state.

2012, cc. 734, 735.

§ 38.2-1845.5. Licensing nonresidents; reciprocal agreements with other states and Canadian provinces.

A. An individual or business entity that is not a resident as defined in subsection B of § 38.2-1800.1 but that is a resident of another state, territory, or province of Canada shall receive a nonresident public adjuster license if:

1. The applicant presents proof in a form acceptable to the Commission that the applicant is currently licensed or otherwise authorized as a resident public adjuster and is in good standing in his home state;

2. The applicant has submitted the proper application for licensure or a copy of the application for licensure submitted to his home state and has paid the fees required by § 38.2-1845.2;

3. The applicant's home state issues nonresident public adjuster licenses to residents of the Commonwealth on the same basis or will permit a resident of the Commonwealth to act as a public adjuster in such state without requiring a license;

4. The applicant, if a corporation, limited liability company, or limited partnership, has obtained from the Clerk of the Commission a certificate of authority, certificate of registration, or certificate of limited partnership, respectively; and

5. The applicant attests that the applicant has, and thereafter shall keep in force for as long as the license remains in effect, a bond in favor of the Commonwealth in the amount of $50,000 with corporate sureties licensed by the Commission, on a form prescribed by the Commission. The bond shall be conditioned that the public adjuster will conduct business under the license in accordance with the laws of the Commonwealth. The bond shall not be terminated unless at least 60 calendar days' prior written notice of the termination is filed with the Commission. If, prior to the expiration date of the bond, the licensed public adjuster fails to file with the Commission a certification or attestation that a new bond satisfying the requirements of this section has been put into effect, the public adjuster license shall terminate, and the licensee shall be required to satisfy any and all prelicensing requirements in order to apply for a new public adjuster license. The Commission may ask for a copy of the bond or other evidence of financial responsibility at any time.

B. For the purposes of this chapter, any individual whose place of residence and place of business are in a city or town located partly within the Commonwealth and partly within another state may be considered as meeting the requirements as a resident of the Commonwealth, provided the other state has established by law or regulation similar requirements as to residence of such individuals.

C. The Commission may enter into a reciprocal agreement with an appropriate official of any other state or province of Canada if such an agreement is required in order for a Virginia resident to be similarly licensed as a nonresident in that state or province.

D. The Commission may verify the public adjuster's licensing status through the Producer Database records maintained by the NAIC, its affiliates, or subsidiaries.

E. The business entity has designated an individual employee, officer, director, manager, member, or partner licensed in Virginia as a public adjuster to be responsible for the business entity's compliance with the laws, rules, and regulations of the Commonwealth applicable to public adjusters.

F. The Commission may require any documents reasonably necessary to verify the information contained in an application.

G. A licensed nonresident public adjuster who changes his home state shall file a change of address within 30 calendar days of the change of legal residence.

H. Any licenses issued to nonresidents pursuant to this section shall be terminated at any time that the nonresident's equivalent authority in his home state is terminated, suspended, or revoked.

2012, cc. 734, 735; 2014, c. 337; 2018, c. 131.

§ 38.2-1845.6. Individual moving into the Commonwealth from another state or Canadian province.

A. An individual holding a nonresident Virginia public adjuster license who has moved into the Commonwealth from another state or a province of Canada shall submit the application and pay the license processing fee required by and in accordance with the requirements set forth in § 38.2-1845.2. A public adjuster with an active nonresident Virginia public adjuster license may continue to operate under his nonresident license for up to 90 calendar days while applying for a resident Virginia public adjuster's license. If a nonresident public adjuster fails to obtain such resident license by the end of the 90-calendar-day period, the equivalent nonresident license shall terminate.

B. An individual licensed as a public adjuster in another state or province of Canada, but not holding a nonresident Virginia public adjuster license, who moves to the Commonwealth shall submit the application to become a resident public adjuster and shall pay the license processing fee set forth in § 38.2-1845.2 within 90 calendar days of establishing residency in the Commonwealth as provided by subsection B of § 38.2-1800.1. No prelicensing examination shall be required of that individual to obtain a public adjuster license. After establishing legal residence in the Commonwealth and prior to obtaining a license as a resident public adjuster, the individual shall be prohibited from conducting the business of public adjusting in the Commonwealth. An individual who fails to submit the application and license processing fee within 90 calendar days of establishing legal residence in the Commonwealth shall be required to satisfy all resident public adjuster prelicensing requirements required by this article.

2012, cc. 734, 735.

§ 38.2-1845.7. Refusal to issue; hearing; new application.

A. If the Commission is of the opinion that any applicant for public adjuster license is not of good character or does not have a good reputation for honesty, it may refuse to issue the license, subject to the right of the applicant to demand a hearing on the application. If the Commission refuses to issue a new license, it shall give the applicant at least 10 calendar days' notice in writing of the time and place of the hearing, if a hearing is requested. The notice shall contain a statement of the objections to the issuance of the license. The notice may be given to the applicant by registered or certified mail, sent to the last known address of record, or the last known business address if the address of record is

incorrect, or in any other lawful manner the Commission prescribes. The Commission may summon witnesses to testify with respect to the applicant, and the applicant may introduce evidence in his or its behalf. No applicant to whom a license is refused after a hearing shall again apply for a license until after the expiration of a period of five years from the date of the Commission's order or such other period as the Commission prescribes in its order.

B. The license of a business entity may be denied if the Commission finds, after notice and an opportunity to be heard, that a violation by an individual licensee acting at the direction of, on behalf of, or with the permission of the business entity was known to be a violation by one or more of the partners, officers, or managers acting on behalf of the business entity or if it can be demonstrated to the satisfaction of the Commission that responsibility for such violation by the individual can reasonably be imputed to one or more of the partners, officers, or managers acting on behalf of the business entity, and neither was the violation reported to the Commission nor corrective action taken.

C. In addition to or in lieu of any applicable denial of a license, a person may, after notice and an opportunity to be heard, be subject to a penalty pursuant to § 38.2-218.

D. The Commission shall retain the authority to enforce the provisions of and impose any penalty or remedy authorized by this title against any person who is under investigation for or charged with a violation of this title, even if the person's license or registration has been surrendered, terminated, suspended, revoked, or has lapsed by operation of law.

2012, cc. 734, 735.

§ 38.2-1845.8. Renewal application and fee; reinstatement; waiver.

A. Beginning January 1, 2021, each individual licensed public adjuster shall submit biennially to the Commission a renewal application in a form and manner prescribed by the Commission, along with the nonrefundable renewal application processing fee prescribed by the Commission for the renewal of the license. Licenses shall be renewed biennially based on the public adjuster's month and year of birth. The license for a public adjuster born in an even-numbered year shall expire at the end of the public adjuster's birth month in even-numbered years. The license for a public adjuster born in an odd-numbered year shall expire at the end of the public adjuster's birth month in odd-numbered years. Any public adjuster license for which the required renewal application and nonrefundable renewal application processing fee have been received by the Commission and all other applicable licensing and renewal provisions in this chapter have been met shall, unless the license has been terminated, suspended, or revoked be renewed for a two-year period. Any public adjuster license for which the renewal application and nonrefundable renewal application processing fee have not been received by the Commission in the manner prescribed by the Commission shall automatically be terminated.

B. On or before May 1, 2021, and biennially thereafter, each business entity licensed as a public adjuster shall submit to the Commission a renewal application, along with a nonrefundable renewal application processing fee prescribed by the Commission, for the renewal of the license. Any public adjuster license for which the renewal application and nonrefundable renewal application processing

fee have been received by the Commission and all other applicable licensing and renewal provisions in this chapter have been met shall, unless the license has been terminated, suspended, or revoked, be renewed for a two-year period. Any license for which the renewal application and nonrefundable renewal application processing fee have not been received by the Commission shall automatically be terminated.

C. The nonrefundable renewal processing fee for each public adjuster license shall be paid in a manner and in an amount prescribed by the Commission. All fees shall be collected by the Commission and paid directly into the state treasury and credited to the fund for the maintenance of the Bureau of Insurance as provided in subsection B of § 38.2-400.

D. No nonresident public adjuster license shall be renewed unless the applicant meets the requirements for initial licensure as set forth in § 38.2-1845.5.

E. An individual public adjuster whose license terminates due to failure to renew may, within 12 months from the renewal date, reinstate the same license without the necessity of passing a written examination by:

1. Submitting a renewal application;

2. Submitting a nonrefundable reinstatement processing fee equivalent to double the nonrefundable renewal application processing fee; and

3. Satisfying the relevant continuing education requirements.

F. An individual public adjuster who is unable to comply with the license renewal requirements due to military service or another extenuating circumstance such as a long-term illness or incapacity may request a waiver of those requirements. Requests for waivers of renewal requirements shall be made in a form and manner prescribed by the Commission. Public adjusters seeking a waiver of renewal requirements shall submit all documentation specified by the Commission so as to be received by the Commission no later than the last day of the renewal period. After the renewal period, public adjusters who have failed to complete the renewal waiver requirements may request a waiver from the reinstatement requirements set forth in subdivisions E 1 and 2 within the 12-month reinstatement period. The Commission shall approve or disapprove the waiver request within 30 calendar days of receipt thereof, and shall provide written notice of its decision to the applicant for waiver within five calendar days of rendering its decision. Any waiver granted pursuant to this section shall be valid only for the renewal period or reinstatement period for which the waiver request was made.

2012, cc. 734, 735; 2014, c. 337; 2019, c. 675; 2020, c. 225.

§ 38.2-1845.9. Repealed.

Repealed by Acts 2021, Sp. Sess. I, c. 441, cl. 2, effective July 1, 2021.

§ 38.2-1845.10. Grounds for placing on probation, refusal to issue or renew, revocation, or suspension of license.

The Commission may, in addition to or in lieu of a penalty imposed under § 38.2-218, place on probation, suspend, revoke, or refuse to issue or renew any person's license for any one or more of the following causes:

1. Providing materially incorrect, misleading, incomplete, or untrue information in the license application or any other document filed with the Commission;

2. Violating any insurance laws or violating any regulation, subpoena, or order of the Commission or of another state's insurance regulatory authority;

3. Obtaining or attempting to obtain a license through misrepresentation or fraud;

4. Improperly withholding, misappropriating, or converting any moneys or properties received in the course of doing business as a public adjuster;

5. Having been convicted of a felony, a crime of moral turpitude, or any criminal offense involving dishonesty or a breach of trust;

6. Having admitted or been found to have committed any insurance unfair trade practice, as set forth in Chapter 5 (§ 38.2-500 et seq.), or fraud;

7. Using fraudulent, coercive, or dishonest practices or demonstrating incompetence or untrustworthiness in the conduct of business in the Commonwealth or elsewhere, or demonstrating financial irresponsibility in the handling of policyholder, agency, or insurance company funds;

8. Having public adjuster license, or its equivalent, denied, suspended, or revoked in any other state, province, district, or territory;

9. Intentionally misrepresenting the terms of an insurance contract;

10. Knowingly accepting public adjusting business from an individual who unlawfully solicited business and who is not licensed but who is required to be licensed under this article;

11. Paying or sharing a commission, fee, or other valuable consideration to a person who is required to be licensed under this article and is not so licensed;

12. Forging another's name to any document related to an insurance transaction;

13. Improperly using notes or any other reference material to complete an examination for a public adjuster license;

14. Failing to comply with an administrative or court order imposing a child support obligation;

15. Failing to pay Virginia income tax or comply with any administrative or court order directing payment of state income tax; or

16. Failing to report to the Commission as required by § 38.2-1845.17.

2012, cc. 734, 735.

§ 38.2-1845.11. Termination, suspension, or revocation of license.

A. A license issued to an individual public adjuster shall authorize him to act as a public adjuster until his license is otherwise terminated, suspended, or revoked.

B. A license issued to a business entity shall authorize such business entity to act as a public adjuster until such license is otherwise terminated, suspended, or revoked. The dissolution or discontinuance of a partnership, whether by intent or by operation of law, shall automatically terminate the public adjuster license issued to such partnership. The Bureau shall automatically terminate all public adjuster licenses within 90 calendar days of receiving notification from the Clerk of the Commission that the certificate of organization or charter of a domestic limited liability company or corporation respectively, whether by intent or by operation of law, has been terminated or that the certificate of registration or certificate of authority of a foreign limited liability company or corporation, respectively, has been revoked.

C. Except as provided in subsection B of § 38.2-1845.5, the license authority of any licensed resident public adjuster shall terminate immediately when such public adjuster has moved his residence from the Commonwealth, whether or not the Commission has been notified of such move.

D. The license authority of any business entity licensed as a public adjuster shall terminate immediately if the sole licensed responsible public adjuster designated pursuant to subdivision F 3 of § 38.2-1845.2 for the business entity's compliance with the insurance laws, rules, and regulations of the Commonwealth is removed for any reason and a new responsible public adjuster has not been designated and the Commission notified within 30 calendar days of such removal and of the newly designated responsible public adjuster.

E. The Commission shall not revoke or suspend an existing license until the licensee is given an opportunity to be heard before the Commission. If the Commission proposes to revoke or suspend an existing license, it shall give the licensee at least 10 calendar days' notice in writing of the time and place of the hearing, if a hearing is requested. The notice shall contain a statement of the objections to the issuance of the license or the reason for its proposed revocation or suspension, as the case may be. The notice may be given to the licensee by registered or certified mail, sent to the last known address of record or the last known business address if the address of record is incorrect, or in any other lawful manner, the Commission prescribes. The Commission may summon witnesses to testify with respect to the licensee, and the licensee may introduce evidence in the licensee's behalf. No licensee whose license is revoked shall again apply for a license until after the expiration of a period of five years from the date of the Commission's order or such other period as the Commission prescribes in its order.

F. The license of a business entity may be suspended or revoked if the Commission finds, after notice and an opportunity to be heard, that a violation by an individual licensee acting at the direction of, on behalf of, or with the permission of the business entity was known to be a violation by one or more of the partners, officers, or managers acting on behalf of the business entity or if it can be demonstrated to the satisfaction of the Commission that responsibility for such violation by the individual can

reasonably be imputed to one or more of the partners, officers, or managers acting on behalf of the business entity, and neither was the violation reported to the Commission nor corrective action taken.

G. In addition to or in lieu of any applicable denial, suspension, or revocation of a license, a person may, after notice and an opportunity to be heard, be subject to a penalty pursuant to § 38.2-218.

H. The Commission shall retain the authority to enforce the provisions of and impose any penalty or remedy authorized by this title against any person who is under investigation for or charged with a violation of this title, even if the person's license or registration has been surrendered, terminated, suspended, revoked, or has lapsed by operation of law.

2012, cc. 734, 735.

§ 38.2-1845.12. Standards of conduct for public adjusters.

A. A public adjuster shall be fair and honest in any and all respects in any communications with an insured and with an insurer or its representatives.

B. No person except a public adjuster duly licensed under this article shall:

1. Accept a commission, fee, or other compensation for investigating or settling claims;

2. Prepare, complete, or file an insurance claim on behalf of an insured;

3. Aid or act on behalf of an insured in negotiating for or effecting the settlement of a claim for loss or damage covered by an insurance contract;

4. Advertise for employment as a public adjuster; or

5. Solicit, investigate, or adjust a claim on behalf of a public adjuster or an insured.

C. No public adjuster shall have a financial interest in any aspect of an insured's claim other than the salary, fee, commission, or compensation that may be established in the written contract between the insured and the public adjuster. For the purposes of this subsection, "financial interest" includes participation by a public adjuster, directly or indirectly, in the reconstruction, repair, or restoration of damaged property that is the subject of a claim adjusted by that public adjuster.

D. No public adjuster shall refer or direct an insured needing repairs or other services in connection with a loss to any person in which the public adjuster has an ownership interest nor to any person who will or is reasonably anticipated to provide the public adjuster with any direct or indirect compensation for the referral of any resulting business.

E. No public adjuster shall prevent or attempt to dissuade an insured from communicating with an insurer, the insurer's adjuster, an independent adjuster representing the insurer, an attorney, or any other person regarding the settlement of the insured's claim.

F. The public adjuster's full consideration for the public adjuster's services shall be stated in the written contract with the insured. If the consideration is based on a share of the insurance proceeds, the exact percentage shall be specified.

G. Any choice of counsel to represent the insured shall be made solely by the insured.

H. No public adjuster shall settle a claim unless the terms and conditions of the settlement are approved by the insured in writing.

I. No public adjuster shall acquire any interest in salvage property except with the express written permission of the insured after settlement with the insurer.

J. No public adjuster shall permit an unlicensed employee or representative of the public adjuster to conduct business for which a license is required under this article.

K. No public adjuster shall represent or act as a company adjuster or independent adjuster on the same claim.

L. No public adjuster shall enter into a contract or accept a power of attorney that vests in the public adjuster the effective authority to choose the persons who shall perform repair work.

M. No public adjuster shall solicit or attempt to solicit a client during the progress of a loss producing occurrence as covered by the insurance contract.

N. No public adjuster shall solicit a client for employment from 8:00 p.m. to 8:00 a.m. daily.

O. A public adjuster shall notify, in writing, the insured or claimant in advance of the name and location of any proposed contractor, architect, engineer, or similar professional before any bid or proposal by any of these persons may be used by the public adjuster in estimating the loss. The insured or claimant may exercise veto power of any of these persons, in which case that person shall not be used in estimating costs.

P. A public adjuster shall ensure that any professional used in formulating estimates, the practice of whose profession in the Commonwealth requires a license issued pursuant to Title 54.1, including any architect or engineer as defined in § 54.1-400 and any contractor as defined in § 54.1-1100, holds a current license from the appropriate licensing authority of the Commonwealth.

Q. No person shall advertise or promise to pay or rebate all or any portion of any insurance deductible as an inducement to the sale of the services of a public adjuster. As used in this subsection, the term "promise to pay or rebate" includes (i) granting any allowance or offering any discount against the fees to be charged, including, but not limited to, an allowance or discount in return for displaying a sign or other advertisement at the insured's premises or (ii) paying the insured or any person directly or indirectly associated with the property any form of compensation, gift, prize, bonus, coupon, credit, referral fee, or other item of monetary value for any reason.

R. No public adjuster shall engage in any activity that may reasonably be construed as a conflict of interest, including soliciting or accepting any remuneration of any kind or nature, directly or indirectly, except as set forth in a public adjusting contract with an insured.

2012, cc. 734, 735; 2019, c. 627; 2022, c. 188.

§ 38.2-1845.13. Contract between public adjuster and insured.

A. Public adjusters shall ensure that all contracts for their services are in writing and contain the following terms:

1. Legible full name of the public adjuster signing the contract, as specified in the records of the Commission;

2. Public adjuster's permanent home state business address and phone number;

3. Public adjuster's license number, as specified in the records of the Commission;

4. Title "Public Adjuster Contract";

5. The insured's full name and street address and the insurance company's name and policy number;

6. A description of the loss and a description of the location of the loss, if applicable;

7. A description of services to be provided to the insured by the public adjuster and all terms and conditions of the engagement;

8. Signatures of the public adjuster and the insured;

9. The date the contract was signed by the public adjuster and the date the contract was signed by the insured;

10. Attestation language stating that the public adjuster is fully bonded pursuant to state law;

11. The full salary, fee, commission, compensation, or other consideration the public adjuster is to receive for services, subject to the provisions of § 38.2-1845.14; and

12. The right to rescind the contract within three business days after the contract has been signed by the insured or, in the event of a catastrophic disaster, the right to rescind the contract within five business days after the contract has been signed by the insured. Such rescission shall be in writing and mailed or delivered to the public adjuster at the address shown in the contract. Within 15 business days following receipt of the notice to rescind, the public adjuster shall return to the insured anything of value given by the insured under the contract.

B. The public adjuster shall provide a separate disclosure document to the insured stating (i) the insured is not required to hire a public adjuster but has the right to do so; (ii) the public adjuster is not an employee or representative of the insurer; (iii) the salary, fee, commission, or other consideration is the obligation of the insured, not the insurer; (iv) property insurance policies obligate the insured to present a claim to the insurer for consideration; (v) the insured has the right to initiate direct communications with the insured's attorney, the insurer, the insurer's adjuster, the insurer's attorney, and any other person regarding the settlement of the insured's claim; and (vi) the insured may contact the Commission for the licensing status of the public adjuster.

C. A public adjuster shall provide the insurer with a notification letter, which has been signed by the insured, authorizing the public adjuster to represent the insured's interest.

D. No public adjuster shall enter into a contract that prevents an insured from pursuing any civil remedy after the revocation or cancellation period set forth in subdivision A 12.

E. Any contract for public adjusting services that is entered into by an insured with a person who is in violation of § 38.2-1845.2 may be voided at the option of the insured.

2012, cc. 734, 735; 2019, c. 627.

§ 38.2-1845.14. Fees.

A. No public adjuster shall require, demand, or accept any fee, retainer, compensation, deposit, or thing of value prior to the settlement of a claim.

B. Except as provided in subsection C, no public adjuster shall charge, agree to, or accept as compensation or reimbursement any payment, commission, fee, or other thing of value that is not fair and reasonable in relation to the work performed. Any such commission, fee, or other thing of value shall include any expenses incurred by the public adjuster in the estimating and settlement of any claim.

C. In the event of a catastrophic disaster, no public adjuster shall charge, agree to, or accept as compensation or reimbursement any payment, commission, fee, or other thing of value equal to more than 10 percent of any insurance settlement proceeds. Any such commission, fee, or other thing of value shall include any expenses incurred by the public adjuster as part of the estimating and settlement of any claim.

D. No public adjuster shall charge a fee, commission, or other valuable consideration based, in whole or in part, on an amount paid to the insured by the insurer prior to the date of the written contract between the insured and the public adjuster.

E. A public adjuster's contract may not contain a provision that allows the public adjuster's percentage fee to be collected when money is due from an insurer, but not paid, or that allows a public adjuster to collect the entire fee from the first check issued by an insurer, rather than as a percentage of each check issued by an insurer.

F. A public adjuster's contract may not contain a provision that requires the insured to authorize an insurer to issue a check only in the name of the public adjuster.

G. A public adjuster's contract may not contain a provision that imposes collection costs or late fees.

H. The public adjuster's contract may specify that the public adjuster shall be named as a copayee on an insurer's payment of a claim, provided that (i) if the compensation is based on a share of the insurance settlement, the exact percentage shall be specified and (ii) initial expenses to be reimbursed to the public adjuster from the proceeds of the claim payment shall be specified by type, with dollar estimates set forth in the contract and with any additional expenses first approved by the insured.

I. If the insurer, not later than 72 hours after the date on which the loss is reported to the insurer, either pays or commits in writing to pay to the insured the policy limit of the insurance policy, the public adjuster shall (i) not receive a commission consisting of a percentage of the total amount paid by an

insurer to resolve a claim, (ii) inform the insured that the loss recovery amount represents the maximum amount recoverable under the policy, and (iii) be entitled only to reasonable compensation from the insured for services provided by the public adjuster on behalf of the insured, based on the time spent on a claim and expenses incurred by the public adjuster.

2012, cc. 734, 735.

§ 38.2-1845.15. Record retention.

The public adjuster shall maintain sufficient records of its affairs so that the Commission may adequately ensure that the public adjuster complies with all provisions of this chapter. The public adjuster shall retain records pertaining to each claim handled for a minimum of five years after the claim is settled. The appropriate licensing authority may prescribe the specific record entries and documents to be kept.

2012, cc. 734, 735.

§ 38.2-1845.16. Escrow or trust accounts.

All funds received by, accepted by, or held by a public adjuster on behalf of an insured toward the settlement of a claim shall be handled in a fiduciary capacity and submitted for collection to or deposited in a separate noninterest-bearing fiduciary trust account or accounts in a financial institution licensed to do business in the Commonwealth no later than the close of the second business day from the receipt or acceptance of such funds. Such funds shall be held separately from any personal or nonbusiness funds, shall not be commingled or combined with other funds, and shall be reasonably ascertainable from the books of accounts and records of the public adjuster. The public adjuster shall maintain an accurate record and itemization of the funds deposited into this account. Any such funds held by such public adjuster shall be disbursed within 30 calendar days of any invoice received by such public adjuster upon approval of the insured or claimant that the work has been satisfactorily completed.

2012, cc. 734, 735; 2019, c. 627.

§ 38.2-1845.17. Requirement to report to Commission.

A. Each licensed public adjuster shall report within 30 calendar days to the Commission any change in his residence address, email address, or name.

B. In addition to the requirements of §§ 59.1-69 and 59.1-70, any individual or business entity licensed as a public adjuster in the Commonwealth and operating under an assumed or fictitious name shall provide notice to the Commission, at the earlier of the time the application for a public adjuster license is filed or within 30 calendar days from the date the assumed or fictitious name is adopted, setting forth the name under which the public adjuster intends to operate in the Commonwealth. The Commission shall also be notified within 30 calendar days from the date of cessation of the use of such assumed or fictitious name.

C. Each licensed public adjuster shall report to the Commission any conviction involving a felony, a crime of moral turpitude, or any criminal offense involving dishonesty or breach of trust in another

jurisdiction or in the Commonwealth within 30 calendar days of the final disposition of the matter. This report shall include a copy of the order and other relevant legal documents.

D. Each licensed public adjuster shall report to the Commission within 30 calendar days of the final disposition of the matter of any administrative action taken against him in another jurisdiction or by another governmental agency in the Commonwealth. Such report shall include a copy of the order, consent order, or other relevant legal documents.

2012, cc. 734, 735; 2019, c. 675.

§ 38.2-1845.18. Information security program.

A. Each public adjuster shall implement a comprehensive written information security program that includes administrative, technical, and physical safeguards for the protection of policyholder information. The administrative, technical, and physical safeguards included in the information security program shall be appropriate to the size and complexity of the public adjuster's business and the nature and scope of its activities.

B. The information security program shall be designed to:

1. Ensure the security and confidentiality of policyholder information;

2. Protect against any anticipated threats or hazards to the security or integrity of the information; and

3. Protect against unauthorized access to or use of the information that could result in substantial harm or inconvenience to any policyholder.

2012, cc. 734, 735.

§ 38.2-1845.19. What laws applicable; rulemaking authority.

A. Except as otherwise provided in this article and except where the context otherwise requires, all of the provisions of this title apply to this article.

B. Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such rules and regulations as may be necessary or appropriate for the administration and enforcement of this article.

2012, cc. 734, 735.

§ 38.2-1845.20. Immunities; confidentiality.

A. Any documents, materials, or other information in the control or possession of the Commission that is furnished by an insurer, agent, or public adjuster or by an employee thereof acting on behalf of the insurer, agent, or public adjuster or obtained by the Commission in an investigation pursuant to this article shall be confidential by law and privileged, shall not be subject to inspection or review by the general public, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the Commission is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the Commission's duties.

B. Neither the Commission nor any person who received documents, materials, or other information while acting under the authority of the Commission shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection A.

C. In order to assist in the performance of the Commission's duties under this chapter, the Commission:

1. May share documents, material, or other information, including the confidential and privileged documents, materials, or information subject to subsection A, with other state, federal, and international regulatory agencies; the NAIC, its affiliates, or subsidiaries; and with local, state, federal, and international law-enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material, or other information.

2. May receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information, from the NAIC, its affiliates, or subsidiaries and from regulatory and law-enforcement officials of other foreign or domestic jurisdictions and shall maintain as confidential or privileged any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information.

D. No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the Commission under this section or as a result of sharing as authorized in subsection C.

E. Nothing in this chapter shall prohibit the Commission from releasing final, adjudicated actions including for cause terminations that are open to public inspection pursuant to Chapter 4 (§ 12.1-18 et seq.) of Title 12.1 to a database or other clearinghouse service maintained by the NAIC, its affiliates, or subsidiaries.

2012, cc. 734, 735.

§ 38.2-1845.21. Authority of Commission to delegate certain functions.

In order to assist in the performance of its duties, the Commission may contract with nongovernmental entities, including the NAIC, any affiliates, or subsidiaries that the NAIC oversees, to perform any ministerial functions, including licensing examination administration, the collection of fees related to public adjuster licensing, and such other functions as the Commission may deem appropriate.

2012, cc. 734, 735.

§ 38.2-1845.22. Power of Commission to investigate affairs of persons engaged in the business of public adjusting; penalties for refusal to permit investigation.

The Commission shall have power to examine and investigate the business affairs of any person engaged or alleged to be engaged in the business of public adjusting in the Commonwealth to determine whether the person has engaged or is engaging in any violation of this title. The Commission shall

have the right to examine all records relating to the business of public adjusting by any such person in the Commonwealth to determine whether the person is now or has been violating any of the provisions of this title. Any licensee under this article or any person purporting to be a licensee under this article or any person whose actions have led any person to believe that he is a licensee under this article who refuses to permit the Commission or any of its employees or agents, including employees of the Bureau of Insurance, to make an examination or who fails or refuses to comply with the provisions of this section, may, after notice and an opportunity to be heard, be subject to any of the penalties relating to licensees under this article, as provided in this title, including the termination, denial, suspension, or revocation of his license.

2012, cc. 734, 735; 2019, c. 675.

§ 38.2-1845.23. False information and advertising generally.

No person shall knowingly make, publish, disseminate, circulate, or place before the public, or cause or knowingly allow, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement relating to (i) the business of public adjusting or (ii) any person in the conduct of his business of public adjusting which is untrue, deceptive, or misleading.

2012, cc. 734, 735.

Article 5 - LICENSING OF REINSURANCE INTERMEDIARIES

§§ 38.2-1846 through 38.2-1857. Repealed.

Repealed by Acts 2001, c. 706, cl. 2, effective September 1, 2002.

Article 5.1 - LICENSING OF SURPLUS LINES BROKERS

§ 38.2-1857.1. Property and casualty insurance agents may be licensed as surplus lines brokers for certain insurance from eligible nonadmitted insurers.

The Commission may issue a surplus lines broker's license to any individual or business entity actively licensed as a property and casualty insurance agent for the procuring of insurance of the classes enumerated in §§ 38.2-109 through 38.2-122.2 and §§ 38.2-124 through 38.2-134 from eligible nonadmitted insurers in the Commonwealth. However, nothing in this article or in Chapter 48 (§ 38.2-4805.1 et seq.) shall apply to the sale, solicitation, or negotiation of (i) the contracts of insurance cited in subsection C of § 38.2-1802 or (ii) contracts of insurance for any insured whose home state, as defined in § 38.2-4805.2, is a state other than the Commonwealth.

2001, c. 706; 2011, c. 498; 2018, c. 205.

§ 38.2-1857.2. Applications for surplus lines broker license; fee required; fingerprinting.

A. Every original applicant for a surplus lines broker license shall apply for such license in a form and manner prescribed by the Commission, and containing any information the Commission requires.

Each applicant shall, at the time of applying for a license, pay a nonrefundable application processing fee in an amount and in a manner prescribed by the Commission. The prescribed application fee shall be collected by the Commission and paid directly into the state treasury and credited to the fund for the maintenance of the Bureau of Insurance as provided in subsection B of § 38.2-400.

B. Each applicant for a surplus lines broker license shall, at the time of applying for a new license, be fingerprinted in a form and manner prescribed by the Commission and shall provide personal descriptive information to be forwarded along with the applicant's fingerprints through the Central Criminal Records Exchange to the Federal Bureau of Investigation for the purpose of obtaining criminal history record information regarding such applicant. The results of the state and national records search shall be forwarded to the Commissioner or the Commissioner's designee, who shall be an employee of the Commission. The cost of fingerprinting and the criminal history record check shall be paid by the applicant. If an applicant's application for a license is denied, the Commission shall provide a copy of the information obtained from the Central Criminal Records Exchange to the applicant upon request. The information provided to the Commission shall not be disseminated except as provided in this subsection.

C. Prior to issuance of a license, the applicant shall file with the Commission a certification or attestation that the applicant has, and thereafter shall keep in force for as long as the license remains in effect, a bond in favor of the Commonwealth in the amount of $25,000 with corporate sureties licensed by the Commission. The bond shall be conditioned that the broker will conduct business under the license in accordance with the provisions of the surplus lines insurance law and that he will promptly remit the taxes provided by such law. The bond shall not be terminated unless at least 30 calendar days' prior written notice of the termination is filed with the Commission. If, prior to the expiration date of the bond, the licensed surplus lines broker fails to file with the Commission a certification or attestation that a new bond satisfying the requirements of this section has been put into effect, the surplus lines broker license shall terminate and the licensee shall be required to apply for a new surplus lines broker license.

D. Notwithstanding any other provisions of this title, a person licensed as a surplus lines broker in his home state, as defined in § 38.2-1800, shall receive a nonresident surplus lines broker license subject to meeting the requirements set forth in § 38.2-1857.9.

E. Except where prohibited by state or federal law, by submitting an application for license, the applicant shall be deemed to have appointed the clerk of the Commission as the agent for service of process on the applicant in any action or proceeding arising in the Commonwealth out of or in connection with the exercise of the license. Such appointment of the clerk of the Commission as agent for service of process shall be irrevocable during the period within which a cause of action against the applicant may arise out of transactions with respect to subjects of insurance in the Commonwealth. Service of process on the clerk of the Commission shall conform to the provisions of Chapter 8 (§ 38.2-800 et seq.).

F. A business entity acting as a surplus lines broker is required to obtain a surplus lines broker license. In addition to the other requirements in this section, and before approving the application, the Commission shall find that:

1. The business entity has paid the fee set forth in subsection A; and

2. If:

a. A resident of the Commonwealth, the business entity has designated an employee, officer, director, manager, member, or partner to serve as the licensed Virginia Property and Casualty insurance agent to be responsible for the business entity's compliance with the insurance laws, rules and regulations of the Commonwealth; or

b. Not a resident of the Commonwealth, the business entity has designated an employee, officer, director, manager, member, or partner licensed in his home state to be responsible for the business entity's compliance with the insurance laws, rules and regulations of the Commonwealth.

G. The Commission may require any documents reasonably necessary to verify the information contained in an application.

2001, c. 706; 2008, c. 213; 2011, c. 498; 2016, c. 552; 2018, c. 131; 2019, c. 675.

§§ 38.2-1857.3 , 38.2-1857.4. Repealed.

Repealed by Acts 2019, c. 675, cl. 2, effective January 1, 2021.

§ 38.2-1857.4:1. Renewal application and fee; reinstatement; waiver.

A. Beginning January 1, 2021, each individual surplus lines broker shall submit biennially to the Commission a renewal application in a form and manner prescribed by the Commission, along with a nonrefundable renewal application processing fee prescribed by the Commission, for the renewal of the license. Licenses shall be renewed biennially based on the broker's month and year of birth. The license for a surplus lines broker born in an even-numbered year shall expire at the end of the broker's birth month in even-numbered years. The license for a surplus lines broker born in an odd-numbered year shall expire at the end of the broker's birth month in odd-numbered years. Any surplus lines broker license for which the renewal application and nonrefundable renewal application processing fee have been received by the Commission and all other applicable licensing and renewal provisions in this chapter have been met shall, unless the license has been terminated, suspended, or revoked, be renewed for a two-year period. Any surplus lines broker license for which the renewal application and nonrefundable renewal application processing fee have not been received by the Commission shall automatically be terminated.

B. On or before May 1, 2021, and biennially thereafter, each business entity licensed as a surplus lines broker shall submit to the Commission a renewal application, along with a nonrefundable renewal application processing fee prescribed by the Commission, for the renewal of the license. Any surplus lines broker license for which the required renewal application and nonrefundable renewal application processing fee have been received by the Commission and all other applicable licensing

and renewal provisions in this chapter have been met shall, unless the license has been terminated, suspended, or revoked, be renewed for a two-year period. Any surplus lines broker license for which the required renewal application and nonrefundable renewal application processing fee have not been received by the Commission shall automatically be terminated.

C. The nonrefundable renewal application processing fee shall be paid in a manner and in an amount prescribed by the Commission. The nonrefundable renewal processing fee shall be collected by the Commission and paid directly into the state treasury and credited to the fund for the maintenance of the Bureau of Insurance as provided in subsection B of § 38.2-400.

D. An individual surplus lines broker whose license terminates due to failure to renew may, within 12 months from the renewal date, reinstate the same license by submitting the renewal application and a nonrefundable reinstatement processing fee equivalent to double the nonrefundable renewal application processing fee and by complying with all other applicable licensing and renewal provisions in this chapter.

E. A licensed surplus lines broker's failure to file the maintenance assessment report required by § 38.2-406 or pay the maintenance assessment and any related fines, penalties, and interest required by § 38.2-403 on or before the first day of March of each year shall result in the termination of the surplus lines broker license.

F. An individual surplus lines broker who is unable to comply with the license renewal requirements due to military service or another extenuating circumstance such as a long-term illness or incapacity may request a waiver of those requirements. Requests for waivers of renewal requirements shall be made in a form and manner prescribed by the Commission. Surplus lines brokers seeking a waiver of renewal requirements shall submit all documentation specified by the Commission so as to be received by the Commission no later than the last day of the renewal period. After the renewal period, surplus lines brokers who have failed to complete the renewal waiver requirements may request a waiver from the reinstatement requirements set forth in subsection D within the 12-month reinstatement period. The Commission shall approve or disapprove the waiver request within 30 calendar days of receipt thereof, and shall provide written notice of its decision to the applicant for waiver within five calendar days of rendering its decision. Any waiver granted pursuant to this section shall be valid only for the renewal period or reinstatement period for which the waiver request was made.

2019, c. 675.

§ 38.2-1857.5. Requirement to report to Commission.

A. Each licensed surplus lines broker shall report within 30 calendar days to the Commission any change in his residence address, email address, or name.

B. In addition to the requirements of §§ 59.1-69 and 59.1-70, any individual or business entity licensed as a surplus lines broker in the Commonwealth and operating under an assumed or fictitious name shall notify the Commission, at the earlier of the time the application for a surplus lines broker license is filed or within 30 calendar days from the date the assumed or fictitious name is adopted, setting forth

the name under which the surplus lines broker intends to operate in Virginia. The Commission shall also be notified within 30 calendar days from the date of cessation of the use of such assumed or fictitious name.

C. Each licensed surplus lines broker convicted of a felony shall report within 30 calendar days to the Commission the facts and circumstances regarding the criminal conviction.

D. Each licensed surplus lines broker shall report to the Commission within 30 calendar days of the final disposition of the matter any administrative action taken against him in another jurisdiction or by another governmental agency in the Commonwealth. Such report shall include a copy of the order, consent to order or other relevant legal documents.

E. Any licensed resident surplus lines broker who has moved his residence from the Commonwealth shall have all licenses immediately terminated by the Commission, whether or not the surplus lines broker has notified the Commission of such move. Nothing shall prohibit such surplus lines broker from applying for a license as a nonresident surplus lines broker.

F. The license authority of any business entity licensed as a surplus lines broker shall terminate immediately if the sole licensed responsible producer designated pursuant to subdivision F 2 of § 38.2-1857.2 for the business entity's compliance with the insurance laws, rules and regulations of the Commonwealth is removed for any reason, and a new responsible producer has not been designated and the Commission notified within 30 calendar days of such removal and of the newly designated responsible producer.

2001, c. 706; 2008, c. 213; 2011, c. 498; 2019, c. 675.

§ 38.2-1857.6. Accepting and placing surplus lines business.

No surplus lines broker shall accept surplus lines business from any person other than an applicant for insurance or a duly licensed property or casualty insurance agent, nor shall such surplus lines broker compensate any person other than a duly licensed property or casualty insurance agent for such business. No person other than an applicant for insurance or a duly licensed property or casualty insurance agent shall place surplus lines business with a surplus lines broker licensed under this article nor shall any person other than a duly licensed property or casualty insurance agent accept compensation for such business.

2001, c. 706; 2011, c. 498.

§ 38.2-1857.7. Grounds for placing on probation, refusal to issue or renew, revocation, or suspension of license.

The Commission may, in addition to or in lieu of a penalty imposed under § 38.2-218, place on probation, suspend, revoke or refuse to issue or renew any surplus lines broker's license for any one or more of the following causes:

1. Providing materially incorrect, misleading, incomplete or untrue information in the license application or any other document filed with the Commission;

2. Violating any insurance laws, or violating any regulation, subpoena or order of the Commission or of another state's insurance regulatory authority;

3. Obtaining or attempting to obtain a license through misrepresentation or fraud;

4. Improperly withholding, misappropriating or converting any moneys or properties received in the course of doing business;

5. Engaging in the practice of rebating;

6. Engaging in twisting or any form thereof, where "twisting" means inducing an insured to terminate an existing policy and purchase a new policy through misrepresentation;

7. Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance;

8. Having been convicted of a felony;

9. Having admitted or been found to have committed any insurance unfair trade practice or fraud;

10. Using fraudulent, coercive, or dishonest practices, or demonstrating incompetence, or untrustworthiness in the conduct of business in this Commonwealth or elsewhere, or demonstrating financial irresponsibility in the handling of applicant, policyholder, agency, or insurance company funds;

11. Having an insurance producer, surplus lines broker, or consultant license, or its equivalent, denied, suspended or revoked in any other state, province, district or territory;

12. Forging another's name to an application for insurance or to any document related to an insurance transaction;

13. Improperly using notes or any other reference material to complete an examination for an insurance license;

14. Knowingly accepting insurance business from an individual who is not licensed;

15. Failing to comply with an administrative or court order imposing a child support obligation; or

16. Failing to pay state income or premium license tax or comply with any administrative or court order directing payment of state income tax.

2001, c. 706; 2011, c. 498.

§ 38.2-1857.8. Refusal to issue and revocation of license; hearing; new application.

A. If the Commission is of the opinion that any applicant for a surplus lines broker's license is not of good character or does not have a good reputation for honesty, it may refuse to issue the license, subject to the right of the applicant to demand a hearing on the application. The Commission shall not revoke or suspend an existing license until the licensee is given an opportunity to be heard before the Commission. If the Commission refuses to issue a new license or proposes to revoke or suspend an existing license, it shall give the applicant or licensee at least ten calendar days' notice in writing of the time and place of the hearing, if a hearing is requested. The notice shall contain a statement of the

objections to the issuance of the license, or the reason for its proposed revocation or suspension as the case may be. The notice may be given to the applicant or licensee by registered or certified mail, sent to the last known address of record pursuant to § 38.2-1857.5, or the last known business address if the address of record is incorrect, or in any other lawful manner the Commission prescribes. The Commission may summon witnesses to testify with respect to the applicant or licensee, and the applicant or licensee may introduce evidence in his or its behalf. No applicant to whom a license is refused after a hearing, nor any licensee whose license is revoked, shall again apply for a license until the expiration of a period of five years from the date of the Commission's order, or such other period of time as the Commission prescribes in its order.

B. The license of a business entity may be suspended, revoked or refused if the Commission finds, after notice and an opportunity to be heard, that a violation by an individual licensee acting at the direction of, on behalf of, or with the permission of the business entity was known to be a violation by one or more of the partners, officers or managers acting on behalf of the business entity, and the violation was neither reported to the Commission nor corrective action taken.

C. In addition to or in lieu of any applicable denial, suspension or revocation of a license, a person may, after notice and an opportunity to be heard, be subject to a penalty pursuant to § 38.2-218.

D. The Commission shall retain the authority to enforce the provisions of and impose any penalty or remedy authorized by this title against any person who is under investigation for or charged with a violation of this title, even if the person's license or registration has been surrendered, terminated, suspended, revoked, or has lapsed by operation of law.

2001, c. 706.

§ 38.2-1857.9. Licensing nonresidents; clerk of the Commission to be appointed agent for service of process; reciprocal agreements with other states and Canadian provinces.

A. An individual or business entity who is not a resident as defined in § 38.2-1800, but who is a resident of another state, territory, or province of Canada, shall receive a nonresident surplus lines broker license if:

1. The applicant presents proof in a form acceptable to the Commission that the applicant is currently licensed or otherwise authorized as a resident surplus lines broker and is in good standing in his home state;

2. The applicant has submitted the proper application for licensure, or in lieu thereof has submitted a copy of the application for a Surplus Lines Broker license submitted to the home state, and has paid the fees prescribed by the Commission; and

3. The applicant's home state issues nonresident surplus lines broker licenses to residents of the Commonwealth on the same basis, or will permit a resident of the Commonwealth to act as a surplus lines broker in such state without requiring a license.

B. For the purposes of this article, any individual whose place of residence and place of business are in a city or town located partly within the Commonwealth and partly within another state may be considered as meeting the requirements as a resident of the Commonwealth, provided the other state has established by law or regulation similar requirements as to residence of such individuals.

C. The Commission may enter into a reciprocal agreement with an appropriate official of any other state or province of Canada if such an agreement is required in order for a Virginia resident to be similarly licensed as a nonresident in that state or province.

D. The Commission may verify the surplus lines broker's licensing status through the Producer Database maintained by the NAIC, its affiliates or subsidiaries.

E. A nonresident surplus lines broker who moves from one state or province to another state or province shall file a change of address within 30 calendar days of the change of legal residence. No fee or license application is required.

F. Any licenses issued to nonresidents pursuant to this section shall be terminated at any time that the nonresident's equivalent authority in his home state is terminated, suspended, or revoked.

G. As used in this section, "home state" has the same meaning that is ascribed to the term in § 38.2-1800.

2001, c. 706; 2008, c. 213; 2011, c. 498; 2019, c. 675.

Article 6 - LICENSING OF MANAGING GENERAL AGENTS

§§ 38.2-1858 through 38.2-1865. Repealed.

Repealed by Acts 2001, c. 706, cl. 2, effective September 1, 2002.

Article 6.1 - Licensing of Viatical Settlement Brokers

§ 38.2-1865.1. License required for viatical settlement brokers; Commission's authority; conditions; renewal application and fee; reinstatement; waiver; fingerprinting.

A. No person shall act as a viatical settlement broker, or solicit a viatical settlement contract while acting as a viatical settlement broker without first obtaining a license from the Commission.

B. A resident or nonresident life and annuities insurance agent shall not be prohibited from obtaining a license, and subsequently acting as, a viatical settlement broker. Such licensed life and annuities agent applying for a license as a viatical settlement broker shall comply with all provisions of this chapter.

C. Application for a viatical settlement broker license shall be made to the Commission in the manner, in the form, and accompanied by the nonrefundable license processing fee prescribed by the Commission.

D. Each individual applicant for a viatical settlement broker license shall, at the time of applying for a new license, be fingerprinted in a form and manner prescribed by the Commission and shall provide

personal descriptive information to be forwarded along with the applicant's fingerprints through the Central Criminal Records Exchange to the Federal Bureau of Investigation for the purpose of obtaining criminal history record information regarding such applicant. The results of the state and national records search shall be forwarded to the Commissioner or the Commissioner's designee, who shall be an employee of the Commission. The cost of fingerprinting and the criminal history record check shall be paid by the applicant. If an applicant's application for a license is denied, the Commission shall provide a copy of the information obtained from the Central Criminal Records Exchange to the applicant upon request. The information provided to the Commission shall not be disseminated except as provided in this subsection.

E. A business entity acting as a viatical settlement broker is required to obtain a viatical settlement broker license. In addition to the other requirements in this section, and before approving the application, the Commission shall find that:

1. The business entity has paid the fee set forth in this section; and

2. The business entity has designated an employee, officer, director, manager, member, or partner who is a licensed viatical settlement broker as the individual responsible for the business entity's compliance with the insurance and other laws of this title, and related rules and regulations of the Commonwealth.

F. The Commission may require any documents reasonably necessary to verify the information contained in an application.

G. Except where prohibited by state or federal law, by submitting an application for license, the applicant shall be deemed to have appointed the clerk of the Commission as the agent for service of process on the applicant in any action or proceeding arising in the Commonwealth out of or in connection with the exercise of the license. Such appointment of the clerk of the Commission as agent for service of process shall be irrevocable during the period within which a cause of action against the applicant may arise out of transactions with respect to subjects of insurance in the Commonwealth. Service of process on the clerk of the Commission shall conform to the provisions of Chapter 8 (§ 38.2-800 et seq.).

H. The license processing fee required by this section shall be collected by the Commission, paid directly into the state treasury, and credited to the "Bureau of Insurance Special Fund – State Corporation Commission" for the maintenance of the Bureau of Insurance as provided in subsection B of § 38.2-400.

I. Beginning January 1, 2021, each individual settlement broker shall submit biennially to the Commission a renewal application in a form and manner prescribed by the Commission, along with a nonrefundable renewal application processing fee prescribed by the Commission, for the renewal of the license. Licenses shall be renewed biennially based on the viatical settlement broker's month and year of birth. The license for a viatical settlement broker born in an even-numbered year shall expire at the end of the broker's birth month in even-numbered years. The license for a viatical settlement

broker born in an odd-numbered year shall expire at the end of the broker's birth month in odd-numbered years. Any viatical settlement broker license for which the renewal application and non-refundable renewal application processing fee have been received by the Commission and all other applicable licensing and renewal provisions in this chapter have been met shall, unless the license has been terminated, suspended, or revoked, be renewed for a two-year period. Any viatical settlement broker license for which the renewal application and nonrefundable renewal application processing fee have not been received by the Commission shall automatically be terminated.

J. On or before May 1, 2021, and biennially thereafter, each business entity licensed as a viatical settlement broker shall submit to the Commission a renewal application, along with a nonrefundable renewal application processing fee prescribed by the Commission, for the renewal of the license. Any viatical settlement broker license for which the renewal application and nonrefundable renewal application processing fee have been received by the Commission and all other applicable licensing and renewal provisions in this chapter have been met shall, unless the license has been terminated, suspended, or revoked, be renewed for a two-year period. Any viatical settlement broker license for which the renewal application and nonrefundable renewal application processing fee have not been received by the Commission shall automatically be terminated.

K. The nonrefundable renewal application processing fee shall be paid in a manner and in an amount prescribed by the Commission. The nonrefundable renewal application processing fee shall be collected by the Commission and paid directly into the state treasury and credited to the fund for the maintenance of the Bureau of Insurance as provided in subsection B of § 38.2-400.

L. An individual viatical settlement broker whose license terminates due to failure to renew may, within 12 months from the renewal date, reinstate the same license by submitting the renewal application and a nonrefundable reinstatement processing fee equivalent to double the nonrefundable renewal application processing fee.

M. An individual viatical settlement broker who is unable to comply with the license renewal requirements due to military service or another extenuating circumstance such as a long-term illness or incapacity may request a waiver of those requirements. Requests for waivers of renewal requirements shall be made in a form and manner prescribed by the Commission. Viatical settlement brokers seeking a waiver of renewal requirements shall submit all documentation specified by the Commission so as to be received by the Commission no later than the last day of the renewal period. After the renewal period, viatical settlement brokers who have failed to complete the renewal waiver requirements may request a waiver from the reinstatement requirements set forth in subsection L within the 12-month reinstatement period. The Commission shall approve or disapprove the waiver request within 30 calendar days of receipt thereof, and shall provide written notice of its decision to the applicant for waiver within five calendar days of rendering its decision. Any waiver granted pursuant to this section shall be valid only for the renewal period or reinstatement period for which the waiver request was made.

N. Each applicant for a viatical settlement broker license shall provide satisfactory evidence that no disciplinary action has resulted in the suspension or revocation of any federal or state license pertaining to the business of viatical settlements or to the insurance or other financial services business.

O. In the absence of a written agreement making the broker the viator's agent, viatical settlement brokers are presumed to be agents of viatical settlement providers.

P. A viatical settlement broker shall not, without the written agreement of the viator obtained before performing any services in connection with a viatical settlement, seek or obtain any compensation from the viator.

2001, c. 706; 2003, c. 717; 2008, c. 213; 2016, c. 552; 2018, c. 131; 2019, c. 675.

§ 38.2-1865.2. Grounds for placing on probation, refusal to issue or renew, revocation, or suspension of license.

The Commission may, in addition to or in lieu of a penalty imposed under § 38.2-218, place on probation, suspend, revoke or refuse to issue or renew any person's license for any one or more of the following causes:

1. Providing materially incorrect, misleading, incomplete or untrue information in the license application or any other document filed with the Commission;

2. Violating any insurance laws, or violating any regulation, subpoena or order of the Commission or of another state's insurance regulatory authority;

3. Obtaining or attempting to obtain a license through misrepresentation or fraud;

4. Improperly withholding, misappropriating or converting any moneys or properties received in the course of doing business;

5. Engaging in the practice of rebating;

6. Engaging in twisting or any form thereof, where "twisting" means inducing an insured to terminate an existing policy and purchase a new policy through misrepresentation;

7. Intentionally misrepresenting the terms of an actual or proposed insurance or viatical settlement contract or application therefor;

8. Having been convicted of a felony;

9. Having admitted or been found to have committed any insurance unfair trade practice or fraud;

10. Using fraudulent, coercive, or dishonest practices, or demonstrating incompetence, or untrustworthiness in the conduct of business in this Commonwealth or elsewhere, or demonstrating financial irresponsibility in the handling of applicant, policyholder, agency, or insurance company funds;

11. Having an insurance producer, viatical settlement broker, or consultant license, or its equivalent, denied, suspended or revoked in any other state, province, district or territory;

12. Forging another's name to an application for insurance or to any document related to an insurance or viatical settlement transaction;

13. Improperly using notes or any other reference material to complete an examination for an insurance license;

14. Knowingly accepting insurance business from an individual who is not licensed;

15. Placing or attempting to place a viatical settlement with a viatical settlement provider not licensed in this Commonwealth;

16. Failing to comply with an administrative or court order imposing a child support obligation; or

17. Failing to pay state income tax or comply with any administrative or court order directing payment of state income tax.

2001, c. 706.

§ 38.2-1865.3. Refusal to issue and revocation of license; hearing; new application.

A. If the Commission is of the opinion that any applicant for a viatical settlement broker's license is not of good character or does not have a good reputation for honesty, it may refuse to issue the license, subject to the right of the applicant to demand a hearing on the application. The Commission shall not revoke or suspend an existing license until the licensee is given an opportunity to be heard before the Commission. If the Commission refuses to issue a new license or proposes to revoke or suspend an existing license, it shall give the applicant or licensee at least ten calendar days' notice in writing of the time and place of the hearing, if a hearing is requested. The notice shall contain a statement of the objections to the issuance of the license, or the reason for its proposed revocation or suspension as the case may be. The notice may be given to the applicant or licensee by registered or certified mail, sent to the last known address of record pursuant to § 38.2-1865.5, the last known business address if the address of record is incorrect, or in any other lawful manner the Commission prescribes. The Commission may summon witnesses to testify with respect to the applicant or licensee, and the applicant or licensee may introduce evidence in his or its behalf. No applicant to whom a license is refused after a hearing, nor any licensee whose license is revoked, shall again apply for a license until the expiration of a period of five years from the date of the Commission's order, or such other period of time as the Commission prescribes in its order.

B. The license of a business entity may be suspended, revoked or refused if the Commission finds, after notice and an opportunity to be heard, that a violation by an individual licensee acting at the direction of, on behalf of, or with the permission of the business entity was known to be a violation by one or more of the partners, officers or managers acting on behalf of the business entity, and the violation was neither reported to the Commission nor corrective action taken.

C. In addition to or in lieu of any applicable denial, suspension or revocation of a license, a person may, after notice and an opportunity to be heard, be subject to a penalty pursuant to § 38.2-218.

D. The Commission shall retain the authority to enforce the provisions of and impose any penalty or remedy authorized by this title against any person who is under investigation for or charged with a violation of this title, even if the person's license or registration has been surrendered, terminated, suspended, revoked, or has lapsed by operation of law.

2001, c. 706.

§ 38.2-1865.4. Licensing nonresidents; reciprocal agreements with other states and Canadian provinces.

A. An individual or business entity who is not a resident as defined in § 38.2-1800, but who is a resident of another state or a province of Canada, shall receive a viatical settlement broker license if:

1. The applicant presents proof in a form acceptable to the Commission that the applicant is currently licensed or otherwise authorized as a resident viatical settlement broker and is in good standing in his home state or province;

2. The applicant has submitted the proper application for licensure and has paid the fees required by § 38.2-1865.1; and

3. The applicant's home state or province issues nonresident viatical settlement broker licenses to residents of this Commonwealth on the same basis, or will permit a resident of this Commonwealth to act as a viatical settlement broker in such state or province without requiring a license.

B. For the purposes of this chapter, any individual whose place of residence and place of business are in a city or town located partly within the Commonwealth and partly within another state may be considered as meeting the requirements as a resident of this Commonwealth, provided the other state has established by law or regulation similar requirements as to residence of such individuals.

C. The Commission may enter into a reciprocal agreement with an appropriate official of any other state or province of Canada if such an agreement is required in order for a Virginia resident to be similarly licensed as a nonresident in that state or province.

D. The Commission may verify the viatical settlement broker's licensing status through the Producer Database maintained by the NAIC, its affiliates or subsidiaries.

E. A nonresident viatical settlement broker who moves from one state or province to another state shall file a change of address and provide a certification from the new home state or province within thirty calendar days of the change of legal residence. No fee or license application is required.

F. Any licenses issued to nonresidents pursuant to this section shall be terminated at any time that the nonresident's equivalent authority in his home state or province is terminated, suspended, or revoked.

2001, c. 706; 2008, c. 213.

§ 38.2-1865.5. Requirement to report to Commission.

A. Each licensed viatical settlement broker shall report, in writing, any change in business or residence address, email address, or name within 30 calendar days to the Commission.

B. In addition to the requirements of §§ 59.1-69 and 59.1-70, any individual or business entity licensed as a viatical settlement broker in the Commonwealth and operating under an assumed or fictitious name shall notify the Commission, at the earlier of the time the application for a viatical settlement broker license is filed or within 30 calendar days from the date the assumed or fictitious name is adopted, setting forth the name under which the viatical settlement broker intends to operate in Virginia. The Commission shall also be notified within 30 calendar days from the date of cessation of the use of such assumed or fictitious name.

C. Each licensed viatical settlement broker convicted of a felony shall report within 30 calendar days to the Commission the facts and circumstances regarding the criminal conviction.

D. Each licensed viatical settlement broker shall report to the Commission within 30 calendar days of the final disposition of the matter any administrative action taken against him in another jurisdiction or by another governmental agency in the Commonwealth. Such report shall include a copy of the order, consent to order, or other relevant legal documents.

E. The license authority of any licensed resident viatical settlement broker shall terminate immediately when such viatical settlement broker has moved his residence from the Commonwealth, whether or not the Commission has been notified of such move.

F. The license authority of any business entity licensed as a viatical settlement broker shall terminate immediately if the designated licensed viatical settlement broker responsible for the business entity's compliance with the insurance laws, rules, and regulations of the Commonwealth pursuant to subdivision E 2 of § 38.2-1865.1 is removed for any reason and a new responsible viatical settlement broker has not been designated and the Commission notified within 30 calendar days of such removal and of the new designated responsible viatical settlement broker.

2001, c. 706; 2016, c. 552; 2019, c. 675.

Article 6.2 - LICENSING OF SURETY BAIL BONDSMEN

§§ 38.2-1865.6 through 38.2-1865.13. Repealed.

Repealed by Acts 2004, c. 460, effective July 1, 2005.

Article 7 - Continuing Education

§ 38.2-1866. Continuing education requirements.

A. Every individual resident and nonresident (i) insurance consultant, (ii) life and annuities insurance agent, (iii) health agent, (iv) property and casualty insurance agent (v) personal lines agent, and (vi) title insurance agent shall, on a biennial basis, furnish evidence as set forth in this article that the continuing education requirements of this article have been satisfied. As used in this article, the term "agent" shall be construed to refer to any of the individual licensees referred to above.

B. Every individual resident and nonresident public adjuster shall, on a biennial basis, furnish evidence as set forth in this article that the continuing education requirements of this article have been satisfied.

C. Any agent who holds a life and annuities license or a health agent license, or both, shall complete 16 hours of relevant continuing education credits.

D. Any agent who holds a personal lines license or a property and casualty license shall complete 16 hours of relevant continuing education credits.

E. Any agent who holds a title agent license shall complete 16 hours of relevant continuing education credits.

F. A public adjuster shall complete 24 hours of relevant continuing education credits.

G. Except as provided in subsection B and § 38.2-1871, any agent who holds licenses from more than one category of licenses identified in subsection A shall complete 24 hours of relevant continuing education credits with a minimum of eight credit hours in each such category.

H. Of the total required credits for each biennium, an agent shall complete three credit hours in insurance ethics, which may include insurance law and regulations applicable in the Commonwealth.

I. Of the total required credits for each biennium, a public adjuster shall complete three credit hours in insurance ethics.

J. Agents may receive no more than 75 percent of their required credits from courses provided by insurance companies or agencies. The Board, in its sole discretion, shall, at the time of course approval, determine whether any particular course shall be considered to be insurance company or agency sponsored and shall require all course sponsors to provide this information clearly and conspicuously to all those enrolling in that course.

1992, c. 570; 1994, c. 175; 1996, c. 159; 1998, c. 46; 1999, c. 86; 2001, c. 706; 2012, c. 294; 2021, Sp. Sess. I, c. 441.

§ 38.2-1867. Insurance continuing education board; approval of credits.

A. An insurance continuing education board, hereinafter called the Board, appointed by the Commission, shall approve all continuing education instructors, programs of instruction, and courses, including technical courses or agency management and operations courses, and shall evaluate credit hours for all programs or courses offered. The Board shall establish and monitor standards for the education of insurance agents and public adjusters and set minimum requirements for course instructors. The Board shall have the authority to disapprove or withdraw approval of course sponsors, courses, or course instructors when the established standards are not satisfied, or where such standards have been violated.

B. The number of credits for each self-study course, correspondence course, or program of classroom instruction shall be determined in a manner prescribed by the Board. However, for an approved

classroom course, a credit hour shall be equivalent to a classroom hour providing at least 50 minutes of continuous instruction or participation. No credits shall be granted for approved classroom courses unless notice to the Board is accompanied by proof of attendance by the course provider. No credits shall be granted for any correspondence or self-study course that does not include a test of the subject matter which shall be successfully completed by each agent requesting credit. The Board shall have the right to review and approve or disapprove the proposed test as part of the course approval process.

C. An instructor of an approved continuing education course shall be eligible to receive the same number of credits as a person enrolled in the course for the purpose of meeting the continuing education course requirements of this article. However, agents, public adjusters, and instructors may apply credits for attending or teaching the same course only once during the two-year period set forth in subsection B of § 38.2-1868.1.

D. Any agent with excess credit hours accumulated during the two-year period set forth in subsection B of § 38.2-1868.1 may carry such hours forward to the next biennium only.

E. Members of the Board shall be appointed by the Commission as follows:

1. One active member of the Independent Insurance Agents of Virginia, as recommended by the Independent Insurance Agents of Virginia;

2. One active member of the Professional Insurance Agents of Virginia and the District of Columbia, as recommended by the Professional Insurance Agents of Virginia and the District of Columbia;

3. One active member of the National Association of Insurance and Financial Advisors of Virginia, as recommended by the National Association of Insurance and Financial Advisors of Virginia;

4. One active member of the Virginia Land Title Association, as recommended by the Virginia Land Title Association;

5. One active member of the Virginia Association of Health Underwriters, as recommended by the Virginia Association of Health Underwriters;

6. Three representatives of the property and casualty insurance industry;

7. Three representatives of the life and health insurance industry; and

8. One representative of the adult education or higher education field.

F. No person shall serve as a member of the Board if, in the opinion of the Commission, such person (i) prepares, submits for approval, or teaches insurance continuing education courses in Virginia or in any other jurisdiction, other than as an incidental part of such person's employment, or (ii) no longer meets the criteria on which the original appointment to the Board was based pursuant to subsection E.

G. No meeting of the Board or any subcommittee of the Board shall be held unless timely notice of such meeting has been provided to the Commission's Bureau of Insurance. At any such meeting of the Board or any subcommittee of the Board, one or more representatives from the Bureau of

Insurance shall be permitted to attend and to participate in such meeting, except that such Bureau of Insurance representative or representatives shall not have the right to vote on any matters before the Board.

H. Actions of the Board shall be exempt from the application of the Administrative Process Act (§ 2.2-4000 et seq.).

1992, c. 570; 1996, c. 159; 2001, cc. 350, 706; 2004, c. 765; 2019, c. 675; 2021, Sp. Sess. I, c. 441.

§ 38.2-1868. Repealed.

Repealed by Acts 1996, c. 159.

§ 38.2-1868.1. Proof of compliance with continuing education requirements; waivers.

A. As used in this article:

"Proof of compliance" means all fees prescribed by the Board and all documents and forms specified by the Board for demonstrating completion of Board-approved continuing education courses relevant to the license held and for the required number of hours.

"Received by the Board or its administrator" means delivered into the possession of the Board or its administrator in a form and manner prescribed by the Board.

B. Each agent and public adjuster holding one or more licenses subject to the continuing education requirements of this article shall complete all continuing education course or waiver requirements and shall submit to the Board or its administrator proof of compliance with such requirements in the form and manner required by the Board biennially, based on the agent's or public adjuster's month and year of birth. An agent or public adjuster born in an even-numbered year shall complete all continuing education course or waiver requirements and shall submit proof of compliance by the end of the agent's or public adjuster's birth month in even-numbered years. An agent or public adjuster born in an odd-numbered year shall complete all continuing education course or waiver requirements and shall submit proof of compliance by the end of the agent's or public adjuster's birth month in odd-numbered years.

C. A licensed agent or public adjuster who is unable to comply with the continuing education requirements of this article due to military service or other extenuating circumstances, including long-term illness or incapacity may request a waiver of such requirements. Requests for waivers of continuing education requirements shall be made in a form and manner prescribed by the Board. An agent or public adjuster seeking a waiver of some or all of the continuing education requirements shall submit all documentation, forms, and fees specified by the Board so as to be received by the Board or its administrator no later than the last day of the two-year period set forth in subsection B and in §§ 38.2-1825.1, 38.2-1840, and 38.2-1845.8. After the two-year period, an agent or public adjuster who has failed to complete the continuing education requirements may request a waiver of the continuing education reinstatement requirements set forth in subsection E of § 38.2-1825.1, subsection E of § 38.2-1840, and subsection E of § 38.2-1845.8 within the 12-month reinstatement period described therein. The Board shall approve or disapprove the waiver request within 30 days of receipt thereof and shall

provide written notice of its decision to the waiver applicant within five days of rendering its decision. Any waiver granted pursuant to this subsection shall be valid only for the biennium for which waiver application was made.

D. All fees specified by the Board shall be nonrefundable once received by the Commission, the Board, or the Board's administrator, except that duplicate payments may be refunded.

1996, c. 159; 1998, c. 46; 2000, c. 522; 2001, c. 706; 2006, c. 589; 2012, c. 294; 2016, c. 285; 2018, c. 668; 2019, c. 675; 2021, Sp. Sess. I, c. 441.

§ 38.2-1869. Failure to satisfy requirements; termination of license.

A. Failure of an agent or public adjuster to complete all continuing education course or waiver requirements, pay any fee imposed by the Board, or otherwise furnish proof of compliance during the two-year period set forth in subsection B of § 38.2-1868.1, or to complete the license renewal requirements set forth in § 38.2-1825.1, 38.2-1840, or 38.2-1845.8, shall result in the termination, pursuant to § 38.2-1825.1, 38.2-1840, or 38.2-1845.8, of each license held by the agent or public adjuster for which the requirements of this article were not satisfied.

B. Neither the Board, its administrator, nor the Commission shall have the power to grant an agent or public adjuster additional time for completing the continuing education credits required by § 38.2-1866, or additional time for seeking waivers or submitting proof of compliance as required by § 38.2-1868.1.

C. An agent or public adjuster whose license has been terminated pursuant to § 38.2-1825.1, 38.2-1840, or 38.2-1845.8 for failure to satisfy the continuing education requirements of this article may appeal the determination of noncompliance to the Board. However, failure of an agent or public adjuster to provide notice of appeal in the form and manner prescribed by the Board within 30 calendar days following expiration of the two-year period set forth in subsection B of § 38.2-1868.1 and in §§ 38.2-1825.1, 38.2-1840, and 38.2-1845.8 shall be deemed a waiver by such agent or public adjuster of the right to appeal the determination of noncompliance with the Board.

D. Pursuant to the requirements of subsection C of § 38.2-1815 and §§ 38.2-1857.1 and 55.1-1003, respectively:

1. A resident variable contract agent whose life and annuities insurance agent license is terminated for failure to satisfy the requirements of this article shall also have such variable contract license terminated by the Commission;

2. A resident agent holding a license as a surplus lines broker whose property and casualty insurance agent license is terminated for failure to satisfy the requirements of this article shall also have such surplus lines broker license terminated by the Commission; and

3. An agent holding a registration as a title settlement agent whose title insurance agent license is terminated for failure to satisfy the requirements of this article shall also have such registration as a title settlement agent terminated by the Commission.

Any such license or registration so terminated may be applied for again after the agent has obtained, respectively, a new life and annuities insurance agent's license, a new property and casualty insurance agent's license, or a new title insurance agent's license and appointment, if appointment is required.

E. An insurance consultant who fails to renew his insurance consultant license by the date specified in § 38.2-1840, but who reinstates his insurance consultant license within 12 months following such renewal date shall be treated, for purposes of determining exemption from continuing education requirements pursuant to § 38.2-1871, as if such insurance consultant license had been renewed in a timely manner.

F. A resident public adjuster whose license has been terminated under the terms of this section and whose license is not reinstated pursuant to § 38.2-1845.8 shall be permitted to make application for a new license if all of the requirements of § 38.2-1845.2 are met.

1992, c. 570; 1994, c. 175; 1995, c. 554; 1996, c. 159; 1997, c. 583; 1998, c. 46; 2000, c. 522; 2001, c. 706; 2002, c. 296; 2006, c. 589; 2010, c. 281; 2012, c. 294; 2016, c. 285; 2018, c. 668; 2019, c. 675; 2021, Sp. Sess. I, c. 441.

§ 38.2-1870. Repealed.

Repealed by Acts 2019, c. 675, cl. 2, effective January 1, 2021.

§ 38.2-1871. Licensees not subject to the continuing education requirements of this article.

A. A resident or nonresident agent or public adjuster who has been issued a license during the last 13 months of the two-year period set forth in subsection B of § 38.2-1868.1 and in §§ 38.2-1825.1, 38.2-1840, and 38.2-1845.8 shall be exempt from fulfilling the continuing education course requirements set forth in this article for that license for that biennium.

B. The following licensees are not subject to the continuing education course requirements set forth in this article:

1. Life and health insurance consultants who are also licensed both as life and annuities insurance agents and as health agents and who satisfy the continuing education course requirements needed for continuation of their life and annuities and health agent licenses;

2. Property and casualty insurance consultants who are also licensed as property and casualty agents and who satisfy the continuing education course requirements needed for continuation of their property and casualty agent license;

3. Nonresident agents who have met the continuing education requirements of their home state and whose home state gives credit to residents of the Commonwealth on the same basis;

4. Nonresident public adjusters who have met the continuing education requirements of their home state and whose home state gives credit to residents of the Commonwealth on the same basis; and

5. Agents who have applied for and received a permanent exemption from the continuing education course requirements set forth in this article by December 31, 2018.

1992, c. 570; 1994, c. 175; 1996, c. 159; 1997, c. 583; 2000, c. 522; 2001, cc. 32, 706; 2018, c. 668; 2019, c. 675; 2021, Sp. Sess. I, c. 441.

§ 38.2-1872. Administrative duties of Board; transfer to outside administrator.

A. The Board shall have the authority to transfer all or part of its administrative duties to an outside administrator. The performance of the administrator shall be confirmed at least annually by the Board and appropriate corrective action shall be taken for any deficiencies. Such administrator shall maintain records reflecting the continuing education status of all licensed agents reporting credits to it, subject to the requirements of this article.

B. The Board or its administrator shall be provided such information from the Commission's records as the Board may reasonably require in order to carry out its duties, including, but not limited to, (i) requesting and receiving from the Commission computer-generated reports, mailing labels, or other computer-generated information containing the names, license identification numbers, license types, and residence addresses of all licensees subject to the requirements of this article and (ii) direct online access to such automated system data as the Commission may deem appropriate.

1992, c. 570; 1996, c. 159; 1998, c. 46; 2000, c. 522; 2001, c. 706; 2012, c. 294; 2018, c. 668; 2019, c. 675.

§ 38.2-1873. Continuing insurance education fees.

The continuing insurance education program established by this article shall be self-supporting, and any costs incurred by the Board, its members, its administrator, or the Commission in connection with the good faith execution of their respective duties pertaining to the continuing education of insurance agents and public adjusters licensed in the Commonwealth shall be borne by the continuing insurance education fees paid by agents, public adjusters, course sponsors, and course instructors, which fees, except for duplicate payments, shall be nonrefundable upon receipt.

1992, c. 570; 1996, c. 159; 2012, c. 294; 2019, c. 675; 2021, Sp. Sess. I, c. 441.

§ 38.2-1874. Continuing education program; plan of operation; approval by Commission.

A. The Board shall submit to the Commission a plan of operation that provides for the fair and nondiscriminatory administration of the continuing insurance education program established pursuant to this article. Such plan shall not become effective until approved by the Commission in writing. The Board may, at any time, propose amendments to the plan of operation, and such amendments shall not become effective until approved by the Commission. The plan of operation shall:

1. Establish guidelines for the Board to utilize in adopting procedures for exercising its powers and duties;

2. Establish guidelines for the Board to utilize in adopting procedures for handling the assets of the continuing insurance education program;

3. Establish guidelines for reimbursing members of the Board for the necessary expenses incurred in the performance of their official duties and for indemnifying members for all expenses and liabilities incurred as a result of their serving as members of the Board;

4. Establish guidelines for determining places and times for meetings of the Board;

5. Establish guidelines for adopting procedures for records to be kept of all financial transactions of the Board and administrator;

6. Establish procedures for the election of Board officers;

7. Establish guidelines pursuant to which the Board may adopt a reasonable means whereby any person aggrieved by an action of the Board or administrator may appeal such action to the Board and, after written request, be heard in person or by an authorized representative to review the grievance. Guidelines may include additional levels of appeal other than those set forth herein, but shall provide, at a minimum, that (i) if the Board or its administrator fails to grant or reject the grievance within 15 calendar days after it is made, the person filing the grievance may proceed in the same manner as if his grievance had been rejected; (ii) any person adversely affected by the action of the Board or its administrator on such request may, within 15 calendar days after written notice of the action, make a written request for informal review by the Bureau of Insurance, which shall affirm or reverse the action upon not less than 10 calendar days' written notice to the person and to the Board or its administrator; and (iii) any person adversely affected by the action of the Bureau of Insurance on such request may, within 15 calendar days after written notice of the action, appeal to the Commission pursuant to the Commission's "Rules of Practice and Procedure." The Commission may affirm or reverse the action upon not less than 10 calendar days' written notice to the person and to the Board or its administrator; and

8. Contain guidelines for the Board to utilize in adopting additional provisions necessary or proper for the execution of the powers and duties of the Board including but not limited to (i) program requirements and approved programs of study; (ii) qualifications and responsibilities of course instructors; (iii) management and record-keeping responsibilities; (iv) fee schedules and filing requirements; and (v) course refund policies and procedures.

B. If the Commission disapproves all or any part of the proposed plan of operation or amendment thereto, the Board shall within 15 calendar days submit for review an appropriate revised plan of operation or amendment thereto. If the Board fails to do so, the Commission shall promulgate a plan of operation or an amended plan of operation. The plan of operation or amended plan of operation approved or promulgated by the Commission shall become effective and operational upon order of the Commission.

C. A regular meeting of the Board shall be held at least annually at such time, date, and place approved by the Board. Special meetings may be called at any time by the chairman. Notices of all regular and special meetings shall be sent to each person serving as a representative on the Board or a subcommittee of the Board and to the Commission. Each notice shall state the purpose of the

meeting and include any proposed changes in rules or procedures. Any such meeting notices shall be given in such form as may be acceptable to the Board at least 20 calendar days prior to the date of the meeting.

D. The books of account, records, reports and other documents of the Board and its administrator shall be open to the Commission for examination at all reasonable hours.

E. There shall be no liability on the part of and no cause of action shall arise against any member of the Board, the Board, the Board's agents or employees, or the Commission or its representatives for any action taken or statement made by them in good faith in the performance of their powers and duties under this article.

1992, c. 570; 1994, c. 175; 1996, c. 159; 2001, c. 706; 2010, c. 335; 2012, c. 294.

Article 8 - PORTABLE ELECTRONICS INSURANCE

§ 38.2-1875. Definitions.

As used in this article, unless the context requires a different meaning:

"Covered customer" means a customer who elects coverage under a portable electronics insurance policy issued to a vendor of portable electronics.

"Customer" means a person who purchases portable electronics or services.

"Portable electronics" means electronic devices that are portable in nature, accessories to such devices, and services related to the use of the devices.

"Portable electronics insurance" means insurance providing coverage for the repair or replacement of portable electronics that may cover portable electronics against any one or more of the following causes of loss: loss, theft, mechanical failure, malfunction, damage, or other applicable peril. "Portable electronics insurance" does not include: (i) an extended service contract governed by Chapter 34 (§ 59.1-435 et seq.) of Title 59.1; (ii) a policy of insurance covering a seller's or a manufacturer's obligations under a warranty; or (iii) a homeowner's, renter's, private passenger automobile, commercial multi-peril, or similar policy.

"Portable electronics transaction" means (i) the sale or lease of portable electronics by a vendor to a customer or (ii) the sale of a service related to the use of portable electronics by a vendor to a customer.

"Vendor" means a person in the business of engaging in portable electronics transactions directly or indirectly.

2011, c. 222.

§ 38.2-1876. Licensure of vendors.

A. A vendor is required to hold a limited lines property and casualty insurance agent license to sell or offer coverage under a policy of portable electronics insurance.

B. On or before May 1, 2021, and biennially thereafter, each vendor licensed as a limited lines property and casualty insurance agent shall submit to the Commission a renewal application, along with a nonrefundable renewal application processing fee prescribed by the Commission, for the renewal of the license. Any limited lines property and casualty insurance agent license for which the renewal application and nonrefundable renewal application processing fee have been received by the Commission and all other applicable licensing and renewal provisions in this chapter have been met shall, unless the license has been terminated, suspended, or revoked, be renewed for a two-year period. Any limited lines property and casualty insurance agent license for which the renewal application and nonrefundable renewal application processing fee have not been received by the Commission shall automatically be terminated.

C. A license issued under this article shall authorize any employee or authorized representative of a licensed vendor to sell or offer portable electronics insurance coverage under a policy of portable electronics insurance to a customer at each location at which the vendor engages in portable electronics transactions.

D. The acts of a licensed vendor's employee or authorized representative offering to sell coverage under a policy of portable electronics insurance shall be deemed to be the acts of the vendor for purposes of this article.

E. Every licensed vendor shall maintain a list of all locations in the Commonwealth where the vendor offers coverage under a policy of portable electronics insurance and shall make the list available to the Commissioner for inspection upon request.

F. Notwithstanding any other provision of law, a license issued pursuant to this article shall authorize the licensed vendor's employees and authorized representatives to engage only in those activities that are expressly permitted in this article.

2011, c. 222; 2019, c. 675.

§ 38.2-1877. Requirements for sale of portable electronics insurance.

A. At every location where portable electronics insurance is offered to customers, the vendor shall make available to a prospective customer brochures or other written materials that:

1. Disclose that portable electronics insurance may provide a duplication of coverage already provided by a customer's homeowner's insurance policy, renter's insurance policy, or other source of coverage;

2. State that the purchase of coverage by a customer of portable electronics insurance is not required in order to purchase or lease portable electronics or services;

3. Summarize the material terms of the insurance coverage, including: (i) the identity of the insurer; (ii) the amount of any applicable deductible and how it is to be paid; (iii) benefits of the coverage; and (iv) key terms and conditions of coverage such as whether portable electronics may be repaired or

replaced with similar make and model reconditioned or nonoriginal manufacturer parts or equipment; and

4. Summarize the process for filing a claim, including a description of (i) any requirements to return portable electronics and the maximum fee applicable in the event the customer fails to comply with any equipment return requirements and (ii) proof of loss requirements.

B. Portable electronics insurance may be offered on a month-to-month or other periodic basis as an individual policy or a group or master commercial inland marine policy issued to a vendor of portable electronics under which the individual customer may elect to purchase coverage.

C. An insurer or vendor of portable electronics insurance may issue notices and correspondence by mail or by electronic means as set forth in this subsection. The consumer may provide an electronic mail address to the insurer or vendor of portable electronics which shall be considered to be the customer's consent to receive notices and correspondence by electronic means so long as a disclosure to that effect is provided to the customer within 30 days following the purchase of portable electronics insurance.

2011, c. 222; 2019, c. 523.

§ 38.2-1878. Authority of vendors of portable electronics.

A. The employees and authorized representatives of vendors may sell or offer portable electronics insurance to customers and shall not be subject to licensure as an insurance producer under this chapter provided that:

1. The vendor obtains a limited lines property and casualty insurance agent license;

2. The vendor selling the portable electronics insurance provides a training program for all employees and authorized representatives of the vendor. The training program shall consist of instruction about the portable electronics insurance offered to customers, the disclosures required under § 38.2-1877, and the conduct prohibited by § 38.2-512. The training required by this subdivision may be delivered in person or in an electronic form. The licensed producer designated by the vendor as being responsible for its compliance with the insurance laws, rules, and regulations of the Commonwealth, as required by § 38.2-1820, shall hold a property and casualty insurance agent license and shall supervise the administration of the training program required by this subdivision;

3. No employee or authorized representative of a vendor of portable electronics is compensated based primarily on the number of customers who purchase portable electronics insurance coverage but may receive compensation for activities under the limited lines license that is incidental to their overall compensation; and

4. The employee or authorized representative of the vendor of portable electronics insurance does not represent or otherwise hold himself out as a licensed insurance producer.

B. The license authority of any vendor licensed as a limited lines property and casualty producer selling portable electronics insurance shall terminate immediately if the sole licensed responsible

producer designated for the vendor's compliance with the insurance laws, rules, and regulations of the Commonwealth is removed for any reason, a new responsible producer has not been appointed, and the Commission notified within 30 calendar days of such removal and of the newly designated responsible producer.

C. A vendor shall report any violation of this article to the Commissioner within 30 days of discovery of the violation by the vendor.

D. Any charge to the customer for portable electronics insurance that is not included in the cost associated with the purchase or lease of portable electronics or related services shall be separately itemized on the customer's bill. If the charge for portable electronics insurance is included in the cost associated with the purchase or lease of portable electronics or related services, the vendor shall clearly and conspicuously disclose to the customer that the charge for the portable electronics or services covers the cost of the insurance.

E. The charges for portable electronics insurance coverage may be billed and collected by the vendor of portable electronics insurance. Vendors billing and collecting premiums for portable electronics insurance shall be required to comply with the provisions of § 38.2-1813. Vendors may receive compensation for billing and collection services.

F. Notwithstanding any other provision of law, applicants for licensure pursuant to this article whose home state does not issue a producer license with a similar line of authority as the license authorized by this article shall be issued a limited lines property and casualty license for portable electronics insurance. Any licensee whose home state does not have property and casualty limited lines for portable electronics insurance or similar line of authority in its home state after July 1, 2014, or such later date as may be determined by the Commission, shall obtain a full property and casualty license or its license shall terminate in Virginia. For purposes of this subsection, "home state" means the District of Columbia and any state or territory of the United States except Virginia, or any province of Canada, in which an applicant maintains such person's principal place of residence or principal place of business.

2011, c. 222; 2013, c. 9.

§ 38.2-1879. Suspension or revocation of license.

If a vendor of portable electronics or its employee or authorized representative violates any provision of this article, the Commission may do any of the following:

1. After notice and hearing, impose fines and penalties in accordance with § 38.2-218; and

2. After notice and hearing, impose any such other penalties that the Commission deems necessary and reasonable to carry out the purpose of this article, including: (i) suspending the privilege of transacting portable electronics insurance pursuant to this article at specific business locations where violations have occurred; (ii) suspending or revoking the ability of individual employees or authorized

representatives to act under the license; and (iii) imposing a penalty in accordance with § 38.2-218 on the licensed producer designated by the vendor pursuant to § 38.2-1820.

2011, c. 222.

§ 38.2-1880. What laws applicable; rulemaking authority.

A. Except as otherwise provided in this article and except where the context otherwise requires, all of the provisions of this title apply to this article.

B. Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such rules and regulations as may be necessary or appropriate for the administration and enforcement of this article.

2011, c. 222.

Article 8.1 - SELF STORAGE INSURANCE

§ 38.2-1881. Definitions.

As used in this article, unless the context requires a different meaning:

"Covered customer" means a customer who elects coverage under a self storage insurance policy issued to a lessor of self storage units.

"Customer" means a person who leases a self storage unit.

"Lessor" means a person in the business of engaging in self storage unit transactions directly or indirectly.

"Self storage insurance" means insurance providing coverage against loss of or damage to items of personal property stored in a self storage unit in accordance with the terms of the self storage unit rental agreement. Self storage insurance may cover the items of personal property against any one or more of the following causes of loss: fire, hurricane, tornado, wind, earthquake, vandalism, lightning, smoke, hail, building collapse, explosion, leaking water, and burglary. "Self storage insurance" does not include a homeowners, renter's, private passenger automobile, commercial multi-peril, or similar policy.

"Self storage unit" means a unit in a building, part of a building, or place used only for storage of personal property by the customer leasing the unit.

"Self storage unit transaction" means the lease of a self storage unit by a lessor to a customer.

2013, c. 203.

§ 38.2-1882. Licensure of lessors.

A. A lessor is required to hold a limited lines property and casualty insurance agent license to sell or offer coverage under a policy of self storage insurance.

B. On or before May 1, 2021, and biennially thereafter, each lessor licensed as a limited lines property and casualty insurance agent shall submit to the Commission a renewal application, along with a nonrefundable renewal application processing fee prescribed by the Commission, for the renewal of the

license. Any limited lines property and casualty insurance agent license for which the renewal application and nonrefundable renewal application processing fee have been received by the Commission and all other applicable licensing and renewal provisions in this chapter have been met shall, unless the license has been terminated, suspended, or revoked, be renewed for a two-year period. Any limited lines property and casualty insurance agent license for which the renewal application and nonrefundable renewal application processing fee have not been received by the Commission shall automatically be terminated.

C. A license issued under this article shall authorize any employee or authorized representative of a licensed lessor to sell or offer self storage insurance coverage under a policy of self storage insurance to a customer at each location at which the lessor engages in self storage unit transactions.

D. The acts of a licensed lessor's employee or authorized representative offering to sell coverage under a policy of self storage insurance shall be deemed to be the acts of the lessor and the insurer for purposes of this article.

E. Every licensed lessor shall maintain a list of all locations in the Commonwealth where the lessor offers coverage under a policy of self storage insurance and shall make the list available to the Commissioner for inspection upon request.

F. Notwithstanding any other provision of law, a license issued pursuant to this article shall authorize the licensed lessor's employees and authorized representatives to engage only in those activities that are expressly permitted in this article.

2013, c. 203; 2019, c. 675.

§ 38.2-1883. Requirements for sale of self storage insurance.

A. At every location where self storage insurance is offered to customers, the lessor shall make available to a prospective customer brochures or other written materials that:

1. Disclose that self storage insurance may provide a duplication of coverage already provided by a customer's homeowners insurance policy, renter's insurance policy, or other source of coverage;

2. State that the purchase of coverage by a customer of self storage insurance is not required in order to lease a self storage unit;

3. Summarize the material terms of the insurance coverage, including (i) the identity of the insurer; (ii) the amount of any applicable deductible and how it is to be paid; (iii) benefits of the coverage; and (iv) key terms and conditions of coverage; and

4. Summarize the process for filing a claim, including proof of loss requirements.

B. Self storage insurance may be offered on a month-to-month or other periodic basis as an individual policy or a group or master policy issued to a lessor under which the individual customer may elect to purchase coverage.

2013, c. 203.

§ 38.2-1884. Authority of lessors of self storage units.

A. The employees and authorized representatives of lessors may sell or offer self storage insurance to customers and shall not be subject to licensure as an insurance producer under this chapter provided that:

1. The lessor obtains a limited lines property and casualty insurance agent license;

2. The lessor selling the self storage insurance provides a training program for all employees and authorized representatives of the lessor. The training program shall consist of instruction about the self storage insurance offered to customers, the disclosures required by this article, and the conduct prohibited by § 38.2-512. The training required by this subdivision may be delivered in person or in an electronic form. The licensed producer designated by the lessor as being responsible for its compliance with the insurance laws, rules, and regulations of the Commonwealth, as required by § 38.2-1820, shall hold a property and casualty insurance agent license and shall supervise the administration of the training program required by this subdivision;

3. No employee or authorized representative of a lessor of self storage units is compensated based primarily on the number of customers who purchase self storage insurance coverage; however, such an employee or authorized representative may receive compensation for activities under the limited lines license that is incidental to their overall compensation; and

4. The employee or authorized representative of the lessor of self storage insurance does not represent or otherwise hold himself out as a licensed insurance producer.

B. No employee or authorized representative of a lessor of a self storage unit may:

1. Evaluate or interpret the technical terms, benefits, and conditions of the offered self storage unit insurance;

2. Evaluate or provide advice concerning a prospective purchaser's existing insurance coverage; or

3. Hold himself out as a licensed insurer, licensed agent, or insurance expert.

C. The license authority of any lessor licensed as a limited lines property and casualty producer selling self storage insurance shall terminate immediately if the sole licensed responsible producer designated for the lessor's compliance with the insurance laws, rules, and regulations of the Commonwealth is removed for any reason, and a new responsible producer has not been appointed. The Commission shall be notified within 30 calendar days of such removal and of the newly designated responsible producer.

D. A lessor shall report any violation of this article to the Commissioner within 30 days of discovery of the violation by the lessor.

E. Any charge to the customer for self storage insurance that is not included in the cost associated with the lease of a self storage unit shall be separately itemized on the customer's rental agreement. If the charge for self storage insurance is included in the cost associated with the lease of the self

storage unit, the lessor shall clearly and conspicuously disclose to the customer that the charge for the self storage unit covers the cost of the insurance.

F. The charges for self storage insurance coverage may be billed and collected by the lessor. Lessors billing and collecting premiums for self storage insurance shall be required to comply with the provisions of § 38.2-1813. Lessors may receive compensation for billing and collection services.

G. Notwithstanding any other provision of law, applicants for licensure pursuant to this article whose home state does not issue a producer license with a similar line of authority as the license authorized by this article shall be issued a limited lines property and casualty license for self storage insurance. Any licensee whose home state does not have property and casualty limited lines for self storage insurance or similar line of authority in its home state after July 1, 2017, or such later date as may be determined by the Commission, shall obtain a full property and casualty license or its license shall terminate in Virginia. For purposes of this subsection, "home state" means the District of Columbia and any state or territory of the United States except Virginia, or any province of Canada, in which an applicant maintains such person's principal place of residence or principal place of business.

2013, c. 203; 2015, c. 334.

§ 38.2-1885. Suspension or revocation of license.

If a lessor or its employee or authorized representative violates any provision of this article, the Commission may do any of the following:

1. After notice and hearing, impose fines and penalties in accordance with § 38.2-218; and

2. After notice and hearing, impose any such other penalties that the Commission deems necessary and reasonable to carry out the purpose of this article, including (i) suspending the privilege of transacting self storage insurance pursuant to this article at specific business locations where violations have occurred; (ii) suspending or revoking the ability of individual employees or authorized representatives to act under the license; and (iii) imposing a penalty in accordance with § 38.2-218 on the licensed producer designated by the lessor pursuant to § 38.2-1820.

2013, c. 203.

§ 38.2-1886. What laws applicable; rulemaking authority.

A. Except as otherwise provided in this article and except where the context otherwise requires, all of the provisions of this title apply to this article.

B. Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such rules and regulations as may be necessary or appropriate for the administration and enforcement of this article.

2013, c. 203.

Article 9 - Travel Insurance

§ 38.2-1887. Application of article; definitions.

A. This article applies to travel insurance that covers any resident of the Commonwealth, any travel insurance sold, solicited, negotiated, or offered in the Commonwealth, and any travel insurance policies or certificates delivered or issued for delivery in the Commonwealth. This article shall not apply to cancellation fee waivers or travel assistance services except as expressly provided in this article. In the event of conflict between the provisions in this article and other provisions of this title, the provisions of this article shall control.

B. As used in this article, unless the context requires a different meaning:

"Aggregator site" means a website that provides access to information, including product and insurer information, regarding insurance products from more than one insurer for use in comparison shopping.

"Blanket travel insurance" means a policy of travel insurance issued to any eligible group providing coverage for specific classes of persons defined in the policy with coverage provided to all members of the eligible group without a separate charge to individual members of the eligible group.

"Cancellation fee waiver" means a contractual agreement between a supplier of travel services and its customer to waive some or all of the nonrefundable cancellation fee provisions of the supplier's underlying travel contract with or without regard to the reason for the cancellation or form of reimbursement. A cancellation fee waiver is not insurance.

"Designated licensed producer" or "DLP" means an employee, officer, director, manager, member, or partner of a limited lines travel insurance agent who (i) is a licensed property and casualty insurance agent, a personal lines insurance agent, or an individual limited lines property and casualty insurance agent and (ii) has been designated by the limited lines travel insurance agent as the person responsible for the limited lines travel insurance agent's compliance with the travel insurance laws, rules, and regulations of the Commonwealth.

"Eligible group" means two or more persons who are engaged in a common enterprise or have an economic, educational, or social affinity or relationship, including:

1. Any entity engaged in the business of providing travel or travel services, including (i) tour operators, (ii) lodging providers, (iii) vacation property owners, (iv) hotels and resorts, (v) travel clubs, (vi) travel agencies, (vii) property managers, (viii) cultural exchange programs, and (ix) common carriers or the operator, owner, or lessor of a means of transportation of passengers, including cruise lines, railroads, steamship companies, and public bus carriers. All members or customers of any group must have a common exposure to risk attendant to such travel;

2. Any public or private school or institution of higher education covering students, teachers, employees, or volunteers;

3. Any employer covering any group of employees, volunteers, contractors, boards of directors, dependents, or guests;

4. Any sports team or camp, or sponsor of such team or camp, covering participants, members, campers, employees, officials, supervisors, or volunteers;

5. Any religious, charitable, recreational, educational, or civic organization or branch thereof covering any group of members, participants, or volunteers;

6. Any financial institution or financial institution vendor, or parent holding company, trustee, or agent designated by one or more financial institutions or financial institution vendors, including accountholders, credit card holders, debtors, guarantors, or purchasers;

7. Any incorporated or unincorporated association, including labor unions, having a common interest, constitution, and bylaws, and organized and maintained in good faith for purposes other than obtaining insurance for members or participants of such association, covering its members;

8. Any trust or the trustees of a fund established, created, or maintained for the benefit of and covering members, employees, or customers, subject to the Commission's permitting the use of a trust and the premium tax provisions in § 58.1-2501.1 of any incorporated or unincorporated association;

9. Any entertainment production company covering any group of participants, volunteers, audience members, contestants, or workers;

10. Any volunteer fire department, emergency medical services department, police department, or court or any first aid, civil defense, or similar volunteer group covering any group of members, participants, or volunteers;

11. Any preschools or daycare institutions covering children or adults and senior citizen clubs;

12. Any automobile or truck rental or leasing company covering a group of individuals who may become renters, lessees, or passengers defined by their travel status in the rented or leased vehicles. The common carrier, the operator, owner, or lessor of a means of transportation, or the automobile or truck rental or leasing company is the policyholder under a policy to which this definition applies; or

13. Any other group where the members are engaged in a common enterprise, or have an economic, educational, or social affinity or relationship, and that issuance of the policy would not be contrary to the public interest.

"Fulfillment materials" means documentation sent to the purchaser of a travel protection plan confirming the purchase and providing the travel protection plan's coverage and assistance details.

"Group travel insurance" means travel insurance issued to an eligible group.

"Limited lines travel insurance agent" means a licensed property and casualty insurance agent, a personal lines insurance agent, or a limited lines property and casualty agent.

"Offer and disseminate" means providing general information, including a description of the coverage and price, as well as processing the application, collecting premiums, and performing other non-licensable activities permitted by the Commonwealth.

"Primary certificate holder" means a person who elects and purchases travel insurance under a group policy.

"Primary policyholder" means a person who elects and purchases individual travel insurance.

"Travel administrator" means a person who directly or indirectly underwrites, collects, charges collateral or premiums from, or adjusts or settles claims on residents of the Commonwealth, in connection with travel insurance. A person shall not be considered a travel administrator if his only actions that would otherwise cause him to be considered a travel administrator are among the following:

1. A person working for a travel administrator to the extent that his activities are subject to the supervision and control of the travel administrator;

2. An insurance agent selling insurance or engaged in administrative and claims-related activities within the scope of the agent's license;

3. A travel retailer offering and disseminating travel insurance and registered under the license of a limited lines travel insurance agent in accordance with this article; or

4. An individual adjusting or settling claims in the normal course of his practice or employment as an attorney at law and who does not collect charges or premiums in connection with insurance coverage.

"Travel assistance services" means noninsurance services for which the consumer is not indemnified based on a fortuitous event, and where providing the service does not result in the transfer or shifting of risk that would constitute the business of insurance. "Travel assistance services" includes (i) security advisories; (ii) destination information; (iii) vaccination and immunization information services; (iv) travel reservation services; (v) entertainment; (vi) activity and event planning; (vii) translation assistance; (viii) emergency messaging; (ix) international legal and medical referrals; (x) medical case monitoring; (xi) coordination of transportation arrangements; (xii) emergency cash transfer assistance; (xiii) medical prescription replacement assistance; (xiv) passport and travel document replacement assistance; (xv) lost luggage assistance; (xvi) concierge services; and (xvii) any other service that is furnished in connection with planned travel. Travel assistance services are not insurance.

"Travel insurance" means insurance coverage for personal risks incident to planned travel, including (i) interruption or cancellation of trip or event; (ii) loss of baggage or personal effects; (iii) damages to accommodations or rental vehicles; (iv) emergency evacuation; (v) repatriation of remains; or (vi) any other contractual obligations to indemnify or pay a specified amount to the traveler upon determinable contingencies related to travel as approved by the Commission. "Travel insurance" may include appropriate provisions obligating the insurer to pay medical, hospital, surgical, and funeral expenses arising out of the death, dismemberment, sickness, or injury of any person, and death and dismemberment benefits in the event of death or dismemberment, if the death, dismemberment, sickness, or injury is caused by or is incidental to a cause of loss insured under the policy. "Travel insurance" does not include major medical plans that provide comprehensive medical protection for travelers with trips lasting longer than six months, including those working or residing overseas as an expatriate.

"Travel protection plan" means any plan that provides travel insurance, travel assistance services, or cancellation fee waivers.

"Travel retailer" means a business entity that offers and disseminates travel insurance on behalf of and under the direction and license of a travel insurance agent.

2013, c. 497; 2019, cc. 266, 346.

§ 38.2-1888. Licensing and registration.

A. The Commission may issue a limited lines travel insurance agent license to an individual or business entity that has filed with the Commission an application for a limited lines travel insurance agent license in a form and manner prescribed by the Commission. The limited lines travel insurance agent shall be licensed to sell, solicit, or negotiate travel insurance through a licensed insurer.

B. No person may act as a limited lines travel insurance agent or travel retailer unless properly licensed or registered, respectively.

C. The grounds for the suspension or revocation of the license of and the penalties applicable to resident insurance agents shall be applicable to limited lines travel insurance agents and travel retailers.

D. A travel retailer may offer and disseminate travel insurance under the license of a limited lines travel insurance agent only if the following conditions are met:

1. Any travel retailer offering or disseminating travel insurance shall make available to prospective purchasers brochures or other written materials that:

a. Provide the identity and contact information of the insurer and the limited lines travel insurance agent;

b. Explain that the purchase of travel insurance is not required in order to purchase any other product or service from the travel retailer; and

c. Explain that an unlicensed travel retailer is permitted to provide general information about the insurance offered by the travel retailer, including a description of the coverage and price, but is not qualified or authorized to answer technical questions about the terms and conditions of the insurance offered by the travel retailer or to evaluate the adequacy of the customer's existing insurance coverage;

2. The limited lines travel insurance agent or travel retailer provides to purchasers of travel insurance:

a. A description of the material terms or the actual material terms of the insurance coverage;

b. A description of the process for filing a claim;

c. A description of the review or cancellation process for the travel insurance policy; and

d. The identity and contact information of the insurer and limited lines travel insurance agent;

3. At the time of licensure, the limited lines travel insurance agent shall establish and maintain a register on a form prescribed by the Commission of each travel retailer that offers travel insurance on the limited lines travel insurance agent's behalf. The register shall be maintained and updated by the limited lines travel insurance agent and shall include the name, address, and contact information of the travel retailer and an officer or person who directs or controls the travel retailer's operations, and

the travel retailer's Federal Tax Identification Number. The limited lines travel insurance agent shall submit such register to the Commission upon reasonable request. The limited lines travel insurance agent shall also certify that the travel retailer registered complies with 18 U.S.C. § 1033;

4. The limited lines travel insurance agent has designated a DLP;

5. The DLP, president, secretary, treasurer, and any other officer or person who directs or controls the limited lines travel insurance agent's insurance operations complies with a background check or fingerprinting requirements applicable to insurance agents;

6. The limited lines travel insurance agent has paid all applicable insurance agent licensing fees as set forth in this title; and

7. The limited lines travel insurance agent requires each employee or authorized representative of the travel retailer whose duties include offering and disseminating travel insurance to receive a program of instruction or training, which may be subject to review by the Commission. The training material shall, at a minimum, contain instructions on the types of insurance offered, ethical sales practices, and required disclosures to prospective customers.

E. A travel retailer's employee or authorized representative who is not licensed as an insurance agent may not:

1. Evaluate or interpret the technical terms, benefits, and conditions of the offered travel insurance coverage;

2. Evaluate or provide advice concerning a prospective purchaser's existing insurance coverage; or

3. Hold himself or itself out as a licensed insurer, licensed agent, or insurance expert.

F. Notwithstanding any other provision of law, a travel retailer whose insurance-related activities, and those of its employees or authorized representatives, are limited to offering and disseminating travel insurance on behalf of and under the direction and license of a limited lines travel insurance agent meeting the conditions stated in this article is authorized to conduct such activities and receive related compensation, upon registration by the limited lines travel insurance agent as described in subdivision D 3. No travel retailer employee or authorized representative may be compensated based primarily on the number of customers who purchase travel insurance coverage; however, nothing in this article shall prohibit payment of compensation to a travel retailer or its employees or authorized representatives for activities under the limited lines travel insurance agent's license that are incidental to the travel retailer's or its employee's or authorized representative's overall compensation.

G. As the insurer designee, the limited lines travel insurance agent and the insurer (i) are responsible for the acts of a travel retailer who is not a limited lines travel insurance agent and (ii) shall use reasonable means to ensure compliance by the travel retailer with this article.

H. No person is authorized to sell, solicit, and negotiate travel insurance unless licensed and appointed as a limited lines travel insurance agent.

2013, c. 497; 2019, cc. 266, 346, 675; 2020, c. 225.

§ 38.2-1888.1. Suspension, revocation, or termination of license.

A. If a limited lines travel insurance agent or travel retailer or its employee or authorized representative violates any provision of this article, the Commission may do any of the following:

1. After notice and hearing, impose fines and penalties in accordance with § 38.2-218; and

2. After notice and hearing, impose such other penalties that the Commission deems necessary and reasonable to carry out the purpose of this article, including (i) suspending the privilege of transacting travel insurance pursuant to this article at specific business locations where violations have occurred, (ii) suspending or revoking the ability of individual employees or authorized representatives or travel retailers to act under the license, and (iii) imposing a penalty in accordance with § 38.2-218 on the licensed producer designated by the travel insurance agent pursuant to § 38.2-1820.

B. The license authority of any licensed limited lines property and casualty producer selling travel insurance may be terminated if the sole licensed producer designated for the limited lines travel insurance agent's compliance with the insurance laws, rules, and regulations of the Commonwealth is removed for any reason and a new designated licensed producer has not been appointed. The Commission shall be notified within 30 calendar days of such removal and of the newly designated licensed producer.

2019, cc. 266, 346.

§ 38.2-1888.2. Travel protection plans.

Travel protection plans may be offered for one price for the combined features that the travel protection plan offers in the Commonwealth if:

1. The travel protection plan clearly discloses to the consumer at or prior to the time of purchase that it includes travel insurance, travel assistance services, and cancellation fee waivers, as applicable, and provides information and an opportunity at or prior to the time of purchase for the consumer to obtain additional information regarding the features and pricing of each; and

2. The fulfillment materials (i) describe and delineate the travel insurance, travel assistance services, and cancellation fee waivers in the travel protection plan and (ii) include the travel insurance disclosures and the contact information for persons providing travel assistance services and cancellation fee waivers, as applicable.

2019, cc. 266, 346.

§ 38.2-1888.3. Sales practices.

A. For the purposes of this section, "delivery" means handing fulfillment materials to the primary policyholder or primary certificate holder or sending fulfillment materials by United States Postal Service mail or by any other delivery service or electronic means to the policyholder or certificate holder.

B. Any person offering travel insurance to residents of the Commonwealth is subject to the unfair trade practice penalties contained in Chapter 5 (§ 38.2-500 et seq.), except as otherwise provided in this

section. In the event of a conflict between this article and other provisions of this title regarding the sale and marketing of travel insurance and travel protection plans, the provisions of this article shall control.

C. Offering or selling a travel insurance policy that could never result in payment of any claims for any insured under the policy is an unfair trade practice.

D. All documents provided to consumers prior to the purchase of travel insurance, including sales materials, advertising materials, and marketing materials, shall be consistent with the travel insurance policy itself, including forms, endorsements, policies, rate filings, and certificates of insurance.

For travel insurance policies or certificates that contain pre-existing condition exclusions, information and an opportunity to learn more about the pre-existing condition exclusions shall be provided any time prior to the time of purchase and in the coverage's fulfillment materials.

The fulfillment materials and the information described in subdivision 2 of § 38.2-1888.2 shall be provided to a primary policyholder or primary certificate holder as soon as practicable following the purchase of a travel protection plan. Unless the insured has either started a covered trip or filed a claim under the travel insurance coverage, a policyholder or certificate holder may cancel a policy or certificate for a full refund of the travel protection plan price from the date of purchase of a travel protection plan until (i) at least 15 days following the date of delivery of the travel protection plan's fulfillment materials sent by United States Postal Service mail or (ii) at least 10 days following the date of delivery of the travel protection plan's fulfillment materials sent by means other than United States Postal Service mail.

E. The company shall disclose in the policy documentation and fulfillment materials whether the travel insurance is primary or secondary to other applicable coverage.

F. Where travel insurance is marketed directly to a consumer through an insurer's website or by others through an aggregator site, it shall not be an unfair trade practice or other violation of law where an accurate summary or short description of coverage is provided on the web page, so long as the consumer has access to the full provisions of the policy through electronic means.

G. No person offering, soliciting, or negotiating travel insurance or travel protection plans on an individual or group basis may do so by using negative option or opt out that would require a consumer to take an affirmative action to deselect coverage, such as unchecking a box on an electronic form when the consumer purchases a trip.

H. It shall be an unfair trade practice to market blanket travel insurance coverage as free.

I. Where a consumer's destination jurisdiction requires insurance coverage, it shall not be an unfair trade practice to require that a consumer choose between the following options as a condition of purchasing a trip or travel package:

1. Purchasing the coverage required by the destination jurisdiction through the travel retailer or limited lines travel insurance agent supplying the trip or travel package; or

2. Agreeing to obtain and provide proof of coverage that meets the destination jurisdiction's requirements prior to departure.

2019, cc. 266, 346.

§ 38.2-1888.4. Travel administrators.

A. Notwithstanding any other provision of this title, no person shall act or represent itself as a travel administrator for travel insurance in the Commonwealth unless that person:

1. Is a licensed property and casualty insurance agent in the Commonwealth for activities permitted under that agent license; or

2. Holds a valid managing general agent (MGA) license in the Commonwealth.

B. An insurer is responsible for the acts of a travel administrator administering travel insurance underwritten by the insurer and is responsible for ensuring that the travel administrator maintains all books and records relevant to the insurer to be made available by the travel administrator to the Commissioner upon request.

2019, cc. 266, 346.

§ 38.2-1888.5. Classification of travel insurance.

A. Notwithstanding any other provision of this title, travel insurance shall be classified and filed for purposes of rates and forms under the inland marine line of insurance as set forth in § 38.2-126.

B. Travel insurance may be in the form of an individual, group, or blanket policy.

2019, cc. 266, 346.

§ 38.2-1889. Suspension, revocation, or termination of license.

A. If a limited lines travel insurance agent or travel retailer or its employee or authorized representative violates any provision of this article, the Commission may do any of the following:

1. After notice and hearing, impose fines and penalties in accordance with § 38.2-218; and

2. After notice and hearing, impose such other penalties that the Commission deems necessary and reasonable to carry out the purpose of this article, including (i) suspending the privilege of transacting travel insurance pursuant to this article at specific business locations where violations have occurred, (ii) suspending or revoking the ability of individual employees or authorized representatives or travel retailers to act under the license, and (iii) imposing a penalty in accordance with § 38.2-218 on the licensed producer designated by the travel insurance agent pursuant to § 38.2-1820.

B. The license authority of any licensed limited lines property and casualty producer selling travel insurance may be terminated if the sole licensed responsible producer designated for the limited lines travel insurance agent's compliance with the insurance laws, rules, and regulations of the Commonwealth is removed for any reason and a new responsible producer has not been appointed. The Commission shall be notified within 30 calendar days of such removal and of the newly designated responsible producer.

2013, c. 497.

§ 38.2-1890. What laws applicable; rulemaking authority.

A. Except as otherwise provided in this article and except where the context otherwise requires, all of the provisions of this title apply to this article.

B. Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such rules and regulations as may be necessary or appropriate for the administration and enforcement of this article.

2013, c. 497.

Chapter 19 - REGULATION OF RATES GENERALLY

§ 38.2-1900. Purposes of chapter.

A. This chapter shall be liberally construed to achieve the purposes stated in subsection B of this section.

B. The purposes of this chapter are to:

1. Protect policyholders and the public against the adverse effects of excessive, inadequate or unfairly discriminatory rates;

2. Encourage independent action by insurers and reasonable price competition among insurers as the most effective way to produce rates that conform to the standards of subdivision 1;

3. Provide formal regulatory controls for use if independent action and price competition fail;

4. Authorize cooperative action among insurers in the rate making process, and regulate such cooperation in order to prevent practices that tend to create monopoly or to lessen or destroy competition;

5. Provide rates that are responsive to competitive market conditions and improve the availability of insurance in this Commonwealth; and

6. Regulate the business of insurance in a manner that will preclude application of federal antitrust laws.

1973, c. 504, § 38.1-279.29; 1986, c. 562.

§ 38.2-1901. Definitions.

As used in this chapter:

"Classification system" or "classification" means the plan, system, or arrangement for grouping risks with similar characteristics or a specified class of risk by recognizing differences in exposure to hazards.

"Client company" shall have the same meaning ascribed to it in § 65.2-101.

"Coemployee" shall have the same meaning ascribed to it in § 65.2-101.

"Experience rating" means a statistical procedure utilizing past risk experience to produce a prospective premium credit, debit, or unity modification.

"Market segment" means any line or class of insurance or, if it is described in general terms, any subdivision of insurance or any class of risks or combination of classes.

"Professional employer organization" shall have the same meaning ascribed to it in § 65.2-101.

"Professional employer services" means services provided to a client company pursuant to a written agreement with a professional employer organization, including, at a minimum, the payment of wages of the coemployees, the reservation of the right of direction and control over the coemployees, and the responsibility for the withholding and payment of payroll taxes of the coemployees.

"Prospective loss costs" means historical aggregate losses and loss adjustment expenses projected through development to their ultimate value and through trending to a future point in time. Prospective loss costs do not include provisions for profit or expenses other than loss adjustment expenses.

"Rate service organization" means any entity, including its affiliates or subsidiaries, which either has two or more member insurers or is controlled either directly or indirectly by two or more insurers, other than a joint underwriting association under § 38.2-1915, which assists insurers in ratemaking or filing by (i) collecting, compiling, and furnishing loss statistics; (ii) recommending, making, or filing prospective loss costs or supplementary rate information; or (iii) advising about rate questions, except as an attorney giving legal advice. Two or more insurers having a common ownership or operating in this Commonwealth under common management or control constitute a single insurer for purposes of this definition.

"Retrospective rating plan" means a rating plan that adjusts the premium for the insurance to which it applies on the basis of losses incurred during the period covered by that insurance.

"Statistical plan" means the plan, system, or arrangement used in collecting data for rate making or other purposes.

"Supplementary rate information" includes any manual or plan of rates, experience rating plan, statistical plan, classification, rating schedule, minimum premium, or minimum premium rule, policy fee, rating rule, rate-related underwriting rule, and any other information not otherwise inconsistent with the purposes of this chapter required by the Commission.

"Supporting data" includes:

1. The experience and judgment of the filer and, to the extent the filer wishes or the Commission requires, the experience and judgment of other insurers or rate service organizations;

2. The filer's interpretation of any statistical data relied upon;

3. Descriptions of the actuarial and statistical methods employed in setting the rates; and

4. Any other relevant information required by the Commission.

1973, c. 504, §§ 38.1-279.30, 38.1-279.40; 1986, c. 562; 1990, c. 596; 1993, c. 985; 1997, c. 153; 2000, cc. 624, 718.

§ 38.2-1902. Scope of chapter.

A. Except as provided in subsection B, this chapter applies to the classes of insurance defined in §§ 38.2-110 through 38.2-122, 38.2-124 through 38.2-128 and 38.2-130 through 38.2-133.

B. This chapter does not apply to:

1. Insurance written through the Virginia Workers' Compensation Plan pursuant to Chapter 20 (§ 38.2-2000 et seq.) of this title;

2. Insurance on a specific risk as provided in § 38.2-1920;

3. Reinsurance, other than joint reinsurance, to the extent stated in § 38.2-1915;

4. Life insurance as defined in § 38.2-102;

5. Annuities as defined in §§ 38.2-106 and 38.2-107;

6. Accident and sickness insurance as defined in § 38.2-109;

7. Title insurance as defined in § 38.2-123;

8. Insurance of vessels or craft used primarily in a trade or business, their cargoes, marine builders' risks and marine protection and indemnity;

9. Insurance against loss of or damage to hulls of aircraft, including their accessories and equipment, or against liability, other than workers' compensation and employers' liability, arising out of the ownership, maintenance or use of aircraft;

10. Insurance written through the Virginia Automobile Insurance Plan. However, § 38.2-1905 shall apply to insurance written through the Plan;

11. Insurance provided pursuant to Chapter 27 (§ 38.2-2700 et seq.);

12. Home protection contracts as defined by § 38.2-2600 and their rates until such time as the Commission determines there is sufficient competition in the industry as provided by § 38.2-2608.

C. This chapter shall not apply to any class of insurance written (i) by any mutual assessment property and casualty insurance company organized and operating under the laws of this Commonwealth and doing business only in this Commonwealth or (ii) by any mutual insurance company or association organized under the laws of this Commonwealth, conducting business only in this Commonwealth, and issuing only policies providing for perpetual insurance.

1973, c. 504, § 38.1-279.31; 1976, c. 636; 1981, c. 530; 1986, c. 562; 1987, c. 519; 1993, cc. 774, 985; 1995, cc. 744, 803; 2000, c. 526; 2002, c. 145; 2022, c. 180.

§ 38.2-1903. Exemptions.

The Commission may by rule exempt any person, class of persons, or market segment from any or all of the provisions of this chapter to the extent that it finds their application unnecessary to achieve the purposes of this chapter. Retrospective rating plans and large deductible plans for use in writing workers' compensation insurance for large risks shall be exempt from the filing requirements of Chapter 19 (§ 38.2-1900 et seq.). For purposes of this section, large risks are risks which generate total estimated

standard premium for workers' compensation insurance of at least $250,000 annually (or less or in combination with other lines if approved by the Commission). Large deductible plans shall be defined for the purposes of this section as workers' compensation rating plans that include a per claim deductible of at least $100,000. Workers' compensation insurance for large risks may be retrospectively rated, or rated under a large deductible rating plan, as mutually agreed upon by the insurer and the insured in writing. A copy of any large risk retrospective rating plan and large deductible plan shall be made available to the Commission upon request. Notwithstanding these exemptions for retrospective rating plans and large deductible plans for large risks, insurers' experience attributable to large risks shall be filed with the Commission in accordance with § 38.2-1919.

1973, c. 504, § 38.1-279.32; 1986, c. 562; 1997, c. 153; 1999, c. 491.

§ 38.2-1903.1. Exemptions of large commercial risks.

A. Notwithstanding any other provision of this title, an insurer shall not be required to file with, or to receive approval from, the Commission for policy forms and rates used in the insurance of large commercial risks.

B. The form approval and rate filing exemption set forth in subsection A shall not apply to rates and forms for writing workers' compensation policies issued to large commercial risks.

C. A "large commercial risk" is a person or entity that:

1. Has a risk manager to negotiate insurance coverage. A risk manager means (i) an employee of the large commercial risk or (ii) a third party consultant retained by the large commercial risk, who provides skilled services in loss prevention, loss reduction, or risk and insurance coverage analysis, and the purchase of insurance, and who possesses at least one of the following credentials:

a. A bachelor's or higher degree in risk management issued by an accredited institution of higher education;

b. A designation as a Chartered Property and Casualty Underwriter (CPCU) issued by the American Institute for CPCU/Insurance Institute of America;

c. A designation as an Associate in Risk Management (ARM) issued by the American Institute for CPCU/Insurance Institute of America;

d. A designation as a Certified Risk Manager (CRM) issued by the National Alliance for Insurance Education & Research;

e. A designation as a Fellow in Risk Management (FRM) issued by the Global Risk Management Institute/Risk & Insurance Management; or

f. At least five years of experience in one or more of the following areas of commercial property and casualty insurance: (i) risk financing, (ii) claims administration, (iii) loss prevention, or (iv) risk and insurance coverage analysis; and

2. Meets at least two of the following criteria:

a. Possesses a net worth in excess of $2 million;

b. Generates annual revenues in excess of $2 million;

c. Employs more than 10 full-time or full-time equivalent employees per individual insured;

d. Pays annual aggregate nationwide insurance premiums in excess of $25,000;

e. Is a not-for-profit organization or public body generating annual budgeted expenditures of at least $5 million; or

f. Is a municipality with a population in excess of 30,000.

D. An insurer providing a policy to a large commercial risk must obtain annual, written certification signed by the risk manager and an officer of the corporation from the large commercial risk certifying that the large commercial risk (i) employs the necessary qualified risk manager and stating the basis for the risk manager's qualifications; (ii) meets two of the other criteria set forth in subdivision C 2; (iii) is aware that the policy being purchased is not subject to initial state regulatory review or approval of rates and forms; (iv) has the necessary expertise to negotiate its own policy language and rates; and (v) agrees to the use of the exempted rates and forms by its insurer or insurers.

E. The policyholder certification shall be filed with and retained by the insurance company issuing coverage to the large commercial risk.

2000, c. 548; 2002, c. 437; 2005, c. 251; 2009, c. 644; 2011, cc. 618, 636.

§ 38.2-1904. Rate standards.

A. Rates for the classes of insurance to which this chapter applies shall not be excessive, inadequate, or unfairly discriminatory. All rates and all changes and amendments to rates to which this chapter applies for use in this Commonwealth shall consider loss experience and other factors within Virginia if relevant and actuarially sound, provided that other data, including countrywide, regional, or other state data, may be considered where such data is relevant and where a sound actuarial basis exists for considering data other than Virginia-specific data.

1. No rate shall be held to be excessive unless it is unreasonably high for the insurance provided and a reasonable degree of competition does not exist in the area with respect to the classification to which the rate applies.

2. No rate shall be held inadequate unless it is unreasonably low for the insurance provided and (i) continued use of it would endanger solvency of the insurer or (ii) use of the rate by the insurer has or, if continued, will have the effect of destroying competition or creating a monopoly.

3. No rate shall be unfairly discriminatory if a different rate is charged for the same coverage and the rate differential (i) is based on sound actuarial principles or (ii) is related to actual or reasonably anticipated experience.

B. 1. In determining whether rates comply with the standards of subsection A, separate consideration shall be given to (i) past and prospective loss experience within and outside this Commonwealth, (ii)

conflagration or catastrophe hazards, (iii) a reasonable margin for underwriting profit and contingencies, (iv) dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers, (v) past and prospective expenses both countrywide and those specifically applicable to this Commonwealth, (vi) the loss reserving practices, standards and procedures utilized by the insurer, (vii) investment income earned or realized by insurers from their unearned premium and loss reserve and the Commission may give separate consideration to investment income earned on surplus funds, and (viii) all other relevant factors within and outside this Commonwealth. When actual experience or data does not exist, the Commission may consider estimates.

2. In the case of fire insurance rates, consideration shall be given to the experience of the fire insurance business during a period of not less than the most recent five-year period for which such experience is available.

3. In the case of workers' compensation insurance rates for volunteer firefighters or volunteer emergency medical services personnel, the rates shall be calculated based upon the combined experience of both volunteer firefighters or volunteer emergency medical services personnel and paid firefighters or paid emergency medical services personnel, so that the resulting rate is the same for both volunteer and paid members, but in no event shall resulting premiums be less than $40 per year for any volunteer firefighter or volunteer emergency medical services personnel.

4. In the case of uninsured motorist coverage required by subsection A of § 38.2-2206, consideration shall be given to all sums distributed by the Commission from the Uninsured Motorists Fund in accordance with the provisions of Chapter 30 (§ 38.2-3000 et seq.).

C. For the classes of insurance to which this chapter applies, including insurance against contingent, consequential and indirect losses as defined in § 38.2-133 (i) the systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the requirements of the operating methods of any such insurer or group for any class of insurance, or with respect to any subdivision or combination of insurance for which separate expense provisions are applicable, and (ii) risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans that establish standards for measuring variations in hazards, expense provisions, or both. The standards may measure any difference between risks that can be demonstrated to have a probable effect upon losses or expenses. Notwithstanding any other provision of this subsection, except as permitted by § 38.2-1908, each member of a rate service organization shall use the uniform classification system, uniform experience rating plan, and uniform statistical plan of its designated rate service organization in the provision of insurance defined in § 38.2-119.

D. No insurer shall use any information pertaining to any motor vehicle conviction or accident to produce increased or surcharged rates above their filed manual rates for individual risks for a period

longer than 36 months. This period shall begin no later than 12 months after the date of the conviction or accident.

E. Each authorized insurer subject to the provisions of this chapter may file with the Commission an expense reduction plan that permits variations in expense provisions. Such filing may contain provisions permitting agents to reduce their commission resulting in an appropriate reduction in premium. Nothing in this section shall be construed to require an agent to reduce a commission, nor may an insurer unreasonably refuse to reduce a premium due to a commission reduction as permitted by its filed expense reduction plan.

1973, c. 504, § 38.1-279.33; 1975, c. 155; 1977, c. 415; 1981, c. 243; 1982, c. 226; 1986, c. 562; 1987, c. 697; 1991, c. 104; 1993, c. 985; 1996, c. 250; 2002, c. 145; 2015, cc. 502, 503.

§ 38.2-1905. Motor vehicle insurer not to charge points or increase premiums in certain instances.

A. No insurer may increase its insured's premium or may charge points under a safe driver insurance plan to its insured as a result of a motor vehicle accident unless the accident was caused either wholly or partially by the named insured, a resident of the same household, or other customary operator. No insurer may increase its insured's premium or may charge points to its insured where the operator causing the accident is a principal operator insured under a separate policy. Any insurer increasing a premium or charging points as a result of a motor vehicle accident shall notify the named insured in writing and in the same notification shall inform the named insured that he may appeal the decision of the insurer to the Commissioner if he feels his premium has increased or he has been charged points as a result of a motor vehicle accident without just cause. Such notice shall include the requirements that the appeal be in writing and made within 60 days of receipt of the notice of any premium increase adjustment or of any point charge resulting from a motor vehicle accident.

B. An appeal of a premium increase or of a point charge by the named insured shall be requested in writing within sixty days of receipt of the notice of any premium adjustment or of any point charge resulting from a motor vehicle accident. Upon receipt of the request, the Commissioner shall promptly initiate a review to determine whether the premium increase or the point charge is justified. The premium increase or the point charge shall remain in full force and effect until the Commissioner rules that the premium be adjusted or the point charge be removed because it is not justified, or because the point charge was not assigned in accord with the insurer's filed rating plan, and so notifies the insurer and the insured. Upon receipt of the ruling, the insurer shall promptly refund any premiums paid as a direct result of the premium increase or the point charge, and shall adjust future billings to reflect the Commissioner's ruling.

C. No insurer shall assign points under a safe-driver insurance policy to any vehicle other than the vehicle customarily driven by the operator responsible for incurring points.

D. If an insured is a law-enforcement officer, as defined in § 9.1-101, no insurer may increase such insured's personal insurance premium or may charge points under a safe driver insurance plan to such insured as a result of an accident which occurred in the course of the insured's employment as a

law-enforcement officer while the insured was driving a motor vehicle provided by the employing law-enforcement agency and was engaged in a law-enforcement activity at the time of such accident.

1981, c. 243, § 38.1-279.33:1; 1986, c. 562; 1990, cc. 275, 960; 1994, c. 925; 2016, c. 558.

§§ 38.2-1905.1, 38.2-1905.2. Repealed.

Repealed by Acts 1997, c. 199.

§ 38.2-1906. Filing and use of rates.

A. Each authorized insurer subject to the provisions of this chapter shall file with the Commission all rates and supplementary rate information and all changes and amendments to the rates and supplementary rate information made by it for use in the Commonwealth on or before the date they become effective.

In cases where the Commission has made a determination pursuant to § 38.2-1912 that competition is not an effective regulator of rates for a line or subclassification of insurance, such rates, supplementary rate information, changes and amendments to rates and supplementary rate information for that line or subclassification shall be filed in accordance with and shall be subject to the provisions of § 38.2-1912.

B. Each rate service organization licensed under § 38.2-1914 that has been designated by an insurer for the filing of prospective loss costs or supplementary rate information under § 38.2-1908 shall file with the Commission all prospective loss costs or supplementary rate information and all changes and amendments to the prospective loss costs or supplementary rate information made by it for use in the Commonwealth on or before the date they become effective. Prospective loss costs and supplementary rate information for insurance defined in § 38.2-119 must comply with the provisions of § 38.2-1912.1 prior to being used by an insurer in a filing establishing or changing its rate.

C. Prospective loss costs filings and supplementary rate information filed by rate service organizations shall not contain final rates, minimum premiums, or minimum premium rules.

D. No insurer shall make or issue an insurance contract or policy of a class to which this chapter applies, except in accordance with the rate and supplementary rate information filings that are in effect for the insurer.

E. For insurance as defined in § 38.2-119 any authorized insurer that does not rely on prospective loss costs or supplementary rate information filed by a rate service organization shall comply with the filing provisions of § 38.2-1912 as if competition was not an effective regulator of rates.

F. Except with respect to workers' compensation and employers' liability insurance as defined in § 38.2-119, and notwithstanding the provisions of subdivision A 3 of § 38.2-1904, nothing shall prohibit an insurer from filing with the Commission any rate or supplementary rate information that allows the insurer to limit for its renewal policies (i) any rate increase that would otherwise be applicable to such policies or (ii) any rate decrease that would otherwise be applicable to such policies if the insurer is also limiting any rate increase. Such limitation shall apply for the period of time specified in the

insurer's filing. Nothing shall prohibit such limitation from applying to policies (a) acquired by an insurer from another insurer pursuant to a written agreement of acquisition, merger, or sale that transfers all or part of the other insurer's book of business or (b) transferred by an agent from one insurer to another insurer pursuant to an agent book of transfer.

1973, c. 504, § 38.1-279.34; 1976, c. 278; 1986, c. 562; 1987, c. 697; 1990, cc. 596, 597; 1993, c. 985; 1997, c. 199; 2004, c. 838; 2005, c. 95; 2015, c. 619; 2016, c. 277.

§ 38.2-1906.1. Misquote of premium.

Notwithstanding any other provision of this chapter, if an insurer or its agent provides a written quotation for insurance to an insured or applicant for insurance and the rate filing in effect for the insurer results in a premium increase of ten percent or more over the quoted premium, the insured or applicant may, within fifteen days of written notification of the increase by the insurer or its agent, request cancellation of the contract or policy. The insurer shall, upon receipt of such request, cancel the contract or policy calculating the earned premium pro rata using the premium originally quoted by the insurer or its agent. Nothing in this section shall apply to any increase in premium which is the result of incorrect information furnished by the insured or applicant or information omitted by the insured or applicant.

1990, c. 503.

§ 38.2-1907. Filings open to inspection.

Each filing and all supplementary rate information filed under this chapter, other than information contained therein or filed therewith that constitutes a trade secret, as defined in § 59.1-336, shall be open to public inspection. The insurer or other person making such a filing shall have the burden of persuading the Commissioner that information constitutes a trade secret. Copies of materials open to public inspection may be obtained by any person on request and upon payment of a reasonable charge for the copies. Where feasible, the Commission shall compile and make available to the public the lists of rates charged by insurers for or in connection with the insurance contracts or policies to which this chapter applies so as to inform the public of price competition among insurers.

1973, c. 504, § 38.1-279.35; 1986, c. 562; 2010, c. 234.

§ 38.2-1908. Rate making and delegation of filing obligation.

A. An insurer shall establish rates and supplementary rate information for any market segment based on the factors in § 38.2-1904. A rate service organization shall establish prospective loss costs and supplementary rate information for any market segment based on the factors in § 38.2-1904. An insurer may use supplementary rate information prepared by a rate service organization and may use prospective loss costs determined by the rate service organization with modification for its own expense and profit. The insurer may modify the prospective loss costs based on its own loss experience as the credibility of that loss experience allows.

B. An insurer may discharge its obligation to file supplementary rate information under subsection A of § 38.2-1906 by giving notice to the Commission that it uses supplementary rate information prepared

and filed with the Commission by a designated rate service organization of which it is a member, subscriber, or service purchaser. The Commission may by order require an insurer to provide information in addition to that filed by the rate service organization. The insurer's supplementary rate information shall be that filed from time to time by the rate service organization, including any amendments to the supplementary rate information, subject to modifications filed by the insurer.

C. Every insurer shall adhere to the uniform classification system, uniform experience rating plan, and uniform statistical plan approved by the Commission in the provision of insurance defined in § 38.2-119. An insurer may develop subclassifications of the uniform classification system upon which rates for insurance defined in § 38.2-119 may be made; however, such subclassification must first be filed with and approved by the Commission. An insurer filing such subclassifications must certify to the Commission that the data it produces can be reported in a manner consistent with the uniform statistical plan and uniform classification system of its designated rate service organization.

1973, c. 504, § 38.1-279.36; 1976, c. 275; 1982, c. 201; 1986, c. 562; 1987, c. 697; 1990, c. 596; 1993, c. 985.

§ 38.2-1909. Review of rates by Commission.

The Commission may investigate and determine, (i) upon its own motion, (ii) at the request of any citizen or any interested party in this Commonwealth, or (iii) at the request of any insurer subject to this chapter, whether rates in this Commonwealth for the classes of insurance to which this chapter applies are excessive, inadequate or unfairly discriminatory or whether loss experience and other factors within the Commonwealth are being properly used to determine the rates. In any such investigation and determination the Commission shall give separate consideration to those factors in the manner specified in § 38.2-1904.

1973, c. 504, § 38.1-279.37; 1986, c. 562; 1987, c. 697.

§ 38.2-1910. Disapproval of rates.

A. If the Commission finds, after providing notice and opportunity to be heard, that a rate is not in compliance with § 38.2-1904, or is in violation of § 38.2-1916, the Commission shall order that use of the rate be discontinued for any policy issued or renewed after a date specified in the order. The order may provide for rate modifications. The order may also provide for refund of the excessive portion of premiums collected (i) during a period not exceeding one year prior to the date of any request or motion for review made pursuant to § 38.2-1909 and (ii) during all periods subsequent to any such request or motion until the date of the order. If a refund is ordered, the order may provide for the payment of interest thereon at a rate set by the Commission. Except as provided in subsection B of this section, the order shall be issued within thirty days after the close of the hearing or within another reasonable time extension fixed by the Commission.

B. Pending a hearing, the Commission may order the suspension prospectively of a rate filed by an insurer and reimpose the last previous rate in effect if the Commission has reasonable cause to believe that: (i) a reasonable degree of competition does not exist in the area with respect to the

classification to which the rate applies, (ii) the filed rate will have the effect of destroying competition or creating a monopoly, (iii) use of the rate will endanger the solvency of the insurer, or (iv) Virginia loss experience and other factors specifically applicable to the Commonwealth have not been properly used to determine the rates. If the Commission suspends a rate under this provision, it shall hold a hearing within fifteen business days after issuing the order suspending the rate unless the right to a hearing is waived by the insurer. In addition, the Commission shall make its determination and issue its order as to whether the rate shall be disapproved within fifteen business days after the close of the hearing.

C. At any hearing held under the provisions of subsection A or B of this section, the insurer shall have the burden of justifying the rate in question. All determinations of the Commission shall be on the basis of findings of fact and conclusions of law. If the Commission disapproves a rate, the disapproval shall take effect not less than fifteen days after its order and the last previous rate in effect for the insurer shall be reimposed for a period of one year unless the Commission approves a substitute or interim rate under the provisions of subsection D or E of this section.

D. For one year after the effective date of a disapproval order, no rate promulgated to replace a rate disapproved under the order may be used until it has been filed with the Commission and not disapproved within sixty days after filing.

E. Whenever an insurer has no legally effective rates as a result of the Commission's disapproval of rates or other act, the Commission shall, on the insurer's request, specify interim rates for the insurer that are high enough to protect the interests of all parties. The Commission may order that a specified portion of the premiums be placed in an escrow account approved by it. When new rates become legally effective, the Commission shall order the escrowed funds or any overcharge in the interim rates to be distributed appropriately, except that refunds to policyholders that are de minimis shall not be required.

1973, c. 504, § 38.1-279.38; 1976, c. 276; 1986, c. 562; 1987, c. 697; 1990, cc. 290, 597.

§ 38.2-1911. Special restrictions on individual insurers.

A. The Commission may by order require that a particular insurer file any or all of its rates and supplementary rate information thirty days prior to their effective date, if the Commission finds, after providing notice and opportunity to be heard, that the protection of the interests of the insurer's policyholders and the public in this Commonwealth requires closer supervision of the insurer's rates because of the insurer's financial condition or repetitive filing of rates that are not in compliance with § 38.2-1904. The Commission may extend the waiting period of any filing for thirty additional days by written notice to the insurer before the first thirty-day period expires.

B. The filing shall be approved or disapproved during the waiting period or during its extension. If the filing is not disapproved before the expiration of the waiting period or of its extension, the filing shall be deemed to meet the requirements of this chapter, subject to the possibility of subsequent disapproval under § 38.2-1910.

C. Any insurer affected by an order entered under subsection A of this section may request a rehearing by the Commission after the expiration of twelve months from the date of the Commission's former order.

1973, c. 504, § 38.1-279.39; 1986, c. 562.

§ 38.2-1912. Delayed effect of rates; certification of reinsurance with affiliated company.

A. If the Commission finds in any class, line, or subdivision of insurance, or in any rating class or rating territory or for insurance as defined in § 38.2-119 that (i) competition is not an effective regulator of the rates charged, (ii) Virginia loss experience and other factors specifically applicable to the Commonwealth have not been properly used to determine the rate, (iii) a substantial number of insurers are competing irresponsibly through the rates charged, or (iv) there are widespread violations of this chapter, it shall promulgate a rule requiring that any subsequent changes in the rates or supplementary rate information for that class, line, subdivision, rating class or rating territory shall be filed with the Commission at least sixty days before they become effective. The Commission may extend the waiting period for thirty additional days by written notice to the filer before the first sixty-day period expires. Upon filing any rate to which this section is applicable, the insurer shall give notice to the Division of Consumer Counsel of the Office of the Attorney General that such rate has been filed with the Commission and such insurer shall so certify to the Commission in its rate filing.

B. By this rule, the Commission may require the filing of supporting data for any classes, lines or subdivisions of insurance, or classes of risks or combinations thereof it deems necessary for the proper functioning of the rate monitoring and regulating process.

C. A rule promulgated under this section shall expire no later than twenty-seven months after issue. The Commission may renew the rule after a hearing and appropriate findings under this section.

D. If a filing is not accompanied by the information the Commission has required under subsection B of this section, the Commission shall within thirty days of the initial filing inform the insurer that the filing is not complete, and the filing shall be deemed to be made when the information is furnished.

E. If an insurer files for a rate reduction pursuant to a rule promulgated under this section, the Commission may order the provisional use of the requested rate reduction for such period as the Commission may require to evaluate the insurer's rate filing and supplementary rate information. The implementation of such a provisional rate reduction shall not relieve an insurer of its obligation to submit such information as deemed necessary by the Commission for its consideration of the rate filing, nor shall it interfere with the Commission's authority to suspend use of the provisional rate, reimpose the previous rate, consider and approve a revised rate request, or otherwise exercise its authority under § 38.2-1910.

F. Each insurer shall so certify in a rate filing if coverage to which the rate filing applies is reinsured by another company (i) under common management, (ii) under common controlling ownership, or (iii) under other common effective legal control as defined in § 38.2-1322.

1973, c. 504, § 38.1-279.40; 1986, c. 562; 1987, c. 697; 1990, cc. 487, 597; 1993, c. 985.

§ 38.2-1912.1. Approval of prospective loss costs and supplementary rate information; § 38.2-119 rate filings.

A. No prospective loss costs or supplementary rate information for insurance as defined in § 38.2-119 shall be applied or be used in this Commonwealth until it has been approved by the Commission.

B. Prospective loss costs and supplementary rate information filed under this section shall be deemed to meet the requirements of this chapter and may be applied or used unless disapproved by the Commission within sixty days of the time that the filing was made. The Commission may extend the waiting period for an additional thirty days by written notice to the filer before the sixty-day period expires.

C. If a filing is not accompanied by the information necessary for the Commission to determine if the requirements of § 38.2-1904 are satisfied, the Commission shall so inform the filer within sixty days of the initial filing, and the filing shall be deemed to be made when the necessary information is furnished.

D. The provisions of subsection B of this section shall be suspended when the Commission has ordered a hearing to be held. The provisions of § 38.2-2007 pertaining to public notice, hearings, and approvals shall apply to filings made under this section.

E. Upon making a filing under this section, the filer shall give notice to the Division of Consumer Counsel of the Office of Attorney General that such a filing has been made and shall certify to the Commission that such a notice has been given.

F. Once a filing has been approved under this section, an insurer may use the information in such filing pursuant to the provisions of §§ 38.2-1906 and 38.2-1908.

1993, c. 985.

§ 38.2-1913. Operation and control of rate service organizations.

A. No rate service organization shall provide any service relating to the rates of any insurance subject to this chapter, and no insurer shall use the service of a rate service organization for such purposes unless the rate service organization has obtained a license under § 38.2-1914.

B. No rate service organization shall refuse to supply any services for which it is licensed in this Commonwealth to any insurer authorized to do business in this Commonwealth and offering to pay the fair and usual compensation for the services.

C. Any rate service organization subject to this chapter may provide for the examination of policies, daily reports, binders, renewal certificates, endorsements, other evidences of insurance, or evidences of the cancellation of insurance, and may make reasonable rules governing their submission and the correction of any errors or omissions in them. This provision applies to the classes of insurance for which the rate service organization is licensed pursuant to § 38.2-1914.

D. A rate service organization may develop a uniform policy and uniform (i) statistical plans, (ii) experience rating plans, and (iii) classification systems for use by its members in the provision of insurance defined in § 38.2-119 and the reporting of the experience of this line of insurance. Each rate service

organization may also develop manual rules for the recording and reporting of experience data of members pursuant to its uniform plans and systems. Such uniform plans, systems, and rules shall be filed with the Commission by the rate service organization and be approved prior to their use by members of the rate service organization.

E. No insurer shall be required to become a member or subscriber to any rate service organization.

1973, c. 504, § 38.1-279.41; 1986, c. 562; 1990, c. 596; 1993, c. 985.

§ 38.2-1914. Licensing of rate service organizations.

A. A rate service organization applying for a license as required by § 38.2-1913 shall include with its application:

1. A copy of its constitution, charter, articles of organization, agreement, association or incorporation, and a copy of its bylaws, plan of operation and any other rules or regulations governing the conduct of its business;

2. A list of its members and subscribers;

3. The name and address of one or more residents of this Commonwealth upon whom notices, process affecting it or orders of the Commission may be served;

4. A statement showing its technical qualifications for acting in the capacity for which it seeks a license; and

5. Any other relevant information and documents that the Commission may require.

B. Each organization which has applied for a license under subsection A of this section shall promptly notify the Commission of every material change in the facts or in the documents on which its application was based.

C. If the Commission finds that the applicant and the natural persons through whom it acts are competent, trustworthy, and technically qualified to provide the services proposed, and that all requirements of law have been met, the Commission shall issue a license specifying the authorized activity of the applicant.

D. Licenses issued under subsection C of this section shall remain in effect until the licensee withdraws from the Commonwealth or until the license is suspended or revoked.

E. Any amendment to a document filed under subdivision 1 of subsection A of this section shall be filed promptly after it becomes effective. Failure to comply with this subsection shall be a ground for revocation of the license granted under subsection C of this section.

1973, c. 504, § 38.1-279.42; 1986, c. 562.

§ 38.2-1915. Joint underwriting or joint reinsurance organizations.

A. Each group, association or other organization of insurers that engages in joint underwriting or joint reinsurance for a class of insurance to which this chapter applies shall file with the Commission (i) a copy of its constitution, articles of incorporation, agreement or association, and of its bylaws, rules and

regulations governing its activities, all duly certified by the custodian of the originals of the copies, (ii) a list of its members, and (iii) the name and address of a resident of this Commonwealth upon whom notices or orders of the Commission or process may be served.

B. Each such organization of insurers shall notify the Commission promptly of every change in the information required to be filed by subsection A of this section.

C. Each group, association or other organization of insurers that engages in joint underwriting for a class of insurance to which this chapter applies shall be subject to this chapter. Each such organization of insurers that engages in joint reinsurance for a class of insurance to which this chapter applies shall be subject to §§ 38.2-1926, 38.2-1927, and 38.2-1928.

D. If, after providing notice and opportunity to be heard, the Commission finds that any activity or practice of any such organization of insurers is unfair, unreasonable or otherwise inconsistent with this chapter, it shall issue a written order (i) specifying in what respect the activity or practice is unfair, unreasonable or otherwise inconsistent with this chapter, and (ii) requiring the discontinuance of the activity or practice.

1973, c. 504, § 38.1-279.43; 1986, c. 562.

§ 38.2-1916. Certain conduct by insurers and rate service organizations prohibited.

A. As used in this section, the word "insurer" includes two or more insurers (i) under common management, (ii) under common controlling ownership or (iii) under other common effective legal control and in fact engaged in joint or cooperative underwriting, investment management, marketing, servicing or administration of their business and affairs as insurers.

B. No insurer or rate service organization shall:

1. Combine or conspire with any other person to monopolize or attempt to monopolize the business of insurance or any kind, subdivision or class of insurance;

2. Agree with any other insurer or rate service organization to charge or adhere to any rate, although insurers and rate service organizations may continue to exchange statistical information;

3. Make any agreement with any other insurer, rate service organization or other person to restrain trade unreasonably;

4. Make any agreement with any other insurer, rate service organization or other person that may substantially lessen competition in any kind, subdivision or class of insurance; or

5. Make any agreement with any other insurer or rate service organization to refuse to deal with any person in connection with the sale of insurance.

C. No insurer may acquire or retain any capital stock or assets of, or have any common management with, any other insurer if such acquisition, retention or common management substantially lessens competition in the business of insurance or any kind, subdivision or class thereof.

D. No rate service organization, or any of its members or subscribers, shall interfere with the right of any insurer to make its rates independently of the rate service organization.

E. No rate service organization shall have or adopt any rule, exact any agreement, or engage in any program that would require any member, subscriber or other insurer to utilize some or all of its services, or to adhere to its rates, rating plans, rating systems, underwriting rules, or policy forms, or to prevent any insurer from acting independently. Notwithstanding the foregoing, with respect to insurance defined in § 38.2-119, a rate service organization may develop uniform (i) policies, (ii) classification systems, (iii) statistical plans, (iv) experience rating plans, and (v) manual rules which shall be adhered to by its members.

1976, c. 279, § 38.1-279.44:1; 1986, c. 562; 1990, c. 596; 1993, c. 985.

§ 38.2-1916.1. Investigation by Attorney General of suspected violations; investigative demand to witnesses; access to business records, etc.; penalties.

A. 1. Whenever it appears to the Attorney General, either upon complaint or otherwise, that any person has engaged in, or is engaging in, or is about to engage in any act or practice prohibited by § 38.2-1916, or any violation of subsection D of § 38.2-1919, the Attorney General may, consistent with his powers and duties to enforce the laws of the Commonwealth prohibiting conduct that unreasonably restrains trade, after notice to the Commission:

a. Either require or permit such person to file with him a statement in writing or otherwise, under oath, as to all facts and circumstances concerning the subject matter;

b. Require such other data and information as he may deem relevant to the subject matter of an investigation of a possible violation of § 38.2-1916 or subsection D of § 38.2-1919; and

c. Issue an investigative demand to witnesses by which he may (i) compel the attendance of such witnesses; (ii) examine such witnesses under oath before himself or the Commission; (iii) subject to subsection B of this section, require the production of any documents or things that he deems relevant or material to the inquiry; and (iv) issue written interrogatories to be answered by the witness served or, if the witness served is a public or private corporation or a partnership or association or governmental agency, by any officer or agent, who shall furnish such information as is available to the witness.

2. The investigative powers authorized shall not abate or terminate by reason of any action or proceeding brought by the Attorney General or the Commission under this title. When a document or thing is demanded by an investigative demand, that demand shall not (i) contain any requirement that would be unreasonable or improper if contained in a subpoena duces tecum issued by a court of this Commonwealth; or (ii) require the disclosure of any document or thing that would be privileged, or production of which for any other reason would not be required by a subpoena duces tecum issued by a court of this Commonwealth.

B. Where the information requested pursuant to an investigative demand may be derived or ascertained from the business records of the party upon whom the interrogatory has been served or from an

examination, audit, or inspection of such business records, or from a compilation, abstract, or summary based therein, and the burden of deriving or ascertaining the answer is substantially the same for the Attorney General as for the party from whom such information is requested, it shall be sufficient for that party to specify the records from which the answer may be derived or ascertained and to afford the Attorney General, or other individuals properly designated by the Attorney General, reasonable opportunity to examine, audit, or inspect such records and to make copies, compilations, abstracts, or summaries. The Attorney General is authorized, and may so elect, to require the production pursuant to this section, of documents or things before or after the taking of any testimony of the person summoned pursuant to an investigative demand, in which event, those documents or things shall be made available for inspection and copying during normal business hours at the principal place of business of the person served, or at such other time and place as may be agreed upon by the person served and the Attorney General.

C. Any investigative demand issued by the Attorney General under this section shall contain (i) a citation to this statute and section, (ii) a citation to the statute and section pertaining to the alleged violation under investigation, (iii) the subject matter of the investigation, and (iv) the date, place, and time the person is required to appear to produce testimony or documentary material in his possession, custody or control. Such date shall not be less than twenty days from the date of the investigative demand. Where documentary material is required to be produced, it shall be described by class so as to clearly indicate the material demanded.

D. Service of an investigative demand as provided in this section may be made by:

1. Delivery of a duly executed copy thereof to the person served or, if a person is not a natural person, to the principal place of business of the person to be served; or

2. Mailing by certified mail, return receipt requested, a duly executed copy thereof addressed to the person to be served at his principal place of business in this Commonwealth, or if that person has no place of business in this Commonwealth, to his principal office.

E. Within twenty days after the service of any such demand upon any person or enterprise, or at any time before the return date specified in the demand, whichever period is shorter, such party may file with the Commission and serve upon the Attorney General a petition for an order of the Commission modifying or setting aside such demand. The time allowed for compliance with the demand, in whole or in part as deemed proper and ordered by the Commission, shall not run during the pendency of such petition in the Commission. Such petition shall specify each ground upon which the petitioner relies in seeking such relief, and may be based upon any failure of such demand to comply with the provisions of this section or upon any constitutional or other legal right or privilege of such party. The provisions of this subsection shall be the exclusive means for a witness summoned pursuant to an investigative demand under this section to challenge an investigative demand issued pursuant to subsection A of this section.

F. The examination of all witnesses under this section shall be conducted by the Attorney General, or his designee, before an officer authorized to administer oaths in this Commonwealth. The testimony shall be taken stenographically or by a sound-recording device and shall be transcribed.

G. Any person required to testify or to submit documentary evidence shall be entitled, on payment of lawfully prescribed cost, to procure a copy of any document produced by such person and of his own testimony as stenographically reported or, in the case of depositions, as reduced to writing by or under the direction of a person taking the deposition. Any party compelled to testify or to produce documents or things may be accompanied and advised by counsel, but counsel may not, as a matter of right, otherwise participate in the investigation.

H. All persons served with an investigative demand by the Attorney General under this section, other than any person or persons whose conduct or practices are being investigated or any officer, director, or person in the employ of such person under investigation, shall be paid the same fees and mileage as paid witnesses in the courts of this Commonwealth. No person shall be excused from attending such inquiry pursuant to the mandate of an investigative demand, from producing a document or thing, or from being examined or required to answer questions, on the ground of failure to tender or pay a witness fee or mileage, unless a demand therefor is made at the time testimony is about to be taken and is made as a condition precedent to offering such production or testimony and unless payment is not made.

I. Any natural person who neglects or refuses (i) to attend and testify, (ii) to answer any lawful inquiry, or (iii) to produce documents or things, if in his power to do so, in obedience of an investigative demand or lawful request of the Attorney General or those properly authorized by the Attorney General, pursuant to this section, shall be subject to the penalty provisions of § 38.2-218. Any natural person who commits perjury, false swearing, or contempt in answering or failing to answer, or in producing a document or thing or failing to do so in accordance with an investigative demand or lawful request by the Attorney General, pursuant to this section, shall be guilty of a misdemeanor and upon conviction therefor by a court of competent jurisdiction shall be punished by a fine of not more than $5,000 or by imprisonment in jail for not more than one year, or both.

J. In any investigation brought by the Attorney General pursuant to this chapter, no individual shall be excused from attending, testifying or producing documentary material, objects, or intangible things in obedience to an investigative demand or under order of the Commission on the ground that the testimony, document, or thing required of him may tend to incriminate him or subject him to any penalty. No testimony or other information compelled either by the Attorney General or under order of the Commission or a court or any information directly or indirectly derived from such testimony or other information may be used against the individual or witness in any criminal case. However, he may be prosecuted or subjected to penalty or forfeiture for any perjury, false swearing, or contempt committed in answering or failing to answer, or in producing any document or thing or failing to do so in accordance with the demand of the Attorney General or the Commission. If an individual refuses to testify or produce any document or thing after being granted immunity from criminal prosecution and after being

ordered to testify or produce any document or thing as authorized by this section, he may be found to be in civil contempt by a court of competent jurisdiction and incarcerated until such time as he purges himself of contempt by testifying, producing such document or thing, or presenting a written statement as ordered. Such finding of contempt shall not prevent the Attorney General from instituting other appropriate contempt proceedings against any person who violates any of the provisions of this section.

K. It shall be the duty of all public state and local officials, their employees, and all other persons to render and furnish to the Attorney General or his designee, when so requested, all information and assistance in their possession or within their power. Any officer participating in such inquiry and any person examined as a witness upon such inquiry who discloses to any person other than the Attorney General the name of any witness examined or any other information obtained upon such inquiry, except as so directed by the Attorney General, shall be guilty of a misdemeanor and subject to the sanctions prescribed in subsection I of this section. Such inquiry may upon written authorization by the Attorney General be made public.

L. The Attorney General may recommend rules and regulations to implement and carry out the provisions of this section. All such rules and regulations shall be subject to the approval of the Commission.

M. It shall be the duty of the Attorney General, or his designees, to maintain the secrecy of all evidence, testimony, documents, or other results of such investigations until formal proceedings are instituted. Violation of this subsection shall be punishable pursuant to § 38.2-218. Nothing contained in this section shall be construed to prevent the disclosure of any such investigative evidence by the Attorney General in his discretion to the Commissioner of Insurance, the State Corporation Commission, or to any federal or state law-enforcement authority that has restrictions governing confidentiality similar to those contained in this subsection.

1990, c. 596; 2002, c. 472.

§ 38.2-1916.2. Penalties; injunctive relief; restitution.

A. Notwithstanding the provisions of § 38.2-218, any insurer, rate service organization or other person who knowingly or willfully violates any provision of § 38.2-1916 shall be punished for each such violation by a penalty of not more than $100,000 and may be subject to suspension or revocation of any license issued by the Commission.

B. Any person threatened with injury or damage to his business or property by reason of a violation of § 38.2-1916 may petition the Commission for injunctive relief pursuant to § 38.2-220.

C. The Commission may require an insurer, rate service organization, or other person to make restitution in the amount of the direct actual financial loss, including any costs associated with bringing such a matter before the Commission and reasonable attorney's fees, to (i) the Commonwealth, a political subdivision thereof, or any public agency injured in its business or property or (ii) any person injured in his business or property by reason of a violation of § 38.2-1916. If the Commission finds that

the violation is willful or flagrant, it may increase the restitution payment to an amount not in excess of three times the actual damages sustained.

1990, c. 596.

§ 38.2-1917. Injunctive relief.

Any person injured in his business or property by reason of any violation of § 38.2-1916 may maintain an action to enjoin the violation.

1976, c. 279, § 38.1-279.44:3; 1986, c. 562.

§ 38.2-1918. Agreements for equitable apportionment of insurance.

A. Nothing in this chapter shall prohibit the making of agreements among insurers for the equitable apportionment among them of insurance which may be afforded applicants who are in good faith entitled to but who are unable to procure it through ordinary methods. Insurers may agree among themselves on the use of reasonable rate modifications for such insurance. These agreements and rate modifications shall be subject to the approval of the Commission.

B. The Commission may approve policy forms and endorsements for use by such insurers with respect to insurance afforded such applicants.

1973, c. 504, § 38.1-279.45; 1986, c. 562.

§ 38.2-1919. Collection of experience data; uniformity; compilations available to insurers and rate service organizations.

A. The Commission may promulgate reasonable rules and statistical plans for each of the rating systems on file with it, which may be modified from time to time. These rules and plans shall be used by each insurer in the recording and reporting of its loss and countrywide expense experience, so that the experience of all insurers may be made available, at least annually, in the form and detail necessary to aid the Commission in determining whether rating systems comply with the standards set forth in § 38.2-1904. The rules and plans may also provide for the recording and reporting of expense experience items that are specially applicable to this Commonwealth and cannot be determined by prorating the countrywide experience.

B. In promulgating the rules and plans the Commission shall give due consideration (i) to the rating systems on file with it and (ii) to the rules and to the form of the plans used for rating systems in other states so that the rules and plans may be as uniform as is practicable among the several states.

C. The Commission may designate one or more rate service organizations or other agencies to assist it in gathering the experience data and making compilations of it. These compilations shall be made available, subject to reasonable rules promulgated by the Commission, to insurers and rate service organizations. Any rate service organization designated by the Commission shall retain the experience data and compilations of the experience data in the format and detail required by the applicable statistical plan and shall submit this information to the Commission upon request. Any rate service organization designated by the Commission to gather and compile experience data for any

classification of workers' compensation insurance that includes coal mining shall report such data annually to the Commission for the most recent five years for which such data is available.

D. Every rate service organization that has uniform (i) statistical plans, (ii) classification systems, (iii) experience rating plans, and (iv) manual rules filed and approved in accordance with the provisions of § 38.2-1913 D shall gather and compile the experience data of its members for insurance as defined in § 38.2-119. Each member insurer shall adhere to such uniform plans, systems, and rules of its designated rate service organization in the recording of its experience and the reporting of such information to the rate service organization. Each rate service organization that gathers and compiles information pursuant to this subsection shall be subject to the provisions of subsection C as to the availability, retention, and filing of the experience data of its members.

1973, c. 504, § 38.1-279.46; 1976, c. 329; 1986, c. 562; 1993, c. 985; 2003, c. 222.

§ 38.2-1919.1. Interchange of rating data and information.

To promote uniform administration of rate regulatory laws, the Commission and each insurer and each rate service organization subject to this chapter may (i) exchange information and experience data with insurance supervisory officials, insurers, and rate service organizations in other states and (ii) consult with them regarding rate making and the application of rating schedules and rating plans. Reasonable rules and plans may be promulgated by the Commission for the interchange of data necessary for the application of rating plans.

1993, c. 985.

§ 38.2-1920. Excess rate for a specific risk.

Subject to the Commission's approval, a rate in excess of that provided by an applicable filing may be used for a specific risk upon the filing of (i) written application of the insurer stating its reasons for the increased rate and (ii) the written consent of the insured or prospective insured.

1973, c. 504, § 38.1-279.47; 1986, c. 562.

§ 38.2-1921. Combination policies.

The Commission may approve for use in this Commonwealth policies or forms for writing at divisible or indivisible rates and premiums any combination of the classes of insurance set forth in subsection A of § 38.2-1902, except insurance on or with respect to operating properties of railroads. The rates and premiums for combination policies, whether divisible or indivisible, shall be subject to this chapter.

1973, c. 504, § 38.1-279.49; 1986, c. 562.

§ 38.2-1921.1. Professional employer organization workers' compensation rating.

A. Whenever any professional employer organization enters into an agreement with a client company to provide professional employer services, the experience rating of the professional employer organization shall be used for voluntary market workers' compensation insurance premium computation purposes with respect to such coemployees. In the event that the agreement between a client company

and a professional employer organization is terminated, the coemployees shall become solely the employees of the former client company. If the coemployees have been covered as employees of the professional employer organization under a voluntary market workers' compensation insurance policy for a period of three consecutive years or more, the workers' compensation insurance premium applicable to the policy of the former client company shall be based upon the rating of the professional employer organization until the former client employer has developed sufficient experience to be rated on its own or no longer qualifies for experience rating. If the coemployees have been covered as employees of the professional employer organization for a period of less than three consecutive years, the workers' compensation insurance premium applicable to the policy of the former client company shall be based upon the experience of the former client company which reflects its experience during the experience period specified by the approved experience rating plan, including, if available, experience incurred for coemployees under the professional employer services agreement.

B. Insurers may conduct periodic audits of any professional employer organization, including payrolls, operations and records as related to individual client company operations in order to ensure that the appropriate premium is charged for workers' compensation insurance coverage. Such audits may include audits of the client company in order to verify payroll, losses and classifications, and inspections of the premises where the coemployees work.

C. A professional employer organization may aggregate its coemployees under a single employer plan for the purpose of providing employee benefits provided that the professional employer organization meets the regulatory licensure and filing requirements promulgated by the Commission for fully insured multiple employer welfare arrangements. The following information required to be filed shall be confidential and shall not be disclosed to the public: (i) all information related to the names and addresses of employers participating in the plan and (ii) all information pertaining to the adequacy of the plan's level of reserves and contributions; however, nothing herein shall (i) prevent the Commission from using such information in any regulatory proceeding or (ii) be interpreted to prohibit or limit the production of documents containing such information from the professional employer organization pursuant to an otherwise lawful subpoena issued by a court of competent jurisdiction.

D. The Commission may promulgate regulations as it deems necessary for the administration of this section.

2000, cc. 624, 718.

§ 38.2-1922. No rule prohibiting or regulating payment of dividends, etc., to be adopted.

No rate service organization subject to this chapter shall adopt any rule prohibiting or regulating the payment of dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers.

1973, c. 504, § 38.1-279.50; 1986, c. 562.

§ 38.2-1923. Person aggrieved by application of rating system to be heard; appeal to Commission.

Each rate service organization and each insurer subject to this chapter shall provide within this Commonwealth reasonable means for any person aggrieved by the application of its rating system to be heard in person or by an authorized representative on his written request. Any person who makes the written request shall be entitled to review the manner in which the rating system has been applied to the insurance afforded him. If the rate service organization or insurer fails to grant or reject the request within thirty days after it is made, the applicant may proceed in the same manner as if his application had been rejected. Any person affected by the action of the rate service organization or the insurer on the request may, within thirty days after written notice of the action, appeal to the Commission. The Commission may affirm or reverse the action after a hearing held upon not less than ten days' written notice to the applicant and to the rate service organization or insurer.

1973, c. 504, § 38.1-279.51; 1986, c. 562; 1990, c. 596.

§ 38.2-1924. Cooperation among rate service organizations, or among rate service organizations and insurers, authorized; review by Commission.

Cooperation among rate service organizations or among rate service organizations and insurers in rate making or in other matters within the scope of this chapter is hereby authorized if the filings resulting from such cooperation are subject to all the provisions of this chapter applying to filings generally. The Commission may review such cooperative activities and practices. If, after providing notice and opportunity to be heard, it finds that any cooperative activity or practice is unfair, unreasonable or otherwise inconsistent with this chapter, the Commission shall issue a written order (i) specifying in what respects the cooperative activity or practice is unfair, unreasonable or otherwise inconsistent with this chapter, and (ii) requiring the discontinuance of the cooperative activity or practice.

1973, c. 504, § 38.1-279.52; 1986, c. 562.

§ 38.2-1925. Examination of rate service organizations and joint underwriting and joint reinsurance organizations.

A. Whenever the Commission considers it necessary to be informed about any matter related to the enforcement of the insurance laws, it may examine the affairs and condition of any rate service organization under subsection A of § 38.2-1913 and of any joint underwriting or joint reinsurance organization under § 38.2-1915.

B. So far as reasonably necessary for any examination under subsection A of this section, the Commission may examine the accounts, records, documents or evidence of transactions, so far as they relate to the examinee, of any (i) officer, (ii) manager, (iii) general agent, (iv) employee, (v) person who has executive authority over or is in charge of any segment of the examinee's affairs, (vi) person controlling or having a contract under which he has the right to control the examinee whether exclusively or with others, (vii) person who is under the control of the examinee, or (viii) person who is under the control of a person who controls or has a right to control the examinee whether exclusively or with others.

C. On demand every examinee under subsection A of this section shall make available to the Commission for examination any of its own accounts, records, documents or evidences of transactions and any of those of the persons listed in subsection B of this section.

D. The Commission may examine every licensed rate service organization at intervals established by the Commission.

E. 1. Instead of all or part of an examination under subsections A and B of this section, or in addition to it, the Commission may order an independent audit by certified public accountants or actuarial evaluation by actuaries approved by it of any person subject to the examination requirement. Any accountant or actuary selected shall be subject to standards respecting conflicts of interest used by the Commission. Any audit or evaluation under this subsection shall be subject to subsections H through O of this section, so far as appropriate.

2. Instead of all or part of an examination under this section, the Commission may accept the report of an audit already made by certified public accountants or actuarial evaluation by actuaries approved by it, or the report of an examination made by the insurance department of another state.

F. [Reserved.]

G. An examination may cover comprehensively all aspects of the examinee's affairs and condition. The Commission shall determine the exact nature and scope of each examination, and in doing so shall take into account all relevant factors, including but not limited to (i) the length of time the examinee has been operating, (ii) the length of time it has been licensed in this Commonwealth, (iii) the nature of the services provided, (iv) the nature of the accounting records available and (v) the nature of examinations performed elsewhere.

H. For each examination under this section, the Commission shall issue an order stating the scope of the examination and designating the examiner in charge. On demand a copy of the order shall be exhibited to the examinee.

I. Any examiner authorized by the Commission shall, so far as necessary for the purposes of the examination, have access at all reasonable hours to the premises and to any books, records, files, securities, documents or property of the examinee and to those of persons under subsection B of this section so far as they relate to the affairs of the examinee.

J. The officers, employees and agents of the examinee and of persons under subsection B of this section shall comply with every reasonable request of the examiners for assistance in any matter relating to the examination. No person shall obstruct or interfere with the examination in any way other than by legal process.

K. If the Commission finds the accounts or records to be inadequate for proper examination of the condition and affairs of the examinee or improperly kept or posted, it may employ experts to rewrite, post or balance them at the expense of the examinee.

L. The examiner in charge of an examination shall make a proposed report of the examination that shall include the information and analysis as is ordered in subsection H of this section, together with the examiner's recommendations. At the discretion of the examiner in charge, preparation of the proposed report may include conferences with the examinee or its representatives. The proposed report shall remain confidential until filed under subsection M of this section.

M. The Commission shall serve a copy of the proposed report upon the examinee. Within twenty days after service, the examinee may serve upon the Commission a written demand for a hearing on the contents of the report. If a hearing is demanded the Commission shall give notice and hold a hearing, and on demand by the examinee the hearing shall be informal and private. The Commission shall adopt the report with any necessary modifications and file it for public inspection, or it may order a new examination within either (i) sixty days after the hearing or (ii) if no hearing is demanded, sixty days after the last day on which the examinee might have demanded a hearing.

N. The Commission shall forward a copy of the examination report to the examinee immediately upon adoption, except that if the proposed report is adopted without change, the Commission need only so notify the examinee.

O. The examinee shall furnish copies of the adopted report to each member of its board of directors or other governing board.

P. The Commission may furnish, without cost or at a price to be determined by it, a copy of the adopted report to the insurance commissioner of any jurisdiction in which the examinee is licensed and to any other interested person in this Commonwealth or elsewhere.

Q. In any proceeding by or against the examinee or any officer or agent of the examinee, the examination report as adopted by the Commission shall be admissible as evidence of the facts stated in the examination report. In any proceeding by or against the examinee the facts asserted in any report properly admitted in evidence shall be presumed to be true in the absence of contrary evidence.

R. The reasonable costs of an examination under this section shall be paid by the examinee except as provided in subsection U of this section. The costs shall include the salary and expenses of each examiner and any other expenses directly apportioned to the examination.

S. The amount payable under subsection R of this section shall become due ten days after the examinee has been served a detailed account of the costs.

T. The Commission may require any examinee, before or during an examination, to deposit with the State Treasurer any deposits the Commission considers necessary to pay the cost of the examination. Any deposit and any payment made under subsections R and S of this section shall be credited to the special fund of the Bureau of Insurance.

U. On the examinee's request or on its own motion, the Commission may pay all or part of the costs of an examination whenever it finds that, because of the frequency of examinations or other factors,

imposition of the costs would place an unreasonable burden on the examinee. The Commission shall include in its annual report information about any instance in which it applied this subsection.

V. Deposits and payments under subsections R through U of this section shall not be considered to be a tax or license fee within the meaning of any law. If any other state charges a per diem fee for examination of examinees domiciled in this Commonwealth, any examinee domiciled in that other state shall pay the same fee when examined by the Commission.

1973, c. 504, § 38.1-279.53; 1986, c. 562.

§ 38.2-1926. Action of Commission upon request for hearing on order or decision made without a hearing.

A. Any person aggrieved by an order or a decision of the Commission made under this chapter without a hearing may, within thirty days after notice of the order or decision, make a written request to the Commission for a hearing on that order or decision. Within a reasonable time after the request the Commission, after having given not less than ten days' written notice of the time and place of hearing, shall hear the person aggrieved by the order or decision. Within a reasonable time after the hearing the Commission shall affirm, reverse or modify its previous action, specifying its reasons for the affirmation, reversal or modification.

B. Pending the hearing and decision on its previous action, the Commission may suspend or postpone the effective date of the order or decision to which the hearing relates.

1973, c. 504, § 38.1-279.54; 1986, c. 562.

§ 38.2-1927. Withholding information; giving false or misleading information.

No person shall willfully withhold information from or knowingly give false or misleading information to (i) the Commission, (ii) any statistical agency designated by the Commission, (iii) any rate service organization or (iv) any insurer, if that information will affect the rates or premiums subject to this chapter.

1973, c. 504, § 38.1-279.55; 1986, c. 562.

§ 38.2-1928. Violations of chapter.

The issuance, procurement or negotiation of a single policy of insurance shall be deemed a separate violation.

1973, c. 504, § 38.1-279.56; 1976, c. 279; 1986, c. 562.

Chapter 20 - REGULATION OF RATES FOR CERTAIN TYPES OF INSURANCE

Article 1 - General Provisions

§ 38.2-2000. Purposes of chapter.

A. The purposes of this chapter are to protect policyholders and the public against the adverse effects of excessive, inadequate, or unfairly discriminatory insurance rates, and to authorize and regulate cooperative action among insurers in rate making and in other matters within the scope of this chapter.

Nothing in this chapter is intended to (i) prohibit or discourage reasonable competition, or (ii) prohibit or encourage uniformity in insurance rates, rating systems and rating plans or practices, except to the extent necessary to accomplish the purposes mentioned above.

B. This chapter shall be liberally interpreted to effect the purposes of this chapter.

1952, c. 317, § 38.1-218; 1986, c. 562.

§ 38.2-2000.1. Definitions.

As used in this chapter:

"Pool" means an arrangement, either voluntary or mandated by law, established on an on-going basis, pursuant to which two or more insurers participate in the sharing of risks on a predetermined basis, which arrangement may operate through an association, syndicate, or other pool arrangement.

"Residual market mechanism" means an arrangement, either voluntary or mandated by law, involving participation by insurers in equitable apportionment among themselves of insurance which may be afforded applicants who are unable to obtain insurance through ordinary methods including any filed and approved plans.

"Virginia Auto Insurance Plan" means that organization established for assigned risks pursuant to the provisions of § 46.2-464.

"Virginia Property Insurance Association" means that organization established pursuant to Chapter 27 (§ 38.2-2700 et seq.) of this title.

"Virginia Workers' Compensation Insurance Plan" means that organization established for assigned risks pursuant to the provisions of § 65.2-820.

1993, c. 985.

§ 38.2-2001. Insurance to which chapter applies.

This chapter applies only to (i) insurance written through the Virginia Workers' Compensation Insurance Plan, (ii) the coverages provided in the Virginia Automobile Insurance Plan, (iii) the coverages provided pursuant to Chapter 27 (§ 38.2-2700 et seq.) of this title, (iv) home protection contracts as defined by § 38.2-2600, and (v) policies and endorsements of credit involuntary unemployment insurance, as defined in § 38.2-122.1, and policies and endorsements of credit property insurance, as defined in § 38.2-122.2, delivered or issued for delivery in this Commonwealth, and certificates of credit involuntary unemployment insurance and certificates of credit property insurance delivered or issued for delivery in this Commonwealth where the group policy is delivered in another state.

Code 1950, §§ 38-195, 38-247, 38-253.43; 1950, p. 1033; 1952, c. 317, § 38.1-220; 1972, c. 836; 1973, c. 504; 1981, c. 530; 1986, c. 562; 1993, c. 985; 2000, c. 526; 2002, c. 145.

§ 38.2-2002. Joint underwriting and joint reinsurance.

A. 1. Each group, association or other organization of insurers that engages in joint underwriting or joint reinsurance for the insurance to which this chapter applies shall file with the Commission (i) a

copy of its constitution, its articles of incorporation, agreement or association, and a copy of its bylaws, rules and regulations governing its activities, all duly certified by the custodian of the originals of the copies, (ii) a list of its members, and (iii) the name and address of a resident of this Commonwealth upon whom notices or orders of the Commission or process may be served.

2. Each such organization of insurers shall notify the Commission promptly of every change in the information required to be filed by this subsection.

3. This subsection shall not apply to the Virginia Automobile Insurance Plan, the Virginia Property Insurance Association and the Virginia Workers' Compensation Insurance Plan.

B. Each group, association or other organization of insurers that engages in joint underwriting for the insurance to which this chapter applies shall be subject to this chapter. Each such organization of insurers that engages in joint reinsurance for the insurance to which this chapter applies shall be subject to § 38.2-2026.

C. If, after providing notice and opportunity to be heard, the Commission finds any activity or practice of any such organization of insurers to be unfair, unreasonable or otherwise inconsistent with this chapter, it shall issue a written order (i) specifying in what respect the activity or practice is unfair, unreasonable or otherwise inconsistent with this chapter, and (ii) requiring the discontinuance of the activity or practice.

Code 1950, §§ 38-218.2, 38-249, 38-253.46; 1952, c. 317, § 38.1-224; 1973, c. 504, § 38.1-279.43; 1986, c. 562; 1993, c. 985.

§ 38.2-2002.1. Residual market mechanism; reinsurance pool.

Notwithstanding any other provision of law, insurers and rate service organizations participating in joint reinsurance pools organized for the purpose of establishing a residual market mechanism may, in connection with such purpose, act in cooperation with each other in the making of rates, rating systems, policy forms, underwriting rules, surveys, inspections, investigations, the furnishing of statistical or other information on losses and expenses, or the conduct of research.

1993, c. 985.

Article 2 - RATE FILINGS AND MAKING OF RATES

§ 38.2-2003. Rate filings by insurer; supporting information.

A. Each insurer writing in this Commonwealth a class of insurance to which this chapter applies shall file with the Commission every manual of classifications, minimum rate, class rate, rating schedule, rating plan, rating rule, and every modification of any of the foregoing that it proposes to use. Every filing shall indicate the character and extent of coverage contemplated. When a filing is not accompanied by the information upon which the insurer supports the filing, and the Commission does not have sufficient information to determine whether the filing meets the requirements of this chapter, the Commission may require the insurer to furnish the information upon which it supports the filing. A filing and any supporting information shall be a public record. Upon filing any rate to which this chapter is

applicable, the insurer shall give notice to the Division of Consumer Counsel of the Office of the Attorney General that such rate has been filed with the Commission and such insurer shall so certify to the Commission in its rate filing. For the purposes of this section, a group or fleet of insurers operating under the same general management may be considered an insurer.

B. Each insurer shall submit with each rate filing so much of the following information as deemed appropriate by the Commission:

1. Number of exposures;

2. Direct premiums written;

3. Direct premiums earned;

4. Direct losses paid identified by such period as the Commission may require;

5. Number of claims paid;

6. Direct losses incurred during the year, direct losses incurred during the year which occurred and were paid during the year, and direct losses incurred during the year which were reported during the year but were not yet paid;

7. Any loss development factor used and supporting data thereon;

8. Number of claims unpaid;

9. Loss adjustment expenses paid identified by such period as the Commission may require;

10. Loss adjustment expenses incurred during the year, loss adjustment expenses incurred during the year for losses which occurred and were paid during the year, and loss adjustment expenses incurred during the year for losses which were reported during the year but were not yet paid;

11. Other expenses incurred, separately by category of expense, excluding loss adjustment expenses;

12. Investment income on assets related to reserve and allocated surplus accounts;

13. Total return on allocated surplus;

14. Any loss trend factor used and supporting data thereon;

15. Any expense trend factor used and supporting data thereon; and

16. Such other information as may be required by rule of the Commission, including statewide rate information presented separately for Virginia and each state wherein the insurer writes the line, subline or rating classification for which the rate filing is made and which the Commission deems necessary for its consideration.

C. Where actual experience does not exist or is not credible, the Commission may allow the use of estimates for the information required by subdivisions 1 through 15 of subsection B of this section and may require the insurer to submit such information as the Commission deems necessary to support such estimates.

D. The Commission shall develop uniform statements or formats specifying the information categories specified in this section. Such statements or formats shall be utilized by all insurers in all rate filings.

E. In determining the appropriateness of rates for credit involuntary unemployment insurance and credit property insurance, the Commission may not approve any rate that is calculated based upon loss experience producing a loss ratio of less than forty percent on and after January 1, 2001, forty-five percent on and after January 1, 2003, and fifty percent on and after January 1, 2005. For the purposes of this subsection, loss experience includes: paid losses, paid loss adjustment expense, any change in case reserves, change in incurred but not reported losses, and any special considerations for catastrophe or comprehensive coverage.

Code 1950, §§ 38-253.26, 38-253.72; 1950, p. 381; 1952, c. 317, § 38.1-241; 1972, c. 836; 1973, c. 504; 1986, c. 562; 1987, c. 697; 1988, c. 189; 2000, c. 526.

§ 38.2-2004. Filings by rate service organization.

An insurer may satisfy its obligation to make the rate filings required in § 38.2-2003 by becoming a member of or a subscriber to a rate service organization that makes such filings and that is licensed pursuant to § 38.2-1914, and by authorizing the Commission to accept the filings on its behalf. Filings made by rate service organizations shall meet the requirements of § 38.2-2003. No insurer shall be required to become a member of or a subscriber to any rate service organization.

Code 1950, §§ 38-253.27, 38-253.73; 1952, c. 317, § 38.1-242; 1972, c. 836; 1973, c. 504; 1986, c. 562.

§ 38.2-2005. Provisions governing making of rates.

A. Rates for the classes of insurance to which this chapter applies shall not be excessive, inadequate, or unfairly discriminatory. All rates and all changes and amendments to rates to which this chapter applies for use in this Commonwealth shall consider loss experience and other factors within Virginia if relevant and actuarially sound; however, other data, including countrywide, regional or other state data, may be considered where such data is relevant and where a sound actuarial basis exists for considering data other than Virginia-specific data.

B. 1. In making rates for the classes of insurance to which this chapter applies, separate consideration shall be given to (i) past and prospective loss experience within and outside this Commonwealth, (ii) conflagration or catastrophe hazards, (iii) a reasonable margin for underwriting profit and contingencies, (iv) dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers, (v) past and prospective expenses both countrywide and those specifically applicable to this Commonwealth, (vi) investment income earned or realized by insurers from their unearned premium and loss reserve and the Commission may give separate consideration to investment income earned on surplus funds, (vii) the loss reserving practices, standards and procedures utilized by the insurer, and (viii) all other relevant factors within and outside this Commonwealth. When actual experience or data does not exist, the Commission may consider estimates.

2. In the case of fire insurance rates, consideration shall be given to the experience of the fire insurance business during a period of not less than the most recent five-year period for which such experience is available.

3. [Repealed.]

In the case of workers' compensation insurance rates for volunteer firefighters or volunteer emergency medical services personnel written through the Virginia Worker's Compensation Insurance Plan, the rates shall be calculated based upon the combined experience of both volunteer firefighters or volunteer emergency medical services personnel and paid firefighters or paid emergency medical services personnel, so that the resulting rate is the same for both volunteer and paid members, but in no event shall resulting premiums be less than $40 per year for any volunteer firefighter or volunteer emergency medical services personnel.

C. For the classes of insurance to which this chapter applies (i) the systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the requirements of the operating methods of any such insurer or group for any class of insurance, or for any subdivision or combination of insurance for which separate expense provisions apply, and (ii) risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans that establish standards for measuring variations in hazards, expense provisions, or both. The standards may measure any difference among risks that can be demonstrated to have a probable effect upon losses or expenses.

D. All rates, rating schedules or rating plans and every manual of classifications, rules and rates, including every modification thereof, approved by the Commission under this chapter, shall be used until a change is approved by the Commission.

Code 1950, §§ 38-208, 38-253.21, 38-253.68; 1950, p. 403; 1952, c. 317, § 38.1-252; 1962, c. 253; 1970, c. 186; 1972, c. 836; 1973, c. 504; 1986, c. 562; 1987, c. 697; 1996, c. 250; 2002, c. 145; 2015, cc. 502, 503.

§ 38.2-2006. Approval by Commission prerequisite to use of filing.

A. Except as provided in § 38.2-2010, no filing shall become effective, be applied, or be used in this Commonwealth until it has been approved by the Commission. However, a rate produced in accordance with a rating schedule or rating plan, previously approved by the Commission, may be used pending the approval.

B. A filing shall be deemed to meet the requirements of this chapter and to become effective unless disapproved by the Commission within sixty days of the time that the filing was made. However, the Commission may extend the waiting period for thirty additional days by written notice to the filer before the sixty-day period expires.

C. If a filing is not accompanied by the information necessary for the Commission to determine if the requirements of § 38.2-2005 are satisfied, the Commission shall so inform the filer within sixty days of the initial filing. The filing shall be deemed to be made when the necessary information is furnished.

D. The provisions of subsection B of this section shall be suspended when the Commission has ordered a hearing to be held under the provisions of § 38.2-2007.

Code 1950, §§ 38-210, 38-253.29, 38-253.75; 1952, c. 317, § 38.1-253; 1986, c. 562; 1987, c. 697.

§ 38.2-2006.1. Approval by the Commission for credit property and credit involuntary unemployment insurance rates.

No rate charged in connection with a credit involuntary unemployment insurance policy, endorsement, or certificate issued in this Commonwealth, and no rate charged in connection with a credit property insurance policy, endorsement, or certificate issued in this Commonwealth, shall be used unless it has been filed with the Commission pursuant to the provisions of this chapter to be approved for use on or after April 1, 2001, April 1, 2003, and April 1, 2005, as set forth in subsection E of § 38.2-2003.

2000, c. 526.

§ 38.2-2007. Commission to determine if notice of filing to be published; hearing; approval or disapproval.

A. When a filing has been made with the Commission, the Commission shall determine whether publication of notice of the filing is necessary. If the Commission determines that such publication is required, the notice shall be published in the form and for the time prescribed by the Commission, not to exceed once a week for four consecutive weeks, in a newspaper or newspapers of general circulation published in the Commonwealth.

B. Prior to publication or upon completion of publication, the Commission shall determine whether a hearing should be held before acting upon the filing. If the Commission determines that a hearing should be held, it shall order one to be held within a reasonable time, but not less than ten days after issuing the order setting the hearing. The Commission shall notify the person making the filing and any other person it deems interested in the filing of the hearing.

C. Upon determination that publication of notice of a filing is unnecessary, upon completion of any required publication when no hearing is ordered, or upon completion of a hearing, the Commission shall (i) approve the filing as submitted or with any modifications deemed appropriate by the Commission, or (ii) disapprove the filing. If a filing is approved with modifications, or is disapproved, the order of such approval or disapproval shall state the reasons for the decision.

Code 1950, §§ 38-209, 38-253.28, 38-253.74; 1952, c. 317, § 38.1-254; 1986, c. 562.

§ 38.2-2008. Review of rates by Commission.

The Commission may investigate and determine, (i) upon its own motion, (ii) at the request of any citizen of this Commonwealth, or (iii) at the request of any insurer subject to this chapter, whether rates in this Commonwealth for the insurance to which this chapter applies are excessive, inadequate or

unfairly discriminatory. In accordance with its findings, the Commission may order changes in the rates that are fair and equitable to all interested parties. In any investigation and determination, the Commission shall give due consideration to those factors specified in subsection B of § 38.2-2005.

Code 1950, §§ 38-212, 38-253.23, 38-253.69; 1952, c. 317, § 38.1-255; 1986, c. 562.

§ 38.2-2009. Repealed.

Repealed by Acts 1993, c. 985, effective January 1, 1994.

§ 38.2-2010. Suspension or modification of requirement for filing.

The Commission, by order, may suspend or modify the filing requirement of this chapter for any kind of insurance or subdivision or combination of insurance, or for classes of risks, where the rates for the insurance cannot practicably be filed before they are used. The order shall be made known to insurers and rate service organizations affected by it. The Commission may make any examination it deems advisable to determine whether any rates affected by the order meet the standards set out in subsection A of § 38.2-2005.

Code 1950, §§ 38-253.31, 38-253.77; 1952, c. 317, § 38.1-259; 1986, c. 562.

§ 38.2-2011. Interchange of rating data and information.

To promote uniform administration of rate regulatory laws, the Commission and each insurer and each rate service organization subject to this chapter may (i) exchange information and experience data with insurance supervisory officials, insurers, and rate service organizations in other states, and (ii) consult with them regarding rate making and the application of rating schedules and rating plans. Reasonable rules and plans may be promulgated by the Commission for the interchange of data necessary for the application of rating plans.

Code 1950, §§ 38-218, 38-253.37, 38-253.38, 38-253.83, 38-253.84; 1952, c. 317, § 38.1-260; 1986, c. 562.

§ 38.2-2012. Collection of experience data; uniformity; compilations available to insurers and rate service organizations.

A. The Commission may promulgate reasonable rules and statistical plans for each of the rating systems on file with it, which may be modified from time to time. These rules and plans shall be used by each insurer in the recording and reporting of its loss and countrywide expense experience, so that the experience of all insurers may be made available, at least annually, in the form and detail as may be necessary to aid the Commission in determining whether rating systems comply with the standards set forth in subsection A of § 38.2-2005. The rules and plans may also provide for the recording and reporting of expense experience items that are specially applicable to this Commonwealth and cannot be determined by prorating the countrywide expense experience.

B. In promulgating the rules and plans, the Commission shall give due consideration to (i) the rating systems on file with it and (ii) the rules and the form of the plans used for rating systems in other states so that the rules and plans may be as uniform as practicable among the several states. No insurer

shall be required to record or report its loss experience on a classification basis that is inconsistent with the rating system filed by it or on its behalf.

C. The Commission may designate one or more rate service organizations or other agencies to assist it in gathering the experience data and making compilations of it. The compilations shall be made available, subject to reasonable rules promulgated by the Commission, to insurers and rate service organizations.

Code 1950, §§ 38-253.36, 38-253.82; 1952, c. 317, § 38.1-261; 1986, c. 562.

§ 38.2-2013. Excess rate for specific risk.

Subject to the Commission's approval, a rate in excess of that provided by an applicable filing may be used for a specific risk upon the filing of (i) written application of an insurer stating its reasons for the increased rate, accompanied by (ii) the written consent of the insured or prospective insured.

Code 1950, §§ 38-211, 38-253.32, 38-253.78; 1952, c. 317, § 38.1-262; 1986, c. 562.

§ 38.2-2014. Contract or policy to accord with filings.

No insurer shall make or issue an insurance policy or contract to which this chapter applies, except in accordance with the filings that are in effect for that insurer, or in accordance with an applicable provision in § 38.2-2010 or § 38.2-2013.

Code 1950, §§ 38-253.33, 38-253.79; 1950, p. 381; 1952, c. 317, § 38.1-263; 1986, c. 562; 1993, c. 985.

§ 38.2-2015. Agreements for equitable apportionment of insurance; reasonable performance standards; Virginia Workers' Compensation Insurance Plan.

A. Agreements among insurers may be made for the equitable apportionment among them of insurance that may be afforded applicants who are in good faith entitled to insurance but who are unable to procure it through ordinary methods. Insurers may agree among themselves on the use of reasonable rate modifications for the insurance. The agreements and rate modifications shall be subject to the approval of the Commission.

B. The Commission may require that the agreements contain reasonable performance standards for insurers or agents, or both, with respect to insurance afforded such applicants. The performance standards may contain, but shall not be limited to: (i) original applications, (ii) premium payments, (iii) policy issuance, (iv) policy changes, (v) return premium, (vi) return commission and (vii) administrative procedures for monitoring compliance with the standards.

C. The Commission may approve policy forms and endorsements for use by such insurers with respect to insurance afforded such applicants.

D. All licensed insurers writing workers' compensation insurance in the Commonwealth shall participate in the Virginia Workers' Compensation Insurance Plan, which shall provide for the equitable apportionment among the participants of insurance that may be afforded applicants who are in good faith entitled to but who are unable to procure such insurance through ordinary methods.

Notwithstanding any other provision of law, insurers and rate service organizations participating in the Virginia Workers' Compensation Insurance Plan may, in connection with such participation, act in cooperation with each other in the making of rates, rating systems, policy forms, underwriting rules, surveys, inspections, investigations, the furnishing of statistical or other information on losses and expenses, or the conduct of research. The rates and supplementary rate information to be used by such plan shall be approved by the Commission. Such rates shall reflect residual market experience to the extent actuarially appropriate and shall be set so that the amount received in premiums, together with reasonable investment income earned on those premiums, is reasonably expected to be sufficient to pay claims and losses incurred and reasonable operating expenses of the servicing insurers.

Code 1950, § 38-250; 1952, c. 317, § 38.1-264; 1964, c. 596; 1966, c. 299; 1980, c. 112; 1986, c. 562; 1993, c. 985.

§ 38.2-2016. Information regarding rates to be furnished insured.

Each rate service organization and each insurer subject to this chapter that makes its own rates shall furnish to any insured affected by those rates, or to the authorized representative of the insured, all pertinent information regarding the rate within a reasonable time after receiving a written request for the information.

Code 1950, §§ 38-215, 38-251, 38-253.47; 1952, c. 317, § 38.1-266; 1986, c. 562.

§ 38.2-2017. No rule prohibiting or regulating payment of dividends, etc., to be adopted.

No rate service organization subject to this chapter shall adopt any rule prohibiting or regulating the payment of dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers.

Code 1950, §§ 38-253.12, 38-253.58; 1952, c. 317, § 38.1-267; 1986, c. 562.

§ 38.2-2018. Person aggrieved by application of rating system to be heard; appeal to Commission.

Each rate service organization and each insurer subject to this chapter that makes its own rates shall provide within this Commonwealth reasonable means whereby any person aggrieved by the application of its rating system may, after written request, be heard in person or by an authorized representative to review the manner in which the rating system has been applied to the insurance afforded him. If the rate service organization or insurer fails to grant or reject the request within thirty days after it is made, the applicant may proceed in the same manner as if his application had been rejected. Any person affected by the action of the rate service organization or the insurer on such request may, within thirty days after written notice of the action, appeal to the Commission. The Commission may affirm or reverse the action after a hearing held upon not less than ten days' written notice to the applicant and to the rate service organization or insurer.

Code 1950, §§ 38-252, 38-253.48; 1952, c. 317, § 38.1-268; 1986, c. 562.

§ 38.2-2019. Cooperation among rate service organizations, or among rate service organizations and insurers, authorized; review by Commission.

Cooperation among rate service organizations or among rate service organizations and insurers in rate making or in other matters within the scope of this chapter is authorized if the filings resulting from the cooperation are subject to all the provisions of this chapter that are applicable to filings generally. The Commission may review cooperative activities and practices. If, after providing notice and opportunity to be heard, it finds that any activity or practice is unfair, unreasonable or otherwise inconsistent with this chapter, it shall issue an order (i) specifying in what respects the activity or practice is unfair, unreasonable or otherwise inconsistent with this chapter, and (ii) requiring the discontinuance of the activity or practice.

Code 1950, §§ 38-253.13, 38-253.59; 1952, c. 317, § 38.1-269; 1986, c. 562.

§ 38.2-2020. Rate service organization may procure actuarial, technical or other services.

Any rate service organization subject to this chapter may subscribe for or purchase actuarial, technical or other services if these services are available without discrimination to all members of and subscribers to the rate service organization.

Code 1950, §§ 38-204, 38-253.14, 38-253.61; 1952, c. 317, § 38.1-270; 1986, c. 562.

§ 38.2-2021. Examination of policies or other evidences of insurance.

Any rate service organization subject to this chapter for the classes of insurance for which it files rates may provide for the examination of policies, daily reports, binders, renewal certificates, endorsements or other evidences of insurance, or evidences of the cancellation of insurance, and may make reasonable rules governing their submission and the correction of any errors or omissions in them.

Code 1950, §§ 38-205, 38-253.15, 38-253.60; 1952, c. 317, § 38.1-271; 1986, c. 562.

Article 3 - ADVISORY ORGANIZATIONS

§ 38.2-2022. Advisory organizations defined.

For the purpose of this article, "advisory organization" means any group, association or other organization of insurers, located within or outside this Commonwealth, that assists insurers who make their own filings or rate service organizations in rate making, by the collection and furnishing of loss or expense statistics or by the submission of recommendations, but that does not make filings under this chapter for the kind of insurance involved.

Code 1950, §§ 38-218.1, 38-253.16, 38-253.63; 1952, c. 317, § 38.1-272; 1986, c. 562.

§ 38.2-2023. What to be filed with Commission by advisory organization.

Each advisory organization shall file with the Commission:

1. A copy of its constitution, its articles of agreement or association or its certificate of incorporation, and of its bylaws, rules and regulations governing its activities;

2. A list of its members; and

3. The name and address of a resident of this Commonwealth upon whom may be served notices or orders of the Commission or process issued at its direction.

Code 1950, §§ 38-218.1, 38-253.17, 38-253.64; 1952, c. 317, § 38.1-273; 1986, c. 562.

§ 38.2-2024. Unfair acts or practices of advisory organization.

If after a hearing the Commission finds that the furnishing of information or assistance by any advisory organization involves any act or practice that is unfair, unreasonable or otherwise inconsistent with this chapter, the Commission may issue a written order (i) specifying in what respects the act or practice is unfair, unreasonable or otherwise inconsistent with this chapter, and (ii) requiring the discontinuance of the act or practice.

Code 1950, §§ 38-218.1, 38-253.18, 38-253.65; 1952, c. 317, § 38.1-274; 1986, c. 562.

§ 38.2-2025. Statistics or recommendations by advisory organization not complying with this article or order of Commission.

No insurer that makes its own filings nor any rate service organization shall support its filings by statistics or adopt rate making recommendations furnished to it by an advisory organization that has not complied with (i) the provisions of this article or (ii) any order of the Commission entered under § 38.2-2024, involving such statistics or recommendations. If the Commission finds any insurer or rate service organization to be in violation of this section it may issue an order requiring the discontinuance of the violation.

Code 1950, §§ 38-253.19, 38-253.66; 1952, c. 317, § 38.1-275; 1986, c. 562.

Article 4 - HEARINGS, OFFENSES AND PENALTIES

§ 38.2-2026. Action of Commission upon request for hearing on order or decision made without a hearing.

A. Any person aggrieved by an order or a decision of the Commission made under this chapter without a hearing may, within thirty days after notice of the order or decision, make a written request to the Commission for a hearing on the order or decision. Within a reasonable time after the request the Commission, after having given at least ten days' written notice of the time and place of hearing, shall hear the person aggrieved by the order or decision. Within a reasonable time after the hearing the Commission shall affirm, reverse or modify its previous action, specifying its reasons for the affirmation, reversal or modification.

B. Pending the hearing and decision on its previous action, the Commission may suspend or postpone the effective date of the order or decision to which the hearing relates.

Code 1950, §§ 38-218.11, 38-253, 38-253.49; 1952, c. 317, § 38.1-276; 1986, c. 562.

§ 38.2-2027. Withholding information; giving false or misleading information.

No person shall willfully withhold information from or knowingly give false or misleading information to (i) the Commission, (ii) any statistical agency designated by the Commission, (iii) any rate service organization or (iv) any insurer that will affect the rates or premiums subject to this chapter.

Code 1950, §§ 38-218.6, 38-253.41, 38-253.87; 1952, c. 317, § 38.1-277; 1986, c. 562.

Chapter 21 - FIRE INSURANCE POLICIES

§ 38.2-2100. Application of chapter.

This chapter applies only to contracts or policies of fire insurance, and contracts or policies of fire insurance in combination with other insurance coverages.

1986, c. 562.

§ 38.2-2101. Policies shall conform to provisions of this chapter.

No insurance policy or contract on any property in this Commonwealth shall be issued or delivered in this Commonwealth unless the policy or contract meets the requirements of this chapter.

Code 1950, § 38-177; 1952, c. 317, § 38.1-363; 1986, c. 562.

§ 38.2-2102. Excluding loss or damage caused by nuclear reaction, nuclear radiation, or radioactive contamination.

A. The standard policy of fire insurance prescribed by this chapter shall not cover loss or damage caused by nuclear reaction, nuclear radiation, or radioactive contamination, whether resulting directly or indirectly from a peril insured under the policy. Insurers issuing the standard policy of fire insurance are authorized to affix to the policy or include therein a written statement that the policy does not cover loss or damage caused by nuclear reaction, nuclear radiation, or radioactive contamination, whether resulting directly or indirectly from a peril insured under the policy. However, an endorsement or endorsements specifically assuming coverage for loss or damage caused by nuclear reaction, nuclear radiation, or radioactive contamination may be attached to the standard policy of fire insurance.

B. Notwithstanding the provisions of § 38.2-2105, for the purposes of commercial property and casualty insurance policies, the standard policy of fire insurance prescribed by this chapter shall not cover loss or damage caused by certified acts of terrorism as defined in the Terrorism Risk Insurance Act (15 U.S.C. § 6701) whether resulting directly or indirectly from a peril insured under the policy if the insured has refused coverage offered pursuant to the Terrorism Risk Insurance Act.

1960, c. 117, § 38.1-363.1; 1986, c. 562; 2003, c. 930.

§ 38.2-2103. Information to be printed on policy.

There shall be prominently printed on every policy issued on property in this Commonwealth (i) the name of the insurer issuing the policy, (ii) the location of the home office of the insurer, and (iii) a statement specifying whether the insurer is a stock company, a mutual company, a reciprocal insurer, or other form of insurer. If the policy is jointly issued by more than one insurer, the information shall be included for each insurer.

Code 1950, § 38-178; 1950, p. 993; 1952, c. 317, § 38.1-364; 1986, c. 562.

§ 38.2-2104. Standard insuring agreement for fire insurance policies.

A. Each policy shall provide space for listing amounts of insurance, rates, and premiums for the coverages provided in the policy and endorsements attached to the policy, and shall show the location of

the agency and the name and location of the insurer issuing the policy. Except as provided in § 38.2-2107, each policy shall contain the following insuring agreement:

In consideration of the provisions and stipulations herein or added hereto and of the premium above specified, this Company for the term of _____ At 12:01 A.M. _____ At 12:01 A.M. _____ from _____ (Standard Time) to _____ (Standard Time) at location of property involved, to an amount not exceeding the amount(s) above specified, does insure _____ and legal representatives, to the extent of the actual cash value of the property at the time of loss, but not exceeding the amount which it would cost to repair or replace the property with material of like kind and quality within a reasonable time after such loss, without allowance for any increased cost of repair or reconstruction by reason of any ordinance or law regulating construction or repair, and without compensation for loss resulting from interruption of business or manufacture, nor in any event for more than the interest of the insured, against all direct loss by fire, lightning and by removal from premises endangered by the perils insured against in this policy, except as hereinafter provided, to the property described hereinafter while located or contained as described in this policy, or pro rata for five days at each proper place to which any of the property shall necessarily be removed for preservation from the perils insured against in this policy, but not elsewhere.

Assignment of this policy shall not be valid except with the written consent of this Company.

This policy is made and accepted subject to the foregoing provisions and stipulations and those hereinafter stated, which are hereby made a part of this policy, together with such other provisions, stipulations and agreements as may be added hereto, as provided in this policy.

B. No change shall be made in the sequence of the words and paragraphs of the insuring agreement except that additional matter relating to the coverage provided under the policy and supplemental contracts or extended coverage endorsements may be inserted following any paragraph. The additional matter shall not be inconsistent or in conflict with the standard provisions for policies set out in this chapter, and shall conform with other applicable laws relating to the regulation of fire insurance.

C. For the purpose of more accurate identification of the subject matter or more accurate reference to other provisions, substitutions may be made in the standard insuring agreement for the words "above specified," "hereinafter," or other similar terms; but no substitution shall be made if the purpose and intent of the contract is changed by the substitution.

Code 1950, §§ 38-186, 38-190; 1950, pp. 994, 995; 1952, c. 317, §§ 38.1-365, 38.1-367; 1986, c. 562.

§ 38.2-2105. Standard provisions, conditions, stipulations and agreements for such policies.

A. Except as provided in § 38.2-2107, each policy shall contain the following provisions, conditions, stipulations, and agreements:

1	Concealment,	This entire policy shall be void, if whether
2	fraud.	before or after a loss, the insured has wil-

fully concealed or misrepresented any material fact or circumstance concerning this insurance or the subject thereof, or the interest of the insured therein, or in case of any fraud or false swearing by the insured relating thereto.

Uninsurable and excepted property. This policy shall not cover accounts, bills, currency, deeds, evidences of debt, money or securities; nor, unless specifically named hereon in writing, bullion or manuscripts.

Perils not included. This Company shall not be liable for loss by fire or other perils insured against in this policy caused, directly or indirectly, by: (a) enemy attack by armed forces, including action taken by military, naval or air forces in resisting in actual or immediately impending enemy attack; (b) invasion; (c) insurrection; (d) rebellion; (e) revolution; (f) civil war; (g) usurped power; (h) order of any civil authority except acts of destruction at the time of and for the purpose of preventing the spread of fire, provided that such fire did not originate from any of the perils excluded by this policy; (i) neglect of the insured to use all reasonable means to save and preserve the property at and after a loss, or when the property is endangered by fire in neighboring premises; (j) nor shall this Company be liable for loss by theft.

Other Insurance. Other insurance may be prohibited or the amount of insurance may be limited by endorsement attached hereto.

Conditions suspending or restricting insurance. Unless otherwise provided in writing added hereto this Company shall not be liable for loss occurring

(a) While the hazard is increased by any means within the control or knowledge of the insured; or

(b) while a described building, whether intended for occupancy by owner or tenant, is vacant or unoccupied beyond a period of sixty consecutive days; or

(c) as a result of explosion or riot, unless fire ensue, and in that event for loss by fire only.

Other perils or subjects. Any other peril to be insured against or subject of insurance to be covered in this policy

shall be by endorsement by writing hereon or added hereto.

Added provisions. The extent of the application of insurance under this policy and of the contribution to be made by this Company in case of loss, and any other provision or agreement not inconsistent with the provisions of this policy, may be provided for in writing added hereto, but no provision may be waived except such as by the terms of this policy is subject to change.

Waiver provisions. No permission affecting this insurance shall exist, or waiver of any provision be valid, unless granted herein or expressed in writing added hereto. No provision, stipulation or forfeiture shall be held to be waived by any requirement or proceeding on the part of this Company relating to appraisal or to any examination provided for herein.

Cancellation of policy. This policy shall be cancelled at any time at the request of insured, in which case this Company shall, upon demand and surrender of this policy, refund the excess of paid premium above the customary short rates for the expired time. This policy may be cancelled at any time by this Company by giving to the insured a five days' written notice of cancellation with or without tender of the excess of paid premium above the pro rata premium for the expired time, which excess, if not tendered, shall be refunded on demand. Notice of cancellation shall state that said excess premium (if not tendered) will be refunded on demand.

Mortgagee interests and obligations. If loss hereunder is made payable in whole or in part, to a designated mortgagee not named herein as the insured, such interest in this policy may be cancelled by giving to such mortgagee a ten days' written notice of cancellation.

If the insured fails to render proof of loss such mortgagee, upon notice, shall render proof of loss in the form herein specified within sixty (60) days thereafter and shall be subject to the pro-

visions hereof relating to appraisal and time of payment and of bringing suit. If this Company shall claim that no liability existed as to the mortgagor or owner, it shall, to the extent of payment of loss to the mortgagee, be subrogated to all mortgagee's rights of recovery, but without impairing mortgagee's right to sue; or it may pay off the mortgage debt and require an assignment thereof and of the mortgage. Other provisions relating to the interest and obligations of such mortgagee may be added hereto by agreement in writing.

Pro rata liability. This Company shall not be liable for a greater proportion of any loss than the amount hereby insured shall bear to the whole insurance covering the property against the peril involved, whether collectible or not.

Requirements in case loss occurs. The insured shall give immediate written notice to this Company of any loss, protect the property from further damage, forthwith separate the damaged and undamaged personal property, put it in the best possible order, and furnish a complete inventory of the destroyed or damaged property setting forth for each item, or by category if itemization is not reasonably practicable, the amount of loss claimed. The Company may, in addition, require the insured to furnish a complete inventory of the destroyed, damaged and undamaged property, showing in detail quantities, costs, actual cash value and amount of loss claimed; and within sixty days after the loss, unless such time is extended in writing by this Company, the insured shall render to this Company a proof of loss, signed and sworn to by the insured, stating the knowledge and belief of the insured as to the following: the time and origin of the loss, the interest of the insured and of all others in the property, the actual cash value of each item thereof and the amount of loss thereto, all encumbrances thereon, all other contracts of insurance, whether valid or not, covering any of said property, any changes in the title, use, occupation, location, possession or exposures of said property since the issuing of this policy, by whom and for what purpose any building herein described and the several parts thereof were occupied at the time of loss and whether or not it

then stood on leased ground, and shall furnish a copy of all the descriptions and schedules in all policies and, if required, verified plans and specifications of any building, fixtures or machinery destroyed or damaged. The insured, as often as may be reasonably required, shall exhibit to any person designated by this Company all that remains of any property herein described, and submit to examinations under oath by any person named by this Company, and subscribe the same; and, as often as may be reasonably required, shall produce for examination all books of account, bills, invoices and other vouchers, or certified copies thereof if originals be lost, at such reasonable time and place as may be designated by this Company or its representative, and shall permit extracts and copies thereof to be made.

Appraisal. In case the insured and this Company shall fail to agree as to the actual cash value or the amount of loss, then, on the written demand of either, each shall select a competent and disinterested appraiser and notify the other of the appraiser selected within twenty days of such demand. The appraisers shall first select a competent and disinterested umpire; and failing for fifteen days to agree upon such umpire, then, on request of the insured or this Company, such umpire shall be selected by a judge of a court of record in the state in which the property covered is located. The appraisers shall then appraise the loss, stating separately actual cash value and loss to each item; and, failing to agree, shall submit their differences, only, to the umpire. An award in writing, so itemized, of any two when filed with this Company shall determine the amount of actual cash value and loss. Each appraiser shall be paid by the party selecting him and the expenses of appraisal and umpire shall be paid by the parties equally; provided, however, if the written demand is made by this Company, then the insured shall be reimbursed by this Company for the reasonable cost of the insured's appraiser and the insured's portion of the cost of the umpire.

Company's options. It shall be optional with this Company to take all, or any part, of the property at the agreed or appraised value, and also to re-

pair, rebuild or replace the property destroyed or damaged with other of like kind and quality within a reasonable time, on giving notice of its intention so to do within thirty days after the receipt of the proof of loss herein required.

Abandonment.	There can be no abandonment to this Company of any property.
When loss payable.	The amount of loss for which this Company may be liable shall be payable sixty days after proof of loss, as herein provided, is received by this Company and ascertainment of the loss is made either by agreement between the insured and this Company expressed in writing or by the filing with this Company of an award as herein provided.
Suit.	No suit or action on this policy for the recovery of any claim shall be sustainable in any court of law or equity unless all the requirements of this policy shall have been complied with, and unless commenced within two years next after inception of the loss.
Subrogation.	This Company may require from the insured an assignment of all right of recovery against any party for loss to the extent that payment therefor is made by this Company.

B. No change shall be made in the sequence of the words and paragraphs of the standard provisions, conditions, stipulations and agreements prescribed by this section, or in the arrangement of the words into lines. The numbers given the lines in the standard form and the catch words placed at the beginning of the paragraphs shall be retained.

Code 1950, § 38-186; 1950, p. 994; 1952, c. 317, § 38.1-366; 1972, c. 115; 1979, c. 458; 1986, c. 562.

§ 38.2-2106. Standard form for execution of policies.

Except as provided in § 38.2-2107, each policy shall contain the following clause, which shall be used in executing and attesting the policy:

IN WITNESS WHEREOF, this Company has executed and attested these presents

Immediately following the execution clause a space shall be left for the signature of the officer or officers of the company authorized to sign the policy.

Code 1950, § 38-186; 1950, p. 994; 1952, c. 317, § 38.1-367; 1986, c. 562.

§ 38.2-2107. Commission may establish guidelines for filing readable fire insurance policy forms.

A. The Commission may establish guidelines for the filing of simplified and readable policies of insurance. An insurer may issue a simplified and readable policy of insurance that deviates in language from the standard policy form provided for in §§ 38.2-2104, 38.2-2105, and 38.2-2106 if the deviating policy form is (i) in no respect less favorable to the insured than the standard policy form, and is (ii) approved by the Commission prior to issuance.

B. Notwithstanding the pro rata liability provision included in § 38.2-2105, such simplified and readable policies or endorsements may be issued to apply on an excess basis if such provisions are clearly stated in the policy form or endorsement.

1977, c. 255, § 38.1-367.1; 1979, c. 176; 1986, c. 562; 2003, c. 930; 2013, c. 12.

§ 38.2-2108. Standards for content of fire insurance policies.

A. The Commission may establish standards for the content of any policy or any rider, endorsement or other supplemental agreement or provision for use in connection with any policy written to insure owner-occupied dwellings which is to be issued or delivered in this Commonwealth.

B. Following adoption of the standards of content and notwithstanding the provisions of §§ 38.2-2104, 38.2-2105 and 38.2-2106, no insurer shall issue or renew any policy or any rider, endorsement, or other supplemental agreement or provision for use in connection with any policy written to insure owner-occupied dwellings unless the policy form has been filed with the Commission. The Commission shall determine whether the policy form meets the standards of content and is in compliance with any other statutory requirements.

C. Nothing in this section prevents an insurer from issuing policies with coverages, terms and conditions which are broader and more favorable to the insured than the standards established by the Commission. The language, style and format of the coverages, terms and conditions shall be consistent with the language, style and format of the entire policy form.

1979, c. 457, § 38.1-367.2; 1986, c. 562.

§ 38.2-2108.1. Commercial fire insurance policies; changes to amount of coverage.

No insurer shall, after a new or renewal contract or policy of fire insurance or fire insurance in combination with other coverage that has been issued or delivered in the Commonwealth to insure commercial property located in the Commonwealth has been in effect for 60 days, initiate and issue any endorsement to the contract or policy that increases or decreases the amount of coverage on such property unless the first named insured has consented in writing to such proposed change in the amount of coverage.

2019, c. 693.

§ 38.2-2109. Execution of policies.

The policy shall be executed by the proper officers of the insurer or insurers, whose signatures on the policy may be in facsimile.

Code 1950, § 38-179; 1950, p. 993; 1952, c. 317, § 38.1-368; 1977, c. 313; 1986, c. 562.

§ 38.2-2110. Other matter permitted in the policy.

The policy may contain information on the insurer, its officers and agents, the agent issuing the policy, the amount of insurance for each peril covered, the premium for each peril, and any other relevant matter not inconsistent or in conflict with the standard provisions for policies prescribed by this chapter.

Code 1950, §§ 38-184, 38-185, 38-190; 1950, pp. 994, 995; 1952, c. 317, § 38.1-369; 1986, c. 562.

§ 38.2-2111. Special regulations to be added to policy.

If the policy is issued by any insurer having special regulations for the payment of assessments by the insured, the regulations shall be printed upon and made a part of the policy. If the policy is issued by an insurer having other regulations appropriate to or required by its form of organization, those other regulations shall be either (i) written or printed upon the policy or (ii) attached to the policy by endorsement.

Code 1950, §§ 38-180, 38-513; 1952, c. 317, § 38.1-370; 1986, c. 562.

§ 38.2-2112. Temporary insurance contracts; duration; what deemed to include.

A. Oral or written binders or other temporary insurance contracts may be made and used for a period not exceeding sixty days pending the issuance of the policy, and shall be deemed to include all agreements and provisions set out in §§ 38.2-2104 and 38.2-2105 and all applicable endorsements designated in the temporary insurance contract. Unless otherwise expressly provided, the contract shall be deemed to include the usual provisions, stipulations and agreements which are commonly used in this Commonwealth in effecting the insurance.

B. No temporary insurance contract shall include any provision or agreement which is inconsistent with or waives any provision, stipulation, agreement or condition required by § 38.2-2104 or § 38.2-2105. However, the cancellation provision and the provision fixing the hour of inception may be superseded by the express terms of the temporary insurance contract.

Code 1950, § 38-181; 1952, c. 317, § 38.1-371; 1986, c. 562.

§ 38.2-2113. Mailing or electronic delivery of notice of cancellation or refusal to renew.

A. No written notice of cancellation of or refusal to renew a policy written to insure owner-occupied dwellings shall be effective when mailed or delivered electronically by an insurer unless the insurer complies with the applicable provisions of subdivisions 1, 2, and 3:

1. If the notice is mailed, proof of mailing a notice of cancellation or refusal to renew shall be obtained using one of the following methods that demonstrates the date that the notice was sent to the named insured at the address stated in the policy or to the named insured's last known address:

a. The notice is sent by:

(1) Registered mail;

(2) Certified mail; or

(3) Any other similar first-class mail tracking method used or approved by the United States Postal Service, including Intelligent Mail barcode Tracing (IMb Tracing); or

b. The notice is sent by another method of mailing for which a certificate of mailing is obtained from the United States Postal Service at the time the notice is accepted for mailing. A certificate of mailing from the United States Postal Service does not include a certificate of bulk mailing.

2. If the notice is delivered electronically, the insurer retains evidence of electronic transmittal or receipt of the notification for at least one year from the date of the transmittal.

3. If the notice is mailed, the insurer retains a copy of the notice of cancellation or refusal to renew for at least one year from the date such action was effective. If the notice is mailed, proof of mailing from the United States Postal Service consistent with the mailing method utilized by the insurer shall be maintained for one year from the date the cancellation or nonrenewal notice is effective.

B. This section shall not apply to policies written through the Virginia Property Insurance Association or any other residual market facility established pursuant to Chapter 27 (§ 38.2-2700 et seq.) of this title.

C. 1. If the terms of the policy require the notice of cancellation or refusal to renew to be given to any lienholder, then the insurer shall mail such notice and retain a copy of the notice in the manner required by subsection A. If the notices sent to the insured and the lienholder are part of the same form, the insurer may retain a single copy of the notice. Proof of mailing from the United States Postal Service consistent with the mailing method utilized by the insurer shall be maintained for one year from the date the cancellation or nonrenewal notice is effective.

2. Notwithstanding the provisions of subdivision 1, if the terms of the policy require the notice of cancellation or refusal to renew to be given to any lienholder, the insurer and lienholder may agree by separate agreement that such notices may be transmitted electronically, provided that the insurer and lienholder agree upon the specifics for transmittal and acknowledgment of notification. Evidence of transmittal or receipt of the notification required by this subsection shall be retained by the insurer for at least one year from the date of termination.

D. "Copy," as used in this section, includes photographs, microphotographs, photostats, microfilm, microcard, printouts, or other reproductions of electronically stored data or copies from optical disks, electronically transmitted facsimiles, or any other reproduction of an original from a process that forms a durable medium for its recording, storing, and reproducing.

1972, c. 110, § 38.1-371.1; 1983, c. 371; 1986, c. 562; 1992, c. 160; 2000, c. 529; 2003, c. 387; 2009, c. 215; 2013, c. 257; 2015, cc. 9, 443; 2016, cc. 4, 71.

§ 38.2-2114. Grounds and procedure for termination of policy; contents of notice; review by Commissioner; exceptions; immunity from liability.

A. Notwithstanding the provisions of § 38.2-2105, no policy or contract written to insure owner-occupied dwellings shall be canceled by an insurer unless written notice is mailed or delivered to the

named insured at the address stated in the policy, or is delivered electronically to the address provided by the named insured, and cancellation is for one of the following reasons:

1. Failure to pay the premium when due;

2. Conviction of a crime arising out of acts increasing the probability that a peril insured against will occur;

3. Discovery of fraud or material misrepresentation;

4. Willful or reckless acts or omissions increasing the probability that a peril insured against will occur as determined from a physical inspection of the insured premises;

5. Physical changes in the property which result in the property becoming uninsurable as determined from a physical inspection of the insured premises; or

6. Foreclosure efforts by the secured party against the subject property covered by the policy that have resulted in the sale of the property by a trustee under a deed of trust as duly recorded in the land title records of the jurisdiction in which the property is located.

B. No policy or contract written to insure owner-occupied dwellings shall be terminated by an insurer by refusal to renew except at the expiration of the stated policy period or term and unless the insurer or its agent acting on behalf of the insurer mails or delivers to the named insured, at the address stated in the policy, or delivers electronically to the address provided by the named insured, written notice of the insurer's refusal to renew the policy or contract.

C. A written notice of cancellation of or refusal to renew a policy or contract written to insure owner-occupied dwellings shall:

1. State the date that the insurer proposes to terminate the policy or contract, which shall be at least 30 days after mailing or delivering to the named insured the notice of cancellation or refusal to renew. However, when the policy is being terminated for the reason set forth in subdivision A 1, the date that the insurer proposes to terminate the policy may be less than 30 days but at least 10 days from the date of mailing or delivery;

2. State the specific reason for terminating the policy or contract and provide for the notification required by the provisions of §§ 38.2-608 and 38.2-609 and subsection B of § 38.2-610. However, those notification requirements shall not apply when the policy is being canceled or not renewed for the reason set forth in subdivision A 1;

3. Advise the insured that within 10 days of receipt of the notice of termination he may request in writing that the Commissioner review the action of the insurer in terminating the policy or contract;

4. Advise the insured of his possible eligibility for fire insurance coverage through the Virginia Property Insurance Association; and

5. Be in a type size authorized by § 38.2-311.

D. Within 10 days of receipt of the notice of termination any insured or his attorney shall be entitled to request in writing to the Commissioner that he review the action of the insurer in terminating a policy or contract written to insure owner-occupied dwellings. Upon receipt of the request, the Commissioner shall promptly initiate a review to determine whether the insurer's cancellation or refusal to renew complies with the requirements of this section and of § 38.2-2113, if sent by mail or delivered electronically. The policy shall remain in full force and effect during the pendency of the review by the Commissioner except where the cancellation or refusal to renew is for reason of nonpayment of premium, in which case the policy shall terminate as of the date stated in the notice. Where the Commissioner finds from the review that the cancellation or refusal to renew has not complied with the requirements of this section or of § 38.2-2113, if sent by mail or delivered electronically, he shall immediately notify the insurer, the insured, and any other person to whom notice of cancellation or refusal to renew was required to be given by the terms of the policy that the cancellation or refusal to renew is not effective. Nothing in this section authorizes the Commissioner to substitute his judgment as to underwriting for that of the insurer.

E. Nothing in this section shall apply:

1. To any policy written to insure owner-occupied dwellings that has been in effect for less than 90 days when the notice of termination is mailed or delivered to the insured, unless it is a renewal policy;

2. If the insurer or its agent acting on behalf of the insurer has manifested its willingness to renew by issuing or offering to issue a renewal policy, certificate or other evidence of renewal, or has otherwise manifested its willingness to renew in writing to the insured. The written manifestation shall include the name of a proposed insurer, the expiration date of the policy, the type of insurance coverage, and information regarding the estimated renewal premium;

3. If the named insured or his duly constituted attorney-in-fact has notified the insurer or its agent orally, or in writing, if the insurer requires such notification to be in writing, that he wishes the policy to be canceled, or that he does not wish the policy to be renewed, or if, prior to the date of expiration, he fails to accept the offer of the insurer to renew the policy;

4. To any contract or policy written through the Virginia Property Insurance Association or any residual market facility established pursuant to Chapter 27 (§ 38.2-2700 et seq.); or

5. If an affiliated insurer has manifested its willingness to provide coverage at a lower premium than would have been charged for the same exposures on the expiring policy. The affiliated insurer shall manifest its willingness to provide coverage by issuing a policy with the types and limits of coverage at least equal to those contained in the expiring policy unless the named insured has requested a change in coverage or limits. When such offer is made by an affiliated insurer, an offer of renewal shall not be required of the insurer of the expiring policy, and the policy issued by the affiliated insurer shall be deemed to be a renewal policy.

F. Each insurer shall maintain, for at least one year, records of cancellation and refusal to renew and copies of every notice or statement referred to in subsection E that it sends to any of its insureds.

G. There shall be no liability on the part of and no cause of action of any nature shall arise against the Commissioner or his subordinates; any insurer, its authorized representative, its agents, or its employees; or any firm, person or corporation furnishing to the insurer information as to reasons for cancellation or refusal to renew, for any statement made by any of them in complying with this section or for providing information pertaining to the cancellation or refusal to renew.

H. Nothing in this section requires an insurer to renew a policy written to insure owner-occupied dwellings, if the insured does not conform to the occupational or membership requirements of an insurer who limits its writings to an occupation or membership of an organization.

I. No insurer or agent shall refuse to renew a policy written to insure an owner-occupied dwelling, solely because of any one or more of the following factors:

1. Age;

2. Sex;

3. Residence;

4. Race;

5. Color;

6. Creed;

7. National origin;

8. Ancestry;

9. Marital status;

10. Sexual orientation;

11. Gender identity;

12. Lawful occupation, including the military service; however, nothing in this subsection shall require any insurer to renew a policy for an insured where the insured's occupation has changed so as to increase materially the risk;

13. Credit information contained in a "consumer report," as defined in the federal Fair Credit Reporting Act, 15 U.S.C. § 1681 et seq., bearing on a natural person's creditworthiness, credit standing or credit capacity. If credit information is used, in part, as the basis for the nonrenewal, such credit information shall be based on a consumer report procured within 120 days from the effective date of the nonrenewal;

14. Any claim resulting primarily from natural causes;

15. One or more claims that were incurred more than 60 months immediately prior to the expiration of the current policy period; or

16. Any inquiry from an insured about his insurance coverage or policy provisions. For purposes of this subdivision, "inquiry" means a written or oral communication by an insured seeking information regarding coverage or policy provisions that does not notify the insurer of a loss, incident or accident, and that does not provide information indicating an increase in the hazard insured against. An insurer shall not report any inquiry as a claim to a loss history database maintained by a consumer reporting agency or insurance support organization.

Nothing in this section prohibits any insurer from setting rates in accordance with relevant actuarial data.

J. No insurer shall cancel or refuse to renew a policy written to insure an owner-occupied dwelling because an insured under the policy is a foster parent and foster children reside at the insured dwelling.

1972, c. 110, § 38.1-371.2; 1975, c. 350; 1978, c. 441; 1983, c. 371; 1986, c. 562; 1990, c. 293; 1995, c. 3; 1996, c. 237; 1998, c. 142; 2003, cc. 543, 553; 2004, c. 300; 2005, c. 872; 2008, cc. 58, 221; 2009, cc. 215, 442; 2013, c. 257; 2020, c. 1137.

§ 38.2-2114.1. Powers of Commission; replacement policies.

Upon the verified petition of an insurer, where the petitioning insurer proposes to replace all or substantially all of its policies in another insurer, the Commission may relieve the insurer of the requirements of subsections B and C of § 38.2-2114 and of the mailing requirements of § 38.2-2113; provided the insurer demonstrates to the satisfaction of the Commission that (i) the replacement policy is underwritten by an affiliate insurer under common control with the petitioning insurer; (ii) the replacement policy is substantially similar to the existing policy with the petitioning insurer; (iii) the premium charged for the replacement policy is no greater than that charged by the petitioning insurer for the existing policy; and (iv) the replacement insurer is duly licensed to transact the business of insurance in the Commonwealth of Virginia. The replacement insurer shall retain a copy of any offer of replacement for a period of one year from the expiration of any existing policy that is not replaced. The Commission may further condition any such relief to protect the best interests of the policyholder.

1991, c. 292.

§ 38.2-2115. Discrimination in issuance of fire insurance.

No insurer or agent shall refuse to issue a policy solely because of any one or more of the following factors: the age, sex, residence, race, color, creed, national origin, ancestry, marital status, sexual orientation, gender identity, or lawful occupation, including the military service, of the person seeking insurance. Nothing in this section prohibits any insurer from limiting the issuance of policies to those who are residents of this Commonwealth, nor does it prohibit any insurer from limiting the issuance of policies only to persons engaging in or who have engaged in a particular profession or occupation, or who are members of a particular religious sect. Nothing in this section prohibits any insurer from setting rates in accordance with relevant actuarial data.

1986, c. 562; 2020, c. 1137.

§ 38.2-2116. Policies issued by two or more insurers.

A. With the consent of the Commission, two or more licensed insurers may jointly issue a policy, using a distinctive title that is prominently printed on the policy followed by the names and the home office addresses of the insurers obligated under the policy. The policy shall be executed by the proper officers of each insurer. Before issuance, the form and any terms of the policy that are in addition to the standard provisions set out in §§ 38.2-2104 and 38.2-2105 shall be approved by the Commission. The terms of the policy shall not be inconsistent with the standard provisions, and shall be placed under a separate title headed as follows: "Provisions specially applicable to this jointly issued policy." The special provisions shall contain in substance that:

1. The insurers executing the policy are severally liable for the full amount of any loss or damage according to the terms of the policy or for specified percentages or amounts of any loss or damage aggregating the full amount of insurance under the policy; and

2. Service of process upon, or notice of proof of loss required by the policy and given to any of the insurers executing the policy, shall be deemed to be service upon or notice to all such insurers.

B. The unearned premium reserve on each policy shall be allocated to each insurer on the basis of each insurer's pro rata share of the face amount of the policy, except to the extent that the risk is transferred under a valid contract of reinsurance.

Code 1950, § 38-183; 1952, c. 317, § 38.1-372; 1986, c. 562.

§ 38.2-2117. Approval of forms or provisions for additional coverage.

The Commission may approve and authorize the use of appropriate forms or provisions contained in supplemental contracts or extended coverage endorsements used in connection with policies on property in this Commonwealth to provide coverage for one or more perils in addition to the perils covered by the standard insuring agreement and standard provisions prescribed in this chapter.

Code 1950, § 38-190; 1950, p. 995; 1952, c. 317, § 38.1-373; 1986, c. 562.

§ 38.2-2118. Required statement on insurance policies for owner-occupied dwellings.

Each insurer writing insurance on owner-occupied dwellings and appurtenant structures with a replacement cost provision under the provisions of Chapter 19 (§ 38.2-1900 et seq.) shall provide on each new and renewal policy a statement summarizing (i) any minimum coverage requirement necessary for the replacement cost provision to be fully effective and (ii) the effect on claim payment of not meeting the minimum coverage requirement.

1977, c. 530, § 38.1-279.49:1; 1986, c. 562; 2016, c. 558.

§ 38.2-2119. Approval of forms or provisions for certain risks.

A. The Commission may approve and authorize the use of appropriate forms or provisions for supplemental contracts or extended coverage endorsements where the insured may be indemnified for (i) the difference between the actual cash value of the property at the time of loss and the cost of repair or replacement of the property on the same site with new materials of like kind and quality, within a

reasonable time after the loss, and without deduction for depreciation, (ii) additional cost or loss by reason of any ordinance or law in force at the time of loss which necessitates the demolition of any portion of the insured property, (iii) any increased cost of repair or replacement by reason of any ordinance or law regulating construction or repair of the insured building, and (iv) loss from interruption of business, untenantability, or termination of leasehold interest because of damage to or destruction of the property described in the policy. These forms or provisions shall apply to coverage provided to an insured having any interest in an insured building or structure which is a part of the building described in the policy, including service equipment for the building.

B. Where any policy of insurance issued or delivered in this Commonwealth pursuant to this chapter provides for the payment of the full replacement cost of property insured thereunder, the policy shall permit the insured to assert a claim for the actual cash value of the property without prejudice to his right to thereafter assert a claim for the difference between the actual cash value and the full replacement cost unless a claim for full replacement cost has been previously resolved. Any claim for such difference must be made within six months of (i) the last date on which the insured received a payment for actual cash value or (ii) date of entry of a final order of a court of competent jurisdiction declaratory of the right of the insured to full replacement cost, whichever shall last occur.

C. Notwithstanding the provisions of § 38.2-2104, insurers may offer, as an option, coverage limited to the amount necessary to repair or replace damaged property with functionally equivalent property at a lower cost than would be required to repair or replace the damaged property with material of like kind and quality. Such policies may also permit, at the option of the insured, settlement based on the market value of the damaged property at the time of loss. No new policy of insurance covering property insured on a functional replacement cost basis shall be issued or delivered in the Commonwealth unless the following statement, printed in boldface type, is enclosed with the policy:

Important Notice

The coverage under this policy applies on a functional replacement cost basis which means that, under certain conditions, claims may be settled for less than the actual cash value of the property insured.

Code 1950, § 38-190; 1950, p. 995; 1952, c. 317, § 38.1-374; 1986, c. 562; 1992, c. 762; 1996, c. 373; 2016, c. 558.

§ 38.2-2120. Optional coverage to be offered with homeowner's policy.

Any insurer who issues or delivers a new or renewal homeowner's insurance policy in this Commonwealth shall offer as an option a provision insuring against loss caused or resulting from water which backs up through sewers or drains.

1974, c. 564, § 38.1-335.2; 1986, c. 562; 2016, c. 558.

§ 38.2-2121. When courts may appoint umpires.

Whenever appraisers selected under the standard provisions for fire insurance policies set out in § 38.2-2105 fail for fifteen days to agree upon a person to serve as umpire, the insured or the insurer

may apply in writing, for the appointment of an umpire, to the judge of the circuit court of the county or city in which the damaged or destroyed property was located at the time of loss. If the application is filed by the insured, a copy of the application shall first be delivered to a registered agent of the insurer. If the application is filed by the insurer, a copy of the application shall first be delivered to the insured. Upon showing, by affidavit or otherwise, the failure or neglect of the appraisers to agree upon and select an umpire within the time specified in the policy, the judge shall upon twenty-one days' notice to all parties appoint a competent and disinterested person to serve as umpire in determining the amount of loss or damage sustained.

Code 1950, § 38-172; 1952, c. 317, § 38.1-375; 1986, c. 562; 1992, c. 470.

§ 38.2-2122. Appraisers and umpires; oath to be taken.

Whenever any appraisal is to be made under the standard provisions of a policy for loss or damage to property, each appraiser and umpire shall, before acting as such, take an oath that he is not directly or indirectly in the employment of the insured, the insurer, or any other insurer, that he is not related to the insured or any officer of the insurer, and that he will faithfully discharge the duties imposed upon him.

Code 1950, §§ 38-173, 38-174; 1952, c. 317, § 38.1-376; 1986, c. 562; 2022, c. 666.

§ 38.2-2123. Chapter not applicable to certain mutual insurers.

This chapter shall not apply to mutual assessment property and casualty insurers, or to mutual insurers and associations organized under the laws of this Commonwealth, conducting business only in this Commonwealth, and issuing only policies providing for perpetual insurance.

Code 1950, §§ 38-182, 38-183, 38-193; 1952, c. 317, § 38.1-378; 1960, c. 293; 1986, c. 562.

§ 38.2-2124. Optional coverage to be offered with fire insurance policy.

Any insurer that issues or delivers in this Commonwealth a new or renewal contract or policy of fire insurance, or a new or renewal contract or policy of fire insurance in combination with other insurance coverages, shall offer in writing as an option a provision that property will be repaired or replaced in accordance with applicable ordinances or laws that regulate construction, repair or demolition.

1993, c. 156.

§ 38.2-2125. Notice regarding flood exclusion.

Any insurer that issues or delivers in this Commonwealth a new or renewal contract or policy of fire insurance, or a new or renewal contract or policy of fire insurance in combination with other insurance coverages, which policy or contract excludes coverage for damage due to flood, surface water, waves, tidal water, or any other overflow of a body of water, shall provide written notice that (i) explicitly states that flood coverage is excluded; (ii) states that information regarding flood insurance is available from the insurer, insurance agent or the National Flood Insurance Program; and (iii) advises the policyholder that contents coverage may be available with the flood policy for an additional premium.

2000, c. 401; 2004, c. 288.

§ 38.2-2126. Insurance credit score disclosure; use of credit information.

A. Any insurer issuing or delivering a policy written to insure an owner-occupied dwelling or the personal property of a tenant's residential property risk that uses credit information contained in a consumer report for underwriting, tier placement or rating an applicant or insured, shall meet the following requirements:

1. Disclose, either on the insurance application or at the time the insurance application is taken (i) that it shall obtain credit information in connection with such application; (ii) that the insured may request that his credit information be updated; and (iii) that, if the insured questions the accuracy of the credit information, the insurer will, upon request of the insured, reevaluate the insured based on corrected credit information from a consumer reporting agency. The disclosure may be made by the insurer or its agent. Such disclosure shall be either written or provided to an applicant in the same medium as the application for insurance. The insurer need not provide the disclosure required under this subsection to any insured on a renewal policy if such insured has previously been provided a disclosure. Use of the following example disclosure constitutes compliance with this subsection: "In connection with this application for insurance, we shall review your credit report or obtain or use an insurance credit score based on the information contained in that credit report. We may use a third party in connection with the development of your insurance credit score. You may request that your credit information be updated and if you question the accuracy of the credit information, we will, upon your request, reevaluate you based on corrected credit information from a consumer reporting agency."

2. If an insurer takes an adverse action, based in whole or in part, upon credit information, the insurer shall provide notice to the applicant or insured that the adverse action was based, in whole or in part, on credit information. Such notice shall also either include a statement advising the applicant or insured of the primary factors or characteristics that were used as the basis for the adverse action, or notify the applicant or insured that he may request such information. For the purposes of this section, adverse action means a denial, nonrenewal or cancellation of, an increase in any charge for or refusal to apply a discount, or placement in a less favorable tier, or a reduction or other adverse or unfavorable change in the terms of coverage or amount of, any insurance, existing or applied for, in connection with the underwriting, tier placement or rating of insurance based on the applicant's or insured's credit information. Adverse action includes circumstances where due to his credit information the applicant or insured (i) receives a higher rate, (ii) is placed in a less favorable tier, and (iii) when there are multiple companies available within a group of insurers, receives coverage in a less favorably priced company of the group. Notice is required when the effect of the credit information would put the applicant or insured in a worse position than if the credit information had not been considered. In the case of renewals, the circumstances listed in clauses (i), (ii), and (iii) shall not be deemed adverse actions if, due to the insured's credit information, the insured is not receiving a less favorable rate or placed in a less favorable tier or company than during the policy period immediately preceding renewal.

B. If an insurer uses credit information from a consumer report for tier placement or rating of its renewal business for a policy insuring an owner-occupied dwelling or the personal property of a tenant's residential property risk, the insurer shall be required to update the credit information at least once every three years, provided, however, that the insurer shall be required to update an insured's credit information within the three-year period if requested by the insured. If an update request is made by the insured at least 45 days prior to the end of the policy term, any adjustment to the premium required by the update of the insured's credit information shall take effect at the first renewal following the request for update of the insured's credit information. If an update request is made by the insured within 45 days of the end of the policy term, the insurer shall have the option of applying any adjustment to the premium required by the update of the insured's credit information to the first renewal or the second renewal following the request for update of the insured's credit information. An insurer need not update the credit information more frequently than once every policy term. Notwithstanding the requirements of this subsection, no insurer need obtain updated credit information if the insured has the most favorably priced tier or rate based on his credit information.

C. Notwithstanding the provisions of subdivision A 3 of § 38.2-1904, if an insurer issuing or delivering a policy to insure an owner-occupied dwelling or the personal property of a tenant's residential property risk is unable to obtain credit information from a consumer report or when an insured or applicant has insufficient credit to produce an insurance credit score, the insurer shall underwrite, tier, or rate the individual risk in one of the following ways: (i) as if the risk received a neutral or average insurance credit score, as defined by the insurer, (ii) by excluding the use of credit information as a factor and using only other underwriting, tiering, or rating criteria, or (iii) in accordance with established underwriting guidelines or filed tiering or rating rules. Any such established underwriting guidelines or filed tiering or rating rules shall consider other actuarially justified factors associated with the risk in addition to the inability to obtain credit information or the insufficiency of the credit information.

D. The following factors shall not be used as credit criteria or to determine an insurance credit score for underwriting, tier placement, or rating purposes for a policy insuring an owner-occupied dwelling or the personal property of a tenant's residential property risk:

1. Information that has been identified by the consumer reporting agency as disputed by the consumer and coded as such, if the use of such disputed information would result in an adverse action;

2. Information that has been identified by the consumer reporting agency as related to insurance inquiries or nonconsumer-initiated inquiries and coded as such;

3. Information that has been identified by the consumer reporting agency as related to collection accounts with a medical industry code;

4. Information that includes multiple lender inquiries, if coded by the consumer reporting agency as being from the home mortgage industry and made within 30 days of one another, unless only one inquiry is considered;

5. Information that includes multiple lender inquiries, if coded by the consumer reporting agency as being from the automobile lending industry and made within 30 days of one another, unless only one inquiry is considered;

6. Income, gender, address, zip code, ethnic group, race, color, religion, marital status, or nationality of the consumer; or

7. The total available line of credit; however, an insurer may consider the total amount of outstanding debt in relation to the total available line of credit.

E. No insurer shall take an adverse action against an applicant for a policy insuring an owner-occupied dwelling or the personal property of a tenant's residential property risk based on credit information, unless an insurer obtains and uses a consumer report procured within 90 days from the date the policy is first written.

F. Notwithstanding anything to the contrary, for a policy insuring an owner-occupied dwelling or the personal property of a tenant's residential property risk, an insurer may, upon request, provide reasonable exceptions for an individual whose credit information is directly and adversely impacted by a catastrophic event, as determined by the insurer, including catastrophic illness or injury or the death of a spouse or member of the same household. The insurer may require reasonable documentation of the event prior to granting an exception. No insurer shall be deemed out of compliance with its filed rules and rates as a result of granting an exception pursuant to this subsection.

G. Upon the request of an insured or applicant with a policy insuring an owner-occupied dwelling or the personal property of a tenant's residential property risk for a reevaluation as set forth in this section, the insurer shall reevaluate the individual based on corrected credit information from a consumer reporting agency. If the reevaluation results in a lower premium, the lower premium shall be applied retroactively to the effective date of the current policy term, and the insurer shall either refund or credit the amount to the insured. The insurer may require reasonable documentation of the corrected information from the consumer reporting agency prior to the reevaluation.

H. An insurer shall indemnify, defend, and hold agents harmless from and against all liability, fees, and costs arising out of or relating to the actions, errors, or omissions of an agent who obtains or uses credit information or insurance credit scores for an insurer, provided the agent follows the instructions or procedures established by the insurer and complies with any applicable law. Nothing in this subsection shall be construed to provide an applicant or insured with a cause of action that does not exist in the absence of this subsection.

I. No consumer reporting agency shall provide or sell data or lists that include any information that in whole or in part was submitted in conjunction with an insurance inquiry about an individual's credit information or a request for a consumer report or an insurance credit score. Such information includes the expiration dates of an insurance policy or any other information that may identify time periods during which an individual's insurance may expire and the terms and conditions of the individual's insurance coverage. The restrictions provided in this subsection do not apply to data or lists the consumer

reporting agency supplies to the insurance agent from whom information was received or the insurer on whose behalf such agent acted. Nothing in this subsection shall be construed to restrict any insurer from being able to obtain a claims history report or a motor vehicle report.

J. For the purposes of this section, "insurance credit score" means a number or rating that is derived from an algorithm, computer application, model, or other process that is based in whole or in part on credit information for the purposes of predicting the future insurance loss exposure of an individual applicant or insured for a policy insuring an owner-occupied dwelling or the personal property of a tenant's residential property risk.

2003, cc. 543, 553; 2019, c. 704.

§ 38.2-2127. Notice of change in deductible.

Whenever an insurer unilaterally changes the deductible under a policy written to insure an owner-occupied dwelling, the insurer shall provide a written notice that (i) explicitly states that the deductible has changed and (ii) explains how the new deductible will be applied. Nothing in this section shall allow an insurer to change a deductible except at renewal. This section shall apply to all policies renewed in the Commonwealth on or after October 1, 2004.

2004, c. 745.

§ 38.2-2128. Certain exclusions permitted.

Notwithstanding the provisions of § 38.2-2108, any insurer that issues or delivers in the Commonwealth a new or renewal policy written to insure an owner-occupied dwelling may, with the named insured's written consent, exclude from coverage any liability resulting from an injury caused by a dangerous or vicious animal owned by or in the care, custody, or control of the insured if such animal has bitten, attacked, or inflicted injury on a person or a companion animal. Such risk shall be specifically identified in the exclusion. Uniform policy forms or endorsements that will be used by the insurer for such exclusions shall be filed with the Commission pursuant to § 38.2-317 and shall contain a disclosure stating that the named insured has agreed to the specified risk being excluded under the policy. The insured's execution of the document evidencing his consent thereto shall be acknowledged before a notary public or witnessed by a disinterested person. Such signed exclusions, evidence of the insured's consent, and the insurer's documentation substantiating the reason for the exclusion shall be made available to the Commission upon request. Upon completion of the notarized or witnessed signed exclusion, the insurer shall not be required to obtain the insured's written consent for any subsequent policy renewals.

2004, c. 751.

§ 38.2-2129. Notice regarding earthquake exclusion.

Any insurer that issues or delivers in the Commonwealth a new or renewal contract or policy of fire insurance, or a new or renewal contract or policy of fire insurance in combination with other insurance coverages, which policy or contract excludes coverage for damage due to earthquake shall provide written notice that (i) explicitly states that "earthquake coverage is excluded unless purchased by

endorsement" and (ii) if such coverage is otherwise available from the insurer, states that information regarding earthquake insurance is available from the insurer or the insurance agent.

2012, cc. 235, 346.

§ 38.2-2130. Coverage for volunteer fire department costs.

Every insurer writing a fire policy or fire policy in combination with other insurance coverages shall provide coverage for the cost charged by a volunteer fire department that is not fully funded by real estate taxes or other property taxes for service charges where the fire department is called in to save or protect property insured under such policy from a peril insured against. The limit of such coverage shall be no less than $250. Higher coverage limits may be offered by an insurer for an additional premium. Any bill for such service charges shall be sent to the owner of the property for which the services were rendered. The amount billed shall not exceed the limit of such coverage. This coverage shall not apply to service charges made in response to a call outside of the volunteer fire department's fire protection district, city, or municipality pursuant to a contract.

2012, cc. 371, 561.

Chapter 22 - Liability Insurance Policies

§ 38.2-2200. Required provisions as to insolvency or bankruptcy, and as to when action maintained against insurer.

No policy or contract insuring or indemnifying against liability for injury to or the death of any person, liability for injury to or destruction of property, or liability for injury to the economic interests of any person, shall be issued or delivered in the Commonwealth unless it contains in substance the following provisions or other provisions that are at least equally favorable to the insured and to judgment creditors:

1. That the insolvency or bankruptcy of the insured, or the insolvency of the insured's estate, shall not relieve the insurer of any of its obligations under the policy or contract.

2. That if execution on a judgment against the insured or his personal representative is returned unsatisfied in an action brought to recover damages for injury sustained or for loss or damage incurred during the life of the policy or contract, then an action may be maintained against the insurer under the terms of the policy or contract for the amount of the judgment not exceeding the amount of the applicable limit of coverage under the policy or contract.

Code 1950, § 38-238; 1952, c. 317, § 38.1-380; 1986, c. 562; 2005, c. 290.

§ 38.2-2201. Provisions for payment of medical expense and loss of income benefits; assignment of certain benefits.

A. Upon request of an insured, each insurer licensed in this Commonwealth issuing or delivering any policy or contract of bodily injury or property damage liability insurance covering liability arising from the ownership, maintenance or use of any motor vehicle shall provide on payment of the premium, as a minimum coverage (i) to persons occupying the insured motor vehicle; and (ii) to the named insured

and, while resident of the named insured's household, the spouse and relatives of the named insured while in or upon, entering or alighting from or through being struck by a motor vehicle while not occupying a motor vehicle, the following health care and disability benefits for each accident:

1. All reasonable and necessary expenses for medical, chiropractic, hospital, dental, surgical, prosthetic and rehabilitation services, services provided by an emergency medical services vehicle as defined in § 32.1-111.1, and funeral expenses, resulting from the accident and incurred within three years after the date of the accident, up to $2,000 per person; however, if the insured does not elect to purchase such limit the insurer and insured may agree to any other limit;

2. If the person is usually engaged in a remunerative occupation, an amount equal to the loss of income incurred after the date of the accident resulting from injuries received in the accident up to $100 per week during the period from the first workday lost as a result of the accident up to the date the person is able to return to his usual occupation. However, the period shall not extend beyond one year from the date of the accident; and

3. An expense described in subdivision 1 shall be deemed to have been incurred:

a. If the insured is directly responsible for payment of the expense;

b. If the expense is paid by (i) a health care insurer pursuant to a negotiated contract with the health care provider or (ii) Medicaid or Medicare, where the actual payment with reference to the medical bill rendered by the provider is less than or equal to the provider's usual and customary fee, in the amount of the actual payment as evidenced by an explanation of benefits, remittance advice, or similar documentation from the health care provider; however, if the insured is required to make a payment in addition to the actual payment by the health care insurer or Medicaid or Medicare, the amount shall be increased by the payment made by the insured; or

c. If no medical bill is rendered or specific charge made by a health care provider to the insured, an insurer, or any other person, in the amount of the usual and customary fee charged in that community for the service rendered.

B. The insured has the option of purchasing either or both of the coverages set forth in subdivisions A 1 and A 2. Either or both of the coverages, as well as any other medical expense or loss of income coverage under any policy of automobile liability insurance, shall be payable to the covered injured person or pursuant to an assignment of benefits in accordance with subsection D, notwithstanding the failure or refusal of the named insured or other person entitled to the coverage to give notice to the insurer of an accident as soon as practicable under the terms of the policy, except where the failure or refusal prejudices the insurer in establishing the validity of the claim.

C. In any policy of personal automobile insurance in which the insured has purchased coverage under subsection A, every insurer providing such coverage arising from the ownership, maintenance or use of no more than four motor vehicles shall be liable to pay up to the maximum policy limit available on

every motor vehicle insured under that coverage if the health care or disability expenses and costs mentioned in subsection A exceed the limits of coverage for any one motor vehicle so insured.

D. Any attempt to assign medical expense benefits shall be subject to the following:

1. An assignment of medical expense benefits shall be valid only if:

a. A copy of the AOB form, executed by the assignor and in compliance with the other requirements of subdivision D 1 and a copy of the notice complying with subdivision g if such notice is provided in a separate document pursuant to subdivision e, is provided to the motor vehicle insurer;

b. The AOB form is (i) in writing, which includes any printed or electronic format, (ii) dated, and (iii) executed by the assignor;

c. The AOB form includes a conspicuous statement that the assignor is not required to execute the AOB form;

d. If the AOB form includes a notice that complies with the provisions of subdivision g, the AOB form is signed, initialed, or otherwise marked by the assignor, at or near the notice provision, to acknowledge that the assignor has read, or had the opportunity to read, the notice;

e. If the AOB form does not include a notice that complies with the provisions of subdivision g, (i) the assignor is given a separate document, in any printed or electronic format, that is delivered to the assignor at the same time as the AOB form and that contains a notice that complies with the provisions of subdivision g; (ii) the AOB form includes a conspicuous statement that a notice regarding the assignment of medical expense benefits is provided in a separate document; and (iii) the AOB form is signed, initialed, or otherwise marked by the assignor at or near the statement described in clause (ii) to acknowledge that the assignor has read, or had the opportunity to read, the separate document containing the notice;

f. The statements required by subdivision D 1 to be included in the AOB form or a separate document, including the notice prescribed by subdivision g, are in not less than eight-point type; and

g. The assignor is provided, either in the AOB form or in a separate document, a notice that summarizes the effect of the assignment of medical expense benefits, which notice states the following:

"Notice: automobile accident patients

If you have been in an automobile accident, you may be entitled to payment from your automobile insurance if you have medical expense benefits coverage. By signing this assignment of benefits form you are giving to your health care provider the right to receive some or all of that payment directly from your automobile insurance company.

If you have health insurance and your healthcare provider is in-network: as long as you provide information necessary to verify your health insurance coverage the healthcare provider may only bill the amount you owe for any copayment, coinsurance, or deductibles to your automobile insurance and you may be entitled to any remainder of your automobile insurance benefit.

If you do not provide information necessary to verify your health insurance coverage, do not have health insurance, or your healthcare provider is not in your health insurer's provider network: your health care provider may bill their full charges to your automobile insurance.

You may want to consult your insurance agent or attorney before signing or initialing this form. You are not required to sign/initial this form to receive care."

2. Upon receipt of a copy of an AOB form that satisfies the requirements of subdivision D 1 and (i) an explanation of benefits or remittance advice or (ii) a bill, claim form, or documentation from the assignee advising that it has been represented to the assignee that the covered injured person does not have health insurance or is covered by a self-insured or self-funded employee welfare benefit plan subject to the Employee Retirement Income Security Act of 1974 which requires medical expense coverage to be primary, a motor vehicle insurer shall pay directly to the health care provider, from any medical expense benefits available to such person under a motor vehicle insurance policy:

a. If the covered injured person is covered under a health care policy, the health care provider is an in-network provider, and the health care provider has submitted its claim to the health insurer for the health care services, the amount of any copayments, coinsurance, or deductibles owed by the injured covered person to the health care provider, as evidenced by an explanation of benefits, remittance advice, or similar documentation provided to the motor vehicle insurer; or

b. If (i) the covered injured person is not covered under a health care policy, (ii) the covered injured person is covered by a self-insured or self-funded employee welfare benefit plan subject to the Employee Retirement Income Security Act of 1974 which requires medical expense coverage to be primary, or (iii) the health care provider is not an in-network provider, amounts to cover the cost of the health care services provided, in the amount of the usual and customary fee charged in that community for the health care services rendered;

3. A motor vehicle insurer shall in all respects be held harmless for making payments pursuant to subdivision D 2 to a health care provider in accordance with an assignment of benefits that satisfies the requirements of subdivision D 1;

4. A covered injured person shall not be required to assign to any person any medical expense benefits he may have under this section, including any assignment of the proceeds of such coverages;

5. An assignment of medical expense benefits shall be void and unenforceable as against public policy if the assignment does not comply with the requirements of subdivision D 1;

6. Medical expense benefits may not be reduced because of any benefits paid, payable, or provided by any insurance contract providing hospital, medical, surgical, and similar or related benefits, or any subscription contract or health services plan delivered or issued for delivery or providing for the payment of benefits to or on behalf of persons residing in or employed in the Commonwealth, except as authorized by this section; and

7. Nothing in this section shall prohibit the payment of medical expense benefits due to the covered injured person directly to any state or federal assistance program that has provided medical benefits to such injured person when the injury arose out of the ownership, maintenance, or use of any motor vehicle.

E. As used in subsection D:

"AOB form" means the document or instrument that contains a provision by which the assignor assigns medical expense benefits, including any assignment of the proceeds of such coverages, to an assignee. The AOB form may be a separate instrument or included in another instrument, including a consent form or a form assigning other benefits.

"Assignee" means the health care provider to which the assignor is assigning medical expense benefits, including any assignment of the proceeds of such coverages.

"Assignor" means the covered injured person or a person authorized to consent on the covered injured person's behalf.

"Health care policy" means any health care plan, subscription contract, evidence of coverage, certificate, health services plan, medical or hospital services plan, accident and sickness insurance policy or certificate, or other similar certificate, policy, contract, or arrangement, and any endorsement or rider thereto, offered, arranged, issued, or administered by a health insurer to an individual or a group contract holder to cover all or a portion of the cost of individuals, or their eligible dependents, receiving covered health care services. Health care policy includes coverages issued pursuant to (i) Chapter 28 (§ 2.2-2800 et seq.) of Title 2.2 (state employees); (ii) § 2.2-1204 (local choice); (iii) 5 U.S.C. § 8901 et seq. (federal employees); and (iv) an employee welfare benefit plan as defined in 29 U.S.C. § 1002(1) of the Employee Retirement Income Security Act of 1974 that is self-insured or self-funded. Health care policy does not include (a) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare); Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid), or Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq. (CHIP); or Chapter 55 of Title 10 of the United States Code, 10 U.S.C. § 1071 et seq. (TRICARE); (b) subscription contracts for one or more dental or optometric services plans that are subject to Chapter 45 (§ 38.2-4500 et seq.); (c) insurance policies that provide coverage, singly or in combination, for death, dismemberment, disability, or hospital and medical care caused by or necessitated as a result of accident or specified kinds of accidents, including student accident, sports accident, blanket accident, specific accident, and accidental death and dismemberment policies; (d) credit life insurance and credit accident and sickness insurance issued pursuant to Chapter 37.1 (§ 38.2-3717 et seq.) of Title 38.2; (e) insurance policies that provide payments when an insured is disabled or unable to work because of illness, disease, or injury, including incidental benefits; (f) long-term care insurance as defined in § 38.2-5200; (g) plans providing only limited health care services under § 38.2-4300 unless offered by endorsement or rider to a group health benefit plan; (h) TRICARE supplement, Medicare supplement,

and workers' compensation coverages; or (i) medical expense coverage issued pursuant to this section.

"Health care provider" has the same meaning that is ascribed to that term in § 8.01-581.1.

"Health care services" means items or services furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability.

"Health insurer" means any entity that is the issuer or sponsor of a health care policy.

"In-network provider" means a health care provider that is employed by or has entered into a provider agreement with the health insurer that has issued the health care policy, under which applicable agreement the health care provider has agreed to provide health care services to covered patients.

"Medical expense benefits" means the benefits of coverages described in subdivision A 1, including any assignment of the proceeds of such coverages.

"Motor vehicle insurer" means the insurer issuing or delivering a policy or contract covering liability arising from the ownership, maintenance, or use of any motor vehicle that provides coverage for medical expense benefits.

"Person authorized to consent on the covered injured person's behalf" means any person authorized by law to consent on behalf of the covered injured person incapable of making an informed decision or, in the case of a minor child, the parent or parents having custody of the child or the child's legal guardian or as otherwise provided by law.

"Provider agreement" means a contract, agreement, or arrangement between a health care provider and a health insurer, or a health insurer's network, provider panel, intermediary, or representative, under which the health care provider has agreed to provide health care services to patients with coverage under a health care policy issued by the health insurer and to accept payment from the health insurer for the health care services provided.

1972, c. 859, § 38.1-380.1; 1973, c. 294; 1977, c. 112; 1982, c. 450; 1983, cc. 197, 370; 1986, c. 562; 1987, c. 429; 1989, c. 243; 1991, c. 4; 1996, c. 276; 1997, c. 503; 2013, c. 75; 2014, cc. 157, 417; 2015, cc. 502, 503.

§ 38.2-2202. Required notice of optional coverage available.

A. No new policy for insurance covering liability arising out of the ownership, maintenance, or use of any motor vehicle shall be issued or delivered in the Commonwealth unless there is enclosed with the policy, in boldface type, the following statement:

IMPORTANT NOTICE

IN ADDITION TO THE MINIMUM INSURANCE REQUIRED BY LAW, YOU MAY PURCHASE ADDITIONAL INSURANCE COVERAGE FOR THE NAMED INSURED AND FOR HIS RELATIVES WHO ARE MEMBERS OF HIS HOUSEHOLD WHILE IN OR UPON, ENTERING OR ALIGHTING FROM A MOTOR VEHICLE, OR THROUGH BEING STRUCK BY A MOTOR VEHICLE WHILE NOT

OCCUPYING A MOTOR VEHICLE, AND FOR OCCUPANTS OF THE INSURED MOTOR VEHICLE. THE FOLLOWING HEALTH CARE AND DISABILITY BENEFITS ARE AVAILABLE FOR EACH ACCIDENT:

1. PAYMENT OF UP TO $2,000 PER PERSON FOR ALL REASONABLE AND NECESSARY EXPENSES FOR MEDICAL, CHIROPRACTIC, HOSPITAL, DENTAL, SURGICAL, PROSTHETIC AND REHABILITATION SERVICES, SERVICES PROVIDED BY AN EMERGENCY MEDICAL SERVICES VEHICLE AS DEFINED IN § 32.1-111.1, AND FUNERAL EXPENSES RESULTING FROM THE ACCIDENT AND INCURRED WITHIN THREE YEARS AFTER THE DATE OF THE ACCIDENT. HOWEVER, IF YOU DO NOT PURCHASE THE $2,000 LIMIT OF COVERAGE, YOU AND THE COMPANY MAY AGREE TO ANY OTHER LIMIT; AND

2. AN AMOUNT EQUAL TO THE LOSS OF INCOME UP TO $100 PER WEEK IF THE INJURED PERSON IS ENGAGED IN AN OCCUPATION FOR WHICH HE RECEIVES COMPENSATION, FROM THE FIRST WORKDAY LOST AS A RESULT OF THE ACCIDENT UP TO THE DATE THE PERSON IS ABLE TO RETURN TO HIS USUAL OCCUPATION. SUCH PAYMENTS ARE LIMITED TO A PERIOD EXTENDING ONE YEAR FROM THE DATE OF THE ACCIDENT.

IF YOU DESIRE TO PURCHASE EITHER OR BOTH OF THESE COVERAGES AT AN ADDITIONAL PREMIUM, YOU MAY DO SO BY CONTACTING THE AGENT OR COMPANY THAT ISSUED YOUR POLICY.

The insurer issuing the policy shall inform the insured by any reasonable means of communication of the approximate premium for the additional coverage.

B. No new policy of insurance covering liability arising out of the ownership, maintenance, or use of any motor vehicle shall be issued or delivered in the Commonwealth unless the following statement, printed in boldface type, is enclosed with the policy:

IMPORTANT NOTICE

YOU ARE ENTITLED TO PURCHASE UNINSURED/UNDERINSURED COVERAGE LIMITS EQUAL TO THE LIABILITY LIMITS ON YOUR MOTOR VEHICLE POLICY. HOWEVER, ANY ONE NAMED INSURED HAS THE RIGHT TO REDUCE THE LIMITS OF THE UNINSURED/UNDERINSURED MOTORIST COVERAGE TO LESS THAN THE LIABILITY LIMITS ON THE POLICY BUT NO LOWER THAN THE FINANCIAL RESPONSIBILITY LIMITS REQUIRED BY § 46.2-472 OF THE CODE OF VIRGINIA. THE INSURER MAY REQUIRE THAT A REQUEST TO REDUCE COVERAGE BE IN WRITING. ONCE ANY ONE NAMED INSURED REDUCES THE POLICY LIMITS FOR UNINSURED/UNDERINSURED MOTORIST COVERAGE BELOW THE POLICY'S LIABILITY LIMITS, THAT ELECTION IS BINDING ON ALL INSUREDS ON THE POLICY. LATER, IF YOU DESIRE TO INCREASE YOUR LIMITS, YOU MUST MAKE A SPECIFIC REQUEST TO YOUR INSURER. YOU MAY WANT TO PUT THIS REQUEST IN WRITING.

BEFORE REDUCING THE LIMITS OF THE UNINSURED/UNDERINSURED MOTORIST COVERAGE, YOU SHOULD CAREFULLY CONSIDER THAT THIS COVERAGE PROVIDES IMPORTANT PROTECTION IN THE EVENT YOU ARE INJURED OR YOUR MOTOR VEHICLE IS DAMAGED DUE TO THE ACTIONS OF AN UNINSURED/UNDERINSURED MOTORIST.

C. No policy of insurance covering liability arising out of the ownership, maintenance, or use of any motor vehicle shall be issued, delivered, or renewed after July 1, 2023, in the Commonwealth unless the following statement, printed in boldface type, is enclosed with the policy:

IMPORTANT NOTICE

PREVIOUSLY, YOUR UNDERINSURED MOTORIST COVERAGE PAID DAMAGES DUE TO AN INSURED AFTER ANY CREDIT OF THE BODILY INJURY OR PROPERTY DAMAGE LIABILITY COVERAGE APPLICABLE TO THE INSURED'S DAMAGES HAD BEEN APPLIED.

THE LAW HAS BEEN AMENDED TO REQUIRE INSURERS TO PROVIDE UNDERINSURED MOTORIST COVERAGE THAT PAYS ANY DAMAGES DUE TO AN INSURED IN ADDITION TO ANY BODILY INJURY OR PROPERTY DAMAGE LIABILITY THAT IS APPLICABLE TO THE INSURED'S DAMAGES. THIS CHANGE MAY AFFECT YOUR PREMIUM.

YOU MAY ELECT TO REFUSE THIS CHANGE IN YOUR UNDERINSURED MOTORIST COVERAGE.

AN ELECTION TO DECREASE YOUR UNDERINSURED MOTORIST COVERAGE MUST BE IN WRITING. ONCE ANY ONE NAMED INSURED ELECTS TO DECREASE THE UNDERINSURED MOTORIST COVERAGE, THAT ELECTION IS BINDING ON ALL INSUREDS ON THE POLICY. LATER, IF YOU DESIRE TO PURCHASE INCREASED UNDERINSURED MOTORIST COVERAGE, YOU MUST MAKE A SPECIFIC REQUEST TO YOUR INSURER. YOU MUST PUT THIS REQUEST IN WRITING.

BEFORE ELECTING TO DECREASE YOUR UNDERINSURED MOTORIST COVERAGE, YOU SHOULD CAREFULLY CONSIDER THAT THIS COVERAGE PROVIDES IMPORTANT PROTECTION IN THE EVENT YOU ARE INJURED OR YOUR MOTOR VEHICLE IS DAMAGED DUE TO THE ACTIONS OF AN UNDERINSURED MOTORIST.

1974, c. 607, § 38.1-380.2; 1977, c. 112; 1981, c. 245; 1982, cc. 450, 642; 1986, c. 562; 1987, c. 429; 1989, c. 243; 1992, c. 230; 2001, c. 564; 2015, cc. 502, 503; 2016, c. 558; 2022, c. 308.

§ 38.2-2203. Policy providing for reimbursement for services that may be performed by certain practitioners other than physicians.

Notwithstanding any provision of any policy or contract of bodily injury liability insurance, when the policy or contract provides for reimbursement for any service that may be legally performed by a person licensed in this Commonwealth for the practice of chiropractic, reimbursement under the policy shall not be denied because the service is rendered by a licensed chiropractor.

1984, c. 441, § 38.1-380.3; 1986, c. 562.

§ 38.2-2204. Liability insurance on motor vehicles, aircraft, and watercraft; standard provisions; "omnibus clause.".

A. No policy or contract of bodily injury or property damage liability insurance, covering liability arising from the ownership, maintenance, or use of any motor vehicle, aircraft, or private pleasure watercraft, shall be issued or delivered in the Commonwealth to the owner of such vehicle, aircraft, or watercraft, or shall be issued or delivered by any insurer licensed in the Commonwealth upon any motor vehicle, aircraft, or private pleasure watercraft that is principally garaged, docked, or used in the Commonwealth, unless the policy contains a provision insuring the named insured, and any other person using or responsible for the use of the motor vehicle, aircraft, or private pleasure watercraft with the expressed or implied consent of the named insured, against liability for death or injury sustained, or loss or damage incurred within the coverage of the policy or contract as a result of negligence in the operation or use of such vehicle, aircraft, or watercraft by the named insured or by any such person; however, nothing contained in this section shall be deemed to prohibit an insurer from limiting its liability under any one policy for bodily injury or property damage resulting from any one accident or occurrence to the liability limits for such coverage set forth in the policy for any such accident or occurrence or for any one person, regardless of the number of insureds under that policy. Provided that, when one accident or occurrence involves more than one defendant who is covered by the policy, the plaintiff may recover the per person limit of the policy against each such defendant, subject to the per accident or occurrence limit of the policy. Each such policy or contract of liability insurance, or endorsement to the policy or contract, insuring private passenger automobiles, aircraft, or private pleasure watercraft principally garaged, docked, or used in the Commonwealth, that has as the named insured an individual or spouses and that includes, with respect to any liability insurance provided by the policy, contract, or endorsement for use of a nonowned automobile, aircraft, or private pleasure watercraft, any provision requiring permission or consent of the owner of such automobile, aircraft, or private pleasure watercraft for the insurance to apply, shall be construed to include permission or consent of the custodian in the provision requiring permission or consent of the owner.

B. Notwithstanding any requirements in this section to the contrary, an insurer may exclude any person from coverage under a personal umbrella or excess policy, if the exclusion is requested in writing by the first named insured and is acknowledged in writing by the excluded driver.

C. For aircraft liability insurance, such policy or contract may contain the exclusions listed in § 38.2-2227. Notwithstanding the provisions of this section or any other provisions of law, no policy or contract shall require pilot experience greater than that prescribed by the Federal Aviation Administration, except for pilots operating air taxis, or pilots operating aircraft applying chemicals, seed, or fertilizer.

D. No policy or contract of bodily injury or property damage liability insurance relating to the ownership, maintenance, or use of a motor vehicle shall be issued or delivered in the Commonwealth to the owner of such vehicle or shall be issued or delivered by an insurer licensed in the Commonwealth upon any motor vehicle principally garaged or used in the Commonwealth without an endorsement or provision insuring the named insured, and any other person using or responsible for the use of the

motor vehicle with the expressed or implied consent of the named insured, against liability for death or injury sustained, or loss or damage incurred within the coverage of the policy or contract as a result of negligence in the operation or use of the motor vehicle by the named insured or by any other such person; however, nothing contained in this section shall be deemed to prohibit an insurer from limiting its liability under any one policy for bodily injury or property damage resulting from any one accident or occurrence to the liability limits for such coverage set forth in the policy for any such accident or occurrence or for any one person regardless of the number of insureds under that policy. Provided that, when one accident or occurrence involves more than one defendant who is covered by the policy, the plaintiff may recover the per person limit of the policy against each such defendant, subject to the per accident or occurrence limit of the policy. This provision shall apply notwithstanding the failure or refusal of the named insured or such other person to cooperate with the insurer under the terms of the policy. If the failure or refusal to cooperate prejudices the insurer in the defense of an action for damages arising from the operation or use of such insured motor vehicle, then the endorsement or provision shall be void. If an insurer has actual notice of a motion for judgment or complaint having been served on an insured, the mere failure of the insured to turn the motion or complaint over to the insurer shall not be a defense to the insurer, nor void the endorsement or provision, nor in any way relieve the insurer of its obligations to the insured, provided the insured otherwise cooperates and in no way prejudices the insurer.

Where the insurer has elected to provide a defense to its insured under such circumstances and files responsive pleadings in the name of its insured, the insured shall not be subject to sanctions for failure to comply with discovery pursuant to Part Four of the Rules of Supreme Court of Virginia unless it can be shown that the suit papers actually reached the insured, and that the insurer has failed after exercising due diligence to locate its insured, and as long as the insurer provides such information in response to discovery as it can without the assistance of the insured.

E. Any endorsement, provision or rider attached to or included in any such policy of insurance which purports or seeks to limit or reduce the coverage afforded by the provisions required by this section shall be void, except an insurer may exclude such coverage as is afforded by this section, where such coverage would inure to the benefit of the United States Government or any agency or subdivision thereof under the provisions of the Federal Tort Claims Act, the Federal Drivers Act and Public Law 86-654 District of Columbia Employee Non-Liability Act, or to the benefit of the Commonwealth under the provisions of the Virginia Tort Claims Act (§ 8.01-195.1 et seq.) and the self-insurance plan established by the Department of General Services pursuant to § 2.2-1837 for any state employee who, in the regular course of his employment, transports patients in his own personal vehicle.

F. An insurer writing a policy of bodily injury or property damage liability motor vehicle insurance, or an endorsement to such policy, may exclude coverage under a motor vehicle policy issued to the owner of a shared vehicle for use of such vehicle on a peer-to-peer vehicle sharing platform during the vehicle sharing period for (i) liability coverage for bodily injury and property damage, (ii) uninsured and underinsured motorist coverage, (iii) medical expense and loss of income benefits coverage, and

(iv) collision and other than collision physical damage coverage. Nothing in this article invalidates or limits an exclusion contained in a motor vehicle liability insurance policy, including any insurance policy in use or approved for use, that excludes coverage for motor vehicles used as a public or livery conveyance. For purposes of this subsection, "peer-to-peer vehicle sharing platform," "shared vehicle," and "vehicle sharing period" have the meanings ascribed to those terms in § 46.2-1408.

Code 1950, § 38-238; 1952, c. 317, § 38.1-381; 1958, c. 282; 1959, Ex. Sess., cc. 42, 70; 1970, c. 462; 1962, c. 457; 1964, c. 477; 1966, cc. 182, 459; 1968, cc. 199, 721; 1970, c. 494; 1971, Ex. Sess., c. 216; 1973, cc. 225, 390; 1974, c. 87; 1976, cc. 121, 122; 1977, c. 78; 1979, c. 113; 1980, cc. 326, 331; 1981, Sp. Sess., c. 6; 1982, cc. 638, 642; 1984, c. 541; 1985, cc. 39, 325; 1986, cc. 544, 562; 1992, c. 140; 1995, c. 652; 1999, c. 4; 2003, cc. 756, 761; 2005, c. 771; 2020, cc. 900, 1266.

§ 38.2-2205. Liability insurance on motor vehicles; standard provisions; applicability of other valid and collectible insurance.

A. 1. Each policy or contract of bodily injury or property damage liability insurance which provides insurance to a named insured in connection with the business of selling, leasing, repairing, servicing, storing or parking motor vehicles, against liability arising from the ownership, maintenance, or use of any motor vehicle incident thereto shall contain a provision that the insurance coverage applicable to those motor vehicles shall not be applicable to a person other than the named insured and his employees in the course of their employment if there is any other valid and collectible insurance applicable to the same loss covering the other person under a policy with limits at least equal to the financial responsibility requirements specified in § 46.2-472. Such provision shall apply to motor vehicles which are either for the purpose of demonstrating to the other person as a prospective purchaser, or which are loaned or leased to the other person as a convenience during the repairing or servicing of a motor vehicle for the other person, or leased to the other person for a period of six months or more. This provision shall apply whether such repair or service is performed by the owner of the vehicle being loaned or leased or by some other person or business.

2. If the other valid and collectible insurance has limits less than the financial responsibility requirements specified in § 46.2-472, then the coverage afforded a person other than the named insured and his employees in the course of their employment shall be applicable to the extent necessary to equal the financial responsibility requirements specified in § 46.2-472.

3. If there is no other valid and collectible insurance available, the coverage under such policy afforded a person, other than the named insured and his employees in the course of their employment, shall be applicable, but the amount recoverable in such case shall not exceed the financial responsibility requirements specified in § 46.2-472. If there is no other valid and collectible collision or upset insurance available and if such policy provides insurance to the named insured for collision or upset, it shall include any such other person as an additional insured, unless in the case of a leased vehicle such other person receives a conspicuous written disclosure at the commencement of the lease, warning such person that he is not an additional insured under the owner's policy for collision or upset coverage.

B. 1. Any policy or contract of bodily injury or property damage liability insurance relating to the ownership, maintenance, or use of a motor vehicle shall exclude coverage to persons other than (i) the named insured, or (ii) directors, stockholders, partners, agents, or employees of the named insured, or (iii) residents of the household of either (i) or (ii), while those persons are employed or otherwise engaged in the business of selling, repairing, servicing, storing, or parking motor vehicles if there is any other valid or collectible insurance applicable to the same loss covering the persons under a policy with limits at least equal to the financial responsibility requirements specified in § 46.2-472.

2. If the other valid and collectible insurance has limits less than the financial responsibility requirements specified in § 46.2-472, then the coverage afforded a person other than the named insured while that person is employed or otherwise engaged in the business of selling, repairing, servicing, storing, or parking motor vehicles shall be applicable to the extent necessary to equal the financial responsibility requirements specified in § 46.2-472.

3. If there is no other valid and collectible insurance available, the coverage afforded a person other than the named insured while that person is employed or otherwise engaged in the business of selling, repairing, servicing, storing, or parking motor vehicles shall apply, but the amount recoverable shall not exceed the financial responsibility requirements specified in § 46.2-472.

Code 1950, § 38-238; 1952, c. 317, § 38.1-381; 1958, c. 282; 1959, Ex. Sess., cc. 42, 70; 1970, c. 462; 1962, c. 457; 1964, c. 477; 1966, cc. 182, 459; 1968, cc. 199, 721; 1970, c. 494; 1971, Ex. Sess., c. 216; 1973, cc. 225, 390; 1974, c. 87; 1976, cc. 121, 122; 1977, c. 78; 1979, c. 113; 1980, cc. 326, 331; 1981, Sp. Sess., c. 6; 1982, cc. 638, 642; 1984, c. 541; 1985, cc. 39, 325; 1986, c. 562; 1987, c. 685; 1992, c. 474.

§ 38.2-2205.1. Suspension of liability coverage at insured's request.

A. Each insurer issuing or delivering a policy or contract of motor vehicle insurance that includes coverage for bodily injury or property damage liability arising from the ownership, maintenance or use of any motor vehicle as provided in this chapter, shall suspend any coverage for any motor vehicle at the request of a named insured ordered to military duty outside this Commonwealth, or his personal representative, during any period that the motor vehicle is impounded in a motor vehicle impound lot on a military base of the United States Armed Forces, the Reserves of the United States Armed Forces or the National Guard. However, an insurer may decline to suspend such coverage (i) unless satisfactory evidence of such impoundment is furnished to it, or (ii) if the period for which coverage suspension is requested is less than thirty days. The suspended coverage shall be reinstated upon request of the named insured, or his personal representative, effective not earlier than the receipt of such request by the insurer or any of its authorized representatives.

B. Any insurer suspending coverage pursuant to this section shall refund any unearned premium to the named insured, or his personal representative, on a pro rata basis.

C. The provisions of this section shall not alter or limit the insured's obligations under Article 8 (§ 46.2-705 et seq.) of Chapter 6 of Title 46.2.

1991, c. 699.

§ 38.2-2206. Uninsured motorist insurance coverage.

A. Except as provided in subsection J, no policy or contract of bodily injury or property damage liability insurance relating to the ownership, maintenance, or use of a motor vehicle shall be issued or delivered in this Commonwealth to the owner of such vehicle or shall be issued or delivered by any insurer licensed in this Commonwealth upon any motor vehicle principally garaged or used in this Commonwealth unless it contains an endorsement or provisions undertaking to pay the insured all sums that he is legally entitled to recover as damages from the owner or operator of an uninsured motor vehicle, within limits not less than the requirements of § 46.2-472. Those limits shall equal but not exceed the limits of the liability insurance provided by the policy, unless any one named insured rejects the additional uninsured motorist insurance coverage by notifying the insurer as provided in subsection B of § 38.2-2202. This rejection of the additional uninsured motorist insurance coverage by any one named insured shall be binding upon all insureds under such policy. The endorsement or provisions shall also provide underinsured motorist insurance coverage with limits that shall be equal to the uninsured motorist insurance coverage limits and shall obligate the insurer to make payment for bodily injury or property damage caused by the operation or use of an underinsured motor vehicle to the extent the vehicle is underinsured.

The endorsement shall provide that underinsured motorist coverage shall be paid without any credit for the bodily injury and property damage coverage available for payment, unless any one named insured signs an election to reduce any underinsured motorist coverage payments by the bodily injury liability or property damage liability coverage available for payment by notifying the insurer as provided in subsection C of § 38.2-2202. This election by any one named insured shall be binding upon all insureds under such policy.

The endorsement or provisions shall also provide for at least $20,000 coverage for damage or destruction of the property of the insured in any one accident but may provide an exclusion of the first $200 of the loss or damage where the loss or damage is a result of any one accident involving an unidentifiable owner or operator of an uninsured motor vehicle.

B. 1. As used in this section:

"Bodily injury" includes death resulting from bodily injury.

"Insured" as used in subsections A, D, G, and H, means the named insured and, while resident of the same household, the spouse of the named insured, and relatives, wards or foster children of either, while in a motor vehicle or otherwise, and any person who uses the motor vehicle to which the policy applies, with the expressed or implied consent of the named insured, and a guest in the motor vehicle to which the policy applies or the personal representative of any of the above.

"Uninsured motor vehicle" means a motor vehicle for which (i) there is no bodily injury liability insurance and property damage liability insurance in the amounts specified by § 46.2-472, (ii) there is such insurance but the insurer writing the insurance denies coverage for any reason whatsoever, including

failure or refusal of the insured to cooperate with the insurer, (iii) there is no bond or deposit of money or securities in lieu of such insurance, (iv) the owner of the motor vehicle has not qualified as a self-insurer under the provisions of § 46.2-368, or (v) the owner or operator of the motor vehicle is immune from liability for negligence under the laws of the Commonwealth or the United States, in which case the provisions of subsection F shall apply and the action shall continue against the insurer. A motor vehicle shall be deemed uninsured if its owner or operator is unknown.

A motor vehicle is "underinsured" when, and to the extent that, the total amount of bodily injury and property damage coverage applicable to the operation or use of the motor vehicle and available for payment for such bodily injury or property damage, including all bonds or deposits of money or securities made pursuant to Article 15 (§ 46.2-435 et seq.) of Chapter 3 of Title 46.2, is less than the total amount of damages sustained up to the total amount of underinsured motorist coverage afforded any person injured as a result of the operation or use of the vehicle.

"Available for payment" means the amount of liability insurance coverage applicable to the claim of the injured person for bodily injury or property damage reduced by the payment of any other claims arising out of the same occurrence.

2. If an injured person is entitled to uninsured or underinsured motorist coverage under more than one policy, the insurers shall be obligated to the injured person in the following order of priority of payment:

a. The policy covering a motor vehicle occupied by the injured person at the time of the accident;

b. The policy covering a motor vehicle not involved in the accident under which the injured person is a named insured;

c. The policy covering a motor vehicle not involved in the accident under which the injured person is an insured other than a named insured.

Where there is more than one insurer providing coverage under one of the payment priorities set forth, their liability shall be proportioned as to their respective available uninsured or underinsured motorist coverages.

3. If an injured person is entitled to underinsured motorist coverage under one or more policies wherein a named insured has elected to reduce the underinsured motorist limits by the available bodily injury liability insurance or property damage liability insurance coverage available for payment, any amount available for payment shall be credited against such policies in payment priority pursuant to subdivision 2 a only, and where there is more than one such policy entitled to such credit, the credit shall be apportioned pro-rata pursuant to the policies' respective available underinsured motorist coverages.

4. Recovery under the endorsement or provisions shall be subject to the conditions set forth in this section.

C. There shall be a rebuttable presumption that a motor vehicle is uninsured if the Commissioner of the Department of Motor Vehicles certifies that, from the records of the Department of Motor Vehicles,

it appears that (i) there is no bodily injury liability insurance and property damage liability insurance in the amounts specified by § 46.2-472 covering the owner or operator of the motor vehicle; (ii) no bond has been given or cash or securities delivered in lieu of the insurance; or (iii) the owner or operator of the motor vehicle has not qualified as a self-insurer in accordance with the provisions of § 46.2-368.

D. If the owner or operator of any motor vehicle that causes bodily injury or property damage to the insured is unknown, and if the damage or injury results from an accident where there has been no contact between that motor vehicle and the motor vehicle occupied by the insured, or where there has been no contact with the person of the insured if the insured was not occupying a motor vehicle, then for the insured to recover under the endorsement required by subsection A, the accident shall be reported promptly to either (i) the insurer or (ii) a law-enforcement officer having jurisdiction in the county or city in which the accident occurred. If it is not reasonably practicable to make the report promptly, the report shall be made as soon as reasonably practicable under the circumstances.

E. If the owner or operator of any vehicle causing injury or damages is unknown, an action may be instituted against the unknown defendant as "John Doe" and service of process may be made by delivering a copy of the motion for judgment or other pleadings to the clerk of the court in which the action is brought. Service upon the insurer issuing the policy shall be made as prescribed by law as though the insurer were a party defendant. The provisions of § 8.01-288 shall not be applicable to the service of process required in this subsection. The insurer shall have the right to file pleadings and take other action allowable by law in the name of John Doe.

F. If any action is instituted against the owner or operator of an uninsured or underinsured motor vehicle by any insured intending to rely on the uninsured or underinsured coverage provision or endorsement of this policy under which the insured is making a claim, then the insured shall serve a copy of the process upon this insurer in the manner prescribed by law, as though the insurer were a party defendant. The provisions of § 8.01-288 shall not be applicable to the service of process required in this subsection. The insurer shall then have the right to file pleadings and take other action allowable by law in the name of the owner or operator of the uninsured or underinsured motor vehicle or in its own name. Notwithstanding the provisions of subsection A, the immunity from liability for negligence of the owner or operator of a motor vehicle shall not be a bar to the insured obtaining a judgment enforceable against the insurer for the negligence of the immune owner or operator, and shall not be a defense available to the insurer to the action brought by the insured, which shall proceed against the named defendant although any judgment obtained against an immune defendant shall be entered in the name of "Immune Defendant" and shall be enforceable against the insurer and any other nonimmune defendant as though it were entered in the actual name of the named immune defendant. Nothing in this subsection shall prevent the owner or operator of the uninsured motor vehicle from employing counsel of his own choice and taking any action in his own interest in connection with the proceeding.

G. Any insurer paying a claim under the endorsement or provisions required by subsection A shall be subrogated to the rights of the insured to whom the claim was paid against the person causing the

injury, death, or damage and that person's insurer, although it may deny coverage for any reason, to the extent that payment was made. The bringing of an action against the unknown owner or operator as John Doe or the conclusion of such an action shall not bar the insured from bringing an action against the owner or operator proceeded against as John Doe, or against the owner's or operator's insurer denying coverage for any reason, if the identity of the owner or operator who caused the injury or damages becomes known. The bringing of an action against an unknown owner or operator as John Doe shall toll the statute of limitations for purposes of bringing an action against the owner or operator who caused the injury or damages until his identity becomes known. In no event shall an action be brought against an owner or operator who caused the injury or damages, previously filed against as John Doe, more than three years from the commencement of the action against the unknown owner or operator as John Doe in a court of competent jurisdiction. Any recovery against the owner or operator, or the insurer of the owner or operator shall be paid to the insurer of the injured party to the extent that the insurer paid the named insured in the action brought against the owner or operator as John Doe. However, the insurer shall pay its proportionate part of all reasonable costs and expenses incurred in connection with the action, including reasonable attorney's fees. Nothing in an endorsement or provisions made under this subsection nor any other provision of law shall prevent the joining in an action against John Doe of the owner or operator of the motor vehicle causing the injury as a party defendant, and the joinder is hereby specifically authorized. No action, verdict or release arising out of a suit brought under this subsection shall give rise to any defenses in any other action brought in the subrogated party's name, including res judicata and collateral estoppel.

H. No endorsement or provisions providing the coverage required by subsection A shall require arbitration of any claim arising under the endorsement or provisions, nor may anything be required of the insured except the establishment of legal liability, nor shall the insured be restricted or prevented in any manner from employing legal counsel or instituting legal proceedings.

I. Except as provided in § 65.2-309.1, the provisions of subsections A and B of § 38.2-2204 and the provisions of subsection A shall not apply to any policy of insurance to the extent that it covers the liability of an employer under any workers' compensation law, or to the extent that it covers liability to which the Federal Tort Claims Act applies. No provision or application of this section shall limit the liability of an insurer of motor vehicles to an employee or other insured under this section who is injured by an uninsured motor vehicle; provided that in the event an employee of a self-insured employer receives a workers' compensation award for injuries resulting from an accident with an uninsured motor vehicle, such award shall be set off against any judgment for damages awarded pursuant to this section for personal injuries resulting from such accident.

J. Policies of insurance whose primary purpose is to provide coverage in excess of other valid and collectible insurance or qualified self-insurance may include uninsured motorist coverage as provided in subsection A. Insurers issuing or providing liability policies that are of an excess or umbrella type or which provide liability coverage incidental to a policy and not related to a specifically insured motor

vehicle, shall not be required to offer, provide or make available to those policies uninsured or underinsured motor vehicle coverage as defined in subsection A.

K. An injured person, or in the case of death or disability his personal representative, may settle a claim with (i) a liability insurer, including any insurer providing liability coverage through an excess or umbrella insurance policy or contract and (ii) the liability insurer's insured for the available limits of the liability insurer's coverage. Upon settlement with the liability insurer, the injured party or personal representative shall proceed to execute a full release in favor of the underinsured motorist's liability insurer and its insured and finalize the proposed settlement without prejudice to any underinsured motorist benefits or claim. Any such release that states that it is being executed pursuant to or consistent with this subsection shall not operate to release any parties other than the liability insurer and underinsured motorist, regardless of the identities of the released parties set forth in the release, and any terms contained in the release that are inconsistent with, or in violation of, this section are null and void. Upon payment of the liability insurer's available limits to the injured person or personal representative or his attorney, the liability insurer shall thereafter have no further duties to its insured, including the duty to defend its insured if an action has been or is brought against the liability insurer's insured, and the insurer providing applicable underinsured motorist coverage shall have no right of subrogation or claim against the underinsured motorist. However, if the underinsured motorist unreasonably fails to cooperate with the underinsured motorist benefits insurer in the defense of any lawsuit brought by the injured person or his personal representative, he may again be subjected to a claim for subrogation by the underinsured motorist benefits insurer pursuant to § 8.01-66.1:1. Nothing in this section or § 8.01-66.1:1 shall create any duty on the part of any underinsured motorist benefits insurer to defend any underinsured motorist. No attorney-client relationship is created between the underinsured motorist and counsel for the underinsured motorist benefits insurer without the express intent and agreement of the underinsured motorist, the underinsured motorist benefits insurer, and counsel for the underinsured motorist benefits insurer. This section provides an alternative means by which the parties may resolve claims and does not eliminate or restrict any other available means.

L. Any settlement between the injured person or his personal representative, any insurer providing liability coverage applicable to the claim, and the underinsured motorist described in subsection K shall be in writing, signed by both the injured person or his personal representative and the underinsured motorist, and shall include the following notice to the underinsured motorist, which must be initialed by the underinsured motorist:

"NOTICE TO RELEASED PARTY: Your insurance company has agreed to pay the available limits of its insurance to settle certain claims on your behalf. This settlement secures a full release of you for all claims the claimant/plaintiff has against you arising out of the subject accident, as well as ensures that no judgment can ever be entered against you by the claimant/plaintiff. In order to protect yourself from subrogation by any underinsured motorist insurer, you are agreeing to cooperate with the underinsured motorist benefits insurer(s). The underinsured motorist benefits insurer is not your insurer and has no duty to defend you.

Under this manner of settlement, the underinsured motorist benefits insurer(s) that is/are involved in this case has/have no right of subrogation against you unless you fail to reasonably cooperate in its/-their defense of the claim by not (i) attending your deposition and trial, if subpoenaed, (ii) assisting in responding to discovery, (iii) meeting with defense counsel at reasonable times after commencement of this suit and before your testimony at a deposition and/or trial, and (iv) notifying the underinsured motorist benefits insurer or its defense counsel of any change in your address, provided that the underinsured motorist benefits insurer or its defense counsel has notified you of its existence and provided you with their contact information.

Upon payment of the agreed settlement amount by your insurance company(ies), such company shall no longer owe you any duties, including the duty to hire and pay for an attorney for you. You are not required to consent to settlement in this manner. If you do not consent to settlement in this manner, your insurance company will still defend you in any lawsuit brought against you by the claimant/-plaintiff, but you will not have the protections of a full release from the claimant/plaintiff, judgment could be entered against you and may exceed your available insurance coverage, and any underinsured motorist benefits insurer would have a right of subrogation against you to recover any moneys it pays to the claimant/plaintiff.

You are encouraged to discuss your rights and obligations related to settlement in this manner with your insurance company and/or an attorney. By signing this document, you agree to consent to this settlement and to reasonably cooperate with the underinsured motorist benefits insurer in the defense of any lawsuit brought by the claimant/plaintiff.

_____ (initial)"

In the alternative to having the underinsured motorist sign the release and initial the notice, the liability insurer may send the notice and release to the underinsured motorist by certified mail return receipt requested to his last known address, which will be deemed to have satisfied the requirements of this subsection.

M. Any action brought by the injured person or his personal representative to recover underinsured motorist benefits after payment of the liability insurer's available limits pursuant to subsection K shall be brought against the released defendant, and a copy of the complaint shall be served on any insurer providing underinsured motorist benefits. If an action is pending at the time the liability insurer's available limits are paid to the injured person or personal representative or his attorney, then the action shall remain pending against the named defendant or defendants who have been released. If such action results in a verdict in favor of the injured person or his personal representative against a released defendant, then judgment as to that defendant shall be entered in the name of "Released Defendant" and shall be enforceable against the underinsured motorist benefits insurer, not to exceed the underinsured motorist benefits limits, and against any unreleased defendant, as though it were entered in the actual name of the released defendant.

N. Any proposed settlement between a liability insurer and a person under a disability or a personal representative as permitted in subsection K that compromises in part a claim for personal injuries by the person under a disability or for death by wrongful act pursuant to § 8.01-50 may be, but is not required to be, approved pursuant to § 8.01-424 or 8.01-55, as applicable. If the personal representative elects not to have the settlement with the liability insurer approved pursuant to § 8.01-55, then any payment made to the personal representative by the liability insurer shall be made payable to the personal representative's attorney, to be held in trust, or paid into the court pursuant to § 8.01-600 if the personal representative is not represented by an attorney, with no disbursements made therefrom until the compromise is approved by the court pursuant to § 8.01-55. Approval by the court of a settlement between the liability insurer and a person under a disability or the personal representative pursuant to this subsection shall not prejudice the person's or personal representative's claim for underinsured motorist benefits.

Code 1950, § 38-238; 1952, c. 317, § 38.1-381; 1958, c. 282; 1959, Ex. Sess., cc. 42, 70; 1960, c. 462; 1962, c. 457; 1964, c. 477; 1966, cc. 182, 459; 1968, cc. 199, 721; 1970, c. 494; 1971, Ex. Sess., c. 216; 1973, cc. 225, 390; 1974, c. 87; 1976, cc. 121, 122; 1977, c. 78; 1979, c. 113; 1980, cc. 326, 331; 1981, Sp. Sess., c. 6; 1982, cc. 638, 642; 1984, c. 541; 1985, cc. 39, 325; 1986, c. 562; 1987, c. 519; 1988, cc. 565, 578, 585, 586, 594; 1989, c. 621; 1993, c. 381; 1995, cc. 189, 267, 476; 1997, cc. 170, 191; 1999, c. 992; 2001, c. 218; 2003, c. 283; 2010, c. 492; 2011, c. 107; 2015, cc. 584, 585; 2019, c. 779; 2022, c. 308.

§ 38.2-2207. No policy to exclude coverage to employee.

No policy or contract of bodily injury or property damage liability insurance relating to the ownership, maintenance, or use of a motor vehicle, aircraft or watercraft shall exclude coverage to an employee of the insured in any controversy arising between employees even though one employee shall be awarded compensation as provided in Title 65.2.

Code 1950, § 38-238; 1952, c. 317, § 38.1-381; 1958, c. 282; 1959, Ex. Sess., cc. 42, 70; 1970, c. 462; 1962, c. 457; 1964, c. 477; 1966, cc. 182, 459; 1968, cc. 199, 721; 1970, c. 494; 1971, Ex. Sess., c. 216; 1973, cc. 225, 390; 1974, c. 87; 1976, cc. 121, 122; 1977, c. 78; 1979, c. 113; 1980, cc. 326, 331; 1981, Sp. Sess., c. 6; 1982, cc. 638, 642; 1984, c. 541; 1985, cc. 39, 325; 1986, c. 562; 1987, c. 519.

§ 38.2-2208. Notices of cancellation of or refusal to renew motor vehicle insurance policies.

A. No written notice of cancellation or refusal to renew that is mailed or delivered electronically by an insurer to an insured in accordance with the provisions of a motor vehicle insurance policy shall be effective unless the insurer complies with the applicable provisions of subdivisions 1, 2, and 3:

1. If the notice is mailed, proof of mailing a notice of cancellation or refusal to renew shall be obtained using one of the following methods that demonstrates the date that the notice was sent to the named insured at the address stated in the policy or to the named insured's last known address:

a. The notice is sent by:

(1) Registered mail;

(2) Certified mail; or

(3) Any other similar first-class mail tracking method used or approved by the United States Postal Service, including Intelligent Mail barcode Tracing (IMb Tracing); or

b. The notice is sent by another method of mailing for which a certificate of mailing is obtained from the United States Postal Service at the time the notice is accepted for mailing. A certificate of mailing from the United States Postal Service does not include a certificate of bulk mailing.

2. If such notice is delivered electronically, the insurer retains evidence of electronic transmittal or receipt of the notification for at least one year from the date of the transmittal.

3. If the notice is mailed, the insurer retains a copy of the notice of cancellation or refusal to renew for at least one year from the date such action was effective. If the notice is mailed, proof of mailing from the United States Postal Service consistent with the mailing method utilized by the insurer shall be maintained for one year from the date the cancellation or nonrenewal notice is effective.

B. 1. If the terms of the policy require the notice of cancellation or refusal to renew to be given to any lienholder, then the insurer shall mail such notice and retain a copy of the notice in the manner required by subsection A. If the notices sent to the insured and the lienholder are part of the same form, the insurer may retain a single copy of the notice. Proof of mailing from the United States Postal Service consistent with the mailing method utilized by the insurer shall be maintained for one year from the date the cancellation or nonrenewal notice is effective.

2. Notwithstanding the provisions of subdivision B 1, if the terms of the policy require the notice of cancellation or refusal to renew to be given to any lienholder, the insurer and lienholder may agree by separate agreement that such notices may be transmitted electronically, provided that the insurer and lienholder agree upon the specifics for transmittal and acknowledgment of notification. Evidence of transmittal or receipt of the notification required by this subsection shall be retained by the insurer for at least one year from the date of termination.

C. "Copy," as used in this section, includes photographs, microphotographs, photostats, microfilm, microcard, printouts or other reproductions of electronically stored data or copies from optical disks, electronically transmitted facsimiles, or any other reproduction of an original from a process that forms a durable medium for its recording, storing, and reproducing.

1954, c. 263, § 38.1-381.1; 1960, c. 127; 1975, c. 164; 1983, c. 371; 1986, c. 562; 1992, c. 160; 2000, c. 529; 2003, c. 387; 2009, c. 215; 2013, c. 257; 2015, cc. 9, 443; 2016, cc. 4, 71.

§ 38.2-2209. Motor vehicle liability medical benefit insurer not to retain right of subrogation to recover from third party.

No policy or contract of bodily injury or property damage liability insurance that contains any representation by an insurer to pay all reasonable medical expenses incurred for bodily injury caused by accident to the insured or any relative or other person coming within the provisions of the policy, shall be issued or delivered by any insurer licensed in this Commonwealth upon any motor vehicle then

principally garaged or principally used in this Commonwealth, if the insurer retains the right of subrogation to recover amounts paid on behalf of an injured person under the provision of the policy from any third party.

1964, c. 612, § 38.1-381.2; 1986, c. 562.

§ 38.2-2210. Warning concerning cancellation to appear on application for motor vehicle liability insurance; reason for cancellation or nonrenewal required on application.

A. Any application for the original issuance of a policy of insurance covering liability arising out of the ownership, maintenance, or use of any motor vehicle as defined in § 38.2-2212 shall have the following statement printed on or attached to the application, in boldface type: READ YOUR POLICY. THE POLICY OF INSURANCE FOR WHICH THIS APPLICATION IS BEING MADE, IF ISSUED, MAY BE CANCELLED WITHOUT CAUSE AT THE OPTION OF THE INSURER AT ANY TIME IN THE FIRST 60 DAYS DURING WHICH IT IS IN EFFECT AND AT ANY TIME THEREAFTER FOR REASONS STATED IN THE POLICY.

B. Any application for the original issuance of a policy of insurance covering liability arising out of the ownership, maintenance, or use of any motor vehicle defined in § 38.2-2212 that requires the insured to disclose information as to any previous cancellation or refusal to renew shall also permit the insured to offer or provide a full explanation of the reason for the cancellation or refusal to renew.

C. The notice required by this section shall be given by the insurer to any applicant within ten days of the application in the event the applicant is not provided a written copy of the application and the coverage has been bound by such insurer.

D. This section shall not apply to the renewal of any policy of insurance.

1966, c. 523, § 38.1-381.3; 1986, c. 562; 1988, cc. 655, 665; 2016, c. 558.

§ 38.2-2211. Motor vehicle liability insurer not to receive credit for other medical expense insurance.

No policy or contract of bodily injury or property damage liability insurance that contains any representation by an insurer to pay all reasonable medical expenses incurred for bodily injury caused by accident to the insured, relative or any other person coming within the provisions of the policy, shall be issued or delivered by any insurer licensed in this Commonwealth upon any motor vehicle then principally garaged or principally used in this Commonwealth, if the policy provides for credit against the medical expense coverage for any other medical expense insurance to which the injured person may be entitled. Nothing in this section allows the injured person to collect more than his actual medical expenses as a result of an accident from any one or any combination of all policies providing motor vehicle medical payment coverage applicable to the accident.

1968, c. 759, § 38.1-381.4; 1986, c. 562.

§ 38.2-2212. Grounds and procedure for cancellation of or refusal to renew motor vehicle insurance policies; review by Commissioner.

A. As used in this section:

"Cancellation" or "to cancel" means a termination of a policy during the policy period.

"Insurer" means any insurance company, association, or exchange licensed to transact motor vehicle insurance in the Commonwealth.

"Policy of motor vehicle insurance" or "policy" means a policy or contract for bodily injury or property damage liability insurance issued or delivered in this Commonwealth covering liability arising from the ownership, maintenance, or use of any motor vehicle, insuring as the named insured one individual or spouses who are residents of the same household, and under which the insured vehicle designated in the policy is either:

1. A motor vehicle of a private passenger, station wagon, or motorcycle type that is not used commercially, rented to others, or used as a public or livery conveyance where the term "public or livery conveyance" does not include car pools, or

2. Any other four-wheel motor vehicle which is not used in the occupation, profession, or business, other than farming, of the insured, or as a public or livery conveyance, or rented to others. The term "policy of motor vehicle insurance" or "policy" does not include (i) any policy issued through the Virginia Automobile Insurance Plan, (ii) any policy covering the operation of a garage, sales agency, repair shop, service station, or public parking place, (iii) any policy providing insurance only on an excess basis, or (iv) any other contract providing insurance to the named insured even though the contract may incidentally provide insurance on motor vehicles.

"Renewal" or "to renew" means (i) the issuance and delivery by an insurer of a policy superseding at the end of the policy period a policy previously issued and delivered by the same insurer, providing types and limits of coverage at least equal to those contained in the policy being superseded, or (ii) the issuance and delivery of a certificate or notice extending the term of a policy beyond its policy period or term with types and limits of coverage at least equal to those contained in the policy. Each renewal shall conform with the requirements of the manual rules and rating program currently filed by the insurer with the Commission. Except as provided in subsection K, any policy with a policy period or term of less than 12 months or any policy with no fixed expiration date shall for the purpose of this section be considered as if written for successive policy periods or terms of six months from the original effective date.

B. This section shall apply only to that portion of a policy of motor vehicle insurance providing the coverage required by §§ 38.2-2204, 38.2-2205, and 38.2-2206.

C. 1. No insurer shall refuse to renew a motor vehicle insurance policy solely because of any one or more of the following factors:

a. Age;

b. Sex;

c. Residence;

d. Race;

e. Color;

f. Creed;

g. National origin;

h. Ancestry;

i. Marital status;

j. Sexual orientation;

k. Gender identity;

l. Lawful occupation, including the military service;

m. Lack of driving experience, or number of years driving experience;

n. Lack of supporting business or lack of the potential for acquiring such business;

o. One or more accidents or violations that occurred more than 48 months immediately preceding the upcoming anniversary date;

p. One or more claims submitted under the uninsured motorists coverage of the policy where the uninsured motorist is known or there is physical evidence of contact;

q. A single claim by a single insured submitted under the medical expense coverage due to an accident for which the insured was neither wholly nor partially at fault;

r. One or more claims submitted under the comprehensive or towing coverages. However, nothing in this section shall prohibit an insurer from modifying or refusing to renew the comprehensive or towing coverages at the time of renewal of the policy on the basis of one or more claims submitted by an insured under those coverages, provided that the insurer shall mail or deliver to the insured at the address shown in the policy, or deliver electronically to the address provided by the named insured, written notice of any such change in coverage at least 45 days prior to the renewal;

s. Two or fewer motor vehicle accidents within a three-year period unless the accident was caused either wholly or partially by the named insured, a resident of the same household, or other customary operator;

t. Credit information contained in a "consumer report," as defined in the federal Fair Credit Reporting Act, 15 U.S.C. § 1681 et seq., bearing on a natural person's creditworthiness, credit standing or credit capacity. If credit information is used, in part, as the basis for the nonrenewal, such credit information shall be based on a consumer report procured within 120 days from the effective date of the nonrenewal. The provisions of this subdivision shall apply only to insurance purchased primarily for personal, family, or household purposes;

u. The refusal of a motor vehicle owner as defined in § 46.2-1088.6 to provide access to recorded data from a recording device as defined in § 46.2-1088.6; or

v. The status of the person as a foster care provider or a person in foster care.

2. Nothing in this section shall require any insurer to renew a policy for an insured where the insured's occupation has changed so as to materially increase the risk. Nothing contained in subdivisions 1 p, q, and r shall prohibit an insurer from refusing to renew a policy where a claim is false or fraudulent. Nothing in this section prohibits any insurer from setting rates in accordance with relevant actuarial data.

D. No insurer shall cancel a policy except for one or more of the following reasons:

1. The named insured or any other operator who either resides in the same household or customarily operates a motor vehicle insured under the policy has had his driving privileges suspended or revoked during the policy period or, if the policy is a renewal, during its policy period or the 90 days immediately preceding the last effective date.

2. The named insured fails to pay the premium for the policy or any installment of the premium, whether payable to the insurer or its agent either directly or indirectly under any premium finance plan or extension of credit.

3. The named insured or his duly constituted attorney-in-fact has notified the insurer of a change in the insured's legal residence to a state other than Virginia and the insured vehicle will be principally garaged in the new state of legal residence.

E. No cancellation or refusal to renew by an insurer of a policy of motor vehicle insurance shall be effective unless the insurer delivers or mails to the named insured at the address shown in the policy a written notice of the cancellation or refusal to renew, or the insurer delivers such notice electronically to the address provided by the named insured. The notice shall:

1. Be in a type size authorized under § 38.2-311.

2. State the effective date of the cancellation or refusal to renew. The effective date of cancellation or refusal to renew shall be at least 45 days after mailing or delivering to the insured the notice of cancellation or notice of refusal to renew. However, when the policy is being canceled or not renewed for the reason set forth in subdivision D 2 the effective date may be less than 45 days but at least 15 days from the date of mailing or delivery.

3. State the specific reason of the insurer for cancellation or refusal to renew and provide for the notification required by §§ 38.2-608, 38.2-609, and subsection B of § 38.2-610. However, those notification requirements shall not apply when the policy is being canceled or not renewed for the reason set forth in subdivision D 2.

4. Inform the insured of his right to request in writing within 15 days of the receipt of the notice that the Commissioner review the action of the insurer.

The notice of cancellation or refusal to renew shall contain the following statement to inform the insured of such right:

IMPORTANT NOTICE

Within 15 days of receiving this notice, you or your attorney may request in writing that the Commissioner of Insurance review this action to determine whether the insurer has complied with Virginia laws in canceling or nonrenewing your policy. If this insurer has failed to comply with the cancellation or nonrenewal laws, the Commissioner may require that your policy be reinstated. However, the Commissioner is prohibited from making underwriting judgments. If this insurer has complied with the cancellation or nonrenewal laws, the Commissioner does not have the authority to overturn this action.

5. Inform the insured of the possible availability of other insurance which may be obtained through his agent, through another insurer, or through the Virginia Automobile Insurance Plan.

6. If sent by mail or delivered electronically, comply with the provisions of § 38.2-2208.

Nothing in this subsection prohibits any insurer or agent from including in the notice of cancellation or refusal to renew, any additional disclosure statements required by state or federal laws, or any additional information relating to the availability of other insurance.

F. Nothing in this section shall apply:

1. If the insurer or its agent acting on behalf of the insurer has manifested its willingness to renew by issuing or offering to issue a renewal policy, certificate, or other evidence of renewal, or has manifested its willingness to renew in writing to the insured. The written manifestation shall include the name of a proposed insurer, the expiration date of the policy, the type of insurance coverage, and information regarding the estimated renewal premium. The insurer shall retain a copy of each written manifestation for a period of at least one year from the expiration date of any policy that is not renewed;

2. If the named insured, or his duly constituted attorney-in-fact, has notified the insurer or its agent orally, or in writing, if the insurer requires such notification to be in writing, that he wishes the policy to be canceled or that he does not wish the policy to be renewed, or if prior to the date of expiration he fails to accept the offer of the insurer to renew the policy;

3. To any motor vehicle insurance policy which has been in effect less than 60 days when the termination notice is mailed or delivered to the insured, unless it is a renewal policy; or

4. If an affiliated insurer has manifested its willingness to provide coverage at a lower premium than would have been charged for the same exposures on the expiring policy. The affiliated insurer shall manifest its willingness to provide coverage by issuing a policy with the types and limits of coverage at least equal to those contained in the expiring policy unless the named insured has requested a change in coverage or limits. When such offer is made by an affiliated insurer, an offer of renewal shall not be required of the insurer of the expiring policy, and the policy issued by the affiliated insurer shall be deemed to be a renewal policy.

G. There shall be no liability on the part of and no cause of action of any nature shall arise against the Commissioner or his subordinates; any insurer, its authorized representatives, its agents, or its employees; or any person furnishing to the insurer information as to reasons for cancellation or refusal to

renew, for any statement made by any of them in complying with this section or for providing information pertaining to the cancellation or refusal to renew. For the purposes of this section, no insurer shall be required to furnish a notice of cancellation or refusal to renew to anyone other than the named insured, any person designated by the named insured, or any other person to whom such notice is required to be given by the terms of the policy and the Commissioner.

H. Within 15 days of receipt of the notice of cancellation or refusal to renew, any insured or his attorney shall be entitled to request in writing to the Commissioner that he review the action of the insurer in canceling or refusing to renew the policy of the insured. Upon receipt of the request, the Commissioner shall promptly begin a review to determine whether the insurer's cancellation or refusal to renew complies with the requirements of this section and of § 38.2-2208 if the notice was sent by mail or delivered electronically. The policy shall remain in full force and effect during the pendency of the review by the Commissioner except where the cancellation or refusal to renew is for the reason set forth in subdivision D 2, in which case the policy shall terminate as of the effective date stated in the notice. Where the Commissioner finds from the review that the cancellation or refusal to renew has not complied with the requirements of this section or of § 38.2-2208, he shall immediately notify the insurer, the insured and any other person to whom such notice was required to be given by the terms of the policy that the cancellation or refusal to renew is not effective. Nothing in this section authorizes the Commissioner to substitute his judgment as to underwriting for that of the insurer. Where the Commissioner finds in favor of the insured, the Commission in its discretion may award the insured reasonable attorney fees.

I. Each insurer shall maintain for at least one year, records of cancellation and refusal to renew and copies of every notice or statement referred to in subsection E that it sends to any of its insureds.

J. The provisions of this section shall not apply to any insurer that limits the issuance of policies of motor vehicle liability insurance to one class or group of persons engaged in any one particular profession, trade, occupation, or business. Nothing in this section requires an insurer to renew a policy of motor vehicle insurance if the insured does not conform to the occupational or membership requirements of an insurer who limits its writings to an occupation or membership of an organization. No insurer is required to renew a policy if the insured becomes a nonresident of Virginia.

K. Notwithstanding any other provision of this section, a motor vehicle insurance policy with a policy period or term of five months or less may expire at its expiration date when the insurer has manifested in writing its willingness to renew the policy for at least 30 days and has mailed or delivered the written manifestation to the insured at least 15 days before the expiration date of the policy. The written manifestation shall include the name of the proposed insurer, the expiration date of the policy, the type of insurance coverage, and the estimated renewal premium. The insurer shall retain a copy of the written manifestation for at least one year from the expiration date of any policy that is not renewed.

1970, c. 564, § 38.1-381.5; 1972, c. 273; 1975, cc. 63, 319; 1978, c. 441; 1982, c. 482; 1983, cc. 125, 371; 1984, c. 340; 1986, c. 562; 1988, c. 655; 1990, c. 960; 1991, c. 116; 1995, c. 3; 1996, cc. 206,

239; 1998, cc. 141, 142; 2003, cc. 543, 553; 2006, cc. 851, 889; 2008, cc. 58, 221; 2009, c. 215; 2013, c. 257; 2019, c. 334; 2020, cc. 900, 1137, 1227, 1246.

§ 38.2-2212.1. Powers of Commission; replacement policies.

Upon the verified petition of an insurer, where the petitioning insurer proposes to replace all or substantially all of its policies in another insurer, the Commission may relieve the insurer of the requirements of subsection E of § 38.2-2212 and of the mailing requirements of § 38.2-2208, provided the insurer demonstrates to the satisfaction of the Commission that (i) the replacement policy is underwritten by an affiliate insurer under common control with the petitioning insurer; (ii) the replacement policy is substantially similar to the existing policy with the petitioning insurer; (iii) the premium charged for the replacement policy is no greater than that charged by the petitioning insurer for the existing policy; and (iv) the replacement insurer is duly licensed to transact the business of insurance in the Commonwealth of Virginia. The replacement insurer shall retain a copy of any offer of replacement for a period of one year from the expiration of any existing policy that is not replaced. The Commission may further condition any such relief to protect the best interests of the policyholder.

1991, c. 215.

§ 38.2-2213. Discrimination in issuance of motor vehicle insurance.

No insurer or agent shall refuse to issue a motor vehicle insurance policy as defined in § 38.2-2212 solely because of any one or more of the following factors: the age, sex, residence, race, color, creed, national origin, ancestry, marital status, sexual orientation, gender identity, status of a person as a foster care provider or a person in foster care, or lawful occupation, including the military service, of the person seeking the coverage. Nothing in this section prohibits any insurer from limiting the issuance of motor vehicle insurance policies to those who are residents of this Commonwealth nor does this section prohibit any insurer from limiting the issuance of motor vehicle insurance policies only to persons engaging in or who have engaged in a particular profession or occupation, or who are members of a particular religious sect. Nothing in this section prohibits any insurer from setting rates in accordance with relevant actuarial data.

1976, c. 495, § 38.1-381.6; 1977, c. 181; 1983, c. 61; 1986, c. 562; 2019, c. 334; 2020, c. 1137.

§ 38.2-2213.1. Certain action prohibited when motor vehicle owner fails to allow access to recorded data from recording device.

No insurer or agent shall reduce coverage, increase the insured's premium, apply a surcharge, refuse to apply a discount other than a discount that is based on data recorded by a recording device as defined in § 46.2-1088.6, place in a less favorable tier, refuse to place in the company's best tier, or when there are multiple companies available within a group of insurers, fail to place in the most favorably priced company solely because a motor vehicle owner refuses to allow an insurer access to recorded data as defined in § 46.2-1088.6 from a recording device as defined in § 46.2-1088.6. However, nothing in this section shall prohibit an insurer from charging an actuarially sound rate in accordance with subdivision A 3 of § 38.2-1904.

2006, cc. 851, 889.

§ 38.2-2214. Statement defining rate classifications to be provided by insurer to insured.

Any insurer issuing motor vehicle insurance policies as defined in § 38.2-2212, including those policies assigned to any insurer by the Virginia Automobile Insurance Plan, shall provide the named insured with a statement defining his rate classifications. This statement shall be provided at the time of issuance or at the time of renewal if there has been a change in the named insured's rate classification. The statement shall not be considered a part of the policy and shall not be deemed a warranty or representation by the insurer to the insured.

The Commission shall approve the form of the statement prior to its use.

1977, c. 188, § 38.1-381.7; 1979, c. 4; 1986, c. 562.

§ 38.2-2215. Failure to issue or failure to renew motor vehicle liability insurance on the basis of a motor vehicle's age prohibited.

No insurer or agent shall refuse to issue or fail to renew a policy of motor vehicle liability insurance solely because of the age of the motor vehicle to be insured, provided the motor vehicle is licensed.

1978, c. 56, § 38.1-381.8; 1983, c. 61; 1986, c. 562.

§ 38.2-2216. Medical benefit offset against liability or uninsured motorist coverage prohibited.

No policy or contract of bodily injury liability insurance which contains any representation by an insurer to pay medical expenses incurred for bodily injuries caused by an accident to the insured or any relative or any other person coming under the provisions of the policy, shall be issued or delivered by any insurer licensed in this Commonwealth upon any motor vehicle then principally garaged or principally used in this Commonwealth, if the policy contains any provision reducing the amount of damages covered under the liability or uninsured motorist coverages of the policy by the amount of payments made by the insurer under the medical expense or other medical payments coverage of the policy.

1984, c. 383, § 38.1-381.9; 1986, c. 562.

§ 38.2-2217. Reduction in rates for certain persons who attend mature driver motor vehicle crash prevention courses and driver improvement clinics.

A. Any schedule of rates, rate classifications or rating plans for motor vehicle insurance as defined in § 38.2-2212 filed with the Commission shall provide for an appropriate reduction in premium charges for those insured persons who are fifty-five years of age and older and who qualify as provided in this subsection. Only those insured persons who have voluntarily and successfully completed a mature driver motor vehicle crash prevention course approved by the Department of Motor Vehicles shall qualify for a three-year period after the completion of the course for the reduction in rates. No reduction in premiums shall be allowed for a self-instructed course or for any course that does not provide actual classroom instruction for a minimum number of hours as determined by the Department of Motor Vehicles. Notwithstanding the foregoing provisions of this section, a course sponsor that has been approved by the Department for the classroom delivery of a mature driver motor vehicle crash prevention course may also be approved to deliver that same substantive course through a secure

computer-based medium provided via the Internet or other electronic means that have been approved by the Department, provided that the sponsor has acceptable security features designed to assure that the certificates issued pursuant to subsection E are issued to the same person who took the course and passed the examination related to the course. No person assigned by the court to attend a mature driver motor vehicle crash prevention course shall be eligible for such reduction in premium charges.

B. Any schedule of rates, rate classifications or rating plans for motor vehicle insurance as defined in § 38.2-2212 filed with the Commission may provide for an appropriate reduction in premium charges for a two-year period for those insured persons who are fifty-four years of age or younger and who have satisfactorily completed a driver improvement clinic approved by the Department of Motor Vehicles, as set forth in Article 19 (§ 46.2-489 et seq.) of Chapter 3 of Title 46.2. No person assigned by the courts or notified by the Department of Motor Vehicles to attend a driver improvement clinic shall be eligible for such reduction in premium charges.

C. The Commission and the Department of Motor Vehicles may promulgate rules and regulations which will assist them in carrying out the provisions of this section.

D. All insurers writing motor vehicle insurance in Virginia as defined in § 38.2-2212 shall allow an appropriate reduction in premium charges to all eligible persons upon successfully completing an approved crash prevention course through actual classroom instruction subject to the provisions of subsection A. Such insurers may allow an appropriate reduction in premium charges to all eligible persons upon successfully completing an approved crash prevention course via the Internet or other electronic means subject to the provisions of subsection A.

E. Upon successfully completing the approved course, the course's sponsor shall issue to each participant a certificate approved by the Department of Motor Vehicles which shall be evidence of satisfactory completion of either a mature driver motor vehicle crash prevention course or a driver improvement clinic for the reduction in premium charges. Participants shall be required to provide satisfactory evidence to the insurance provider that the course or clinic was completed in accordance with this section.

F. Each participant in a mature driver motor vehicle crash prevention course shall take an approved course every three years in order to continue to be eligible for the reduction in premium charges. Each voluntary participant in a driver improvement clinic shall take an approved course every two years in order to continue to be eligible for the reduction in premium charges, if any.

G. Nothing in this section prevents an insurer from offering appropriately reduced rates based solely on age.

1984, c. 686, § 38.1-381.10; 1986, c. 562; 1995, c. 226; 2009, cc. 357, 545; 2014, c. 282.

§ 38.2-2217.1. Insurers required to renew motor vehicle liability coverage for vanpools; exceptions.

A. As used in this section, "vanpooling" means the type of joint arrangement described in subdivision 5 of § 46.2-2000.1 and § 46.2-1400 where such motor vehicles are used to transport commuters to

and from their places of employment on a regular basis. "Motor vehicle" as used in this section shall mean any motor vehicle designed to transport not less than ten nor more than fifteen passengers, including the driver, in fixed seats.

B. If an insurer as defined in § 38.2-2212 who issues or renews a policy of motor vehicle liability insurance to an insured who intends to use a vehicle for vanpooling which was not so used at the time the policy was issued or last renewed has received by certified mail thirty days' written notice that the insured intends to use the vehicle for vanpooling, the insurer shall not cancel or refuse to renew a policy of liability insurance coverage for such motor vehicle used in vanpooling as defined in subsection A of this section, except for one or both of the following specified reasons:

1. The named insured fails to discharge when due any payment of the premium for the policy or any installment thereof; or

2. The driving record of the named insured or any regular driver is such that it substantially increases the risk.

C. [Repealed.]

1986, c. 612, § 38.1-381.11; 1995, cc. 744, 803; 2002, c. 337.

§ 38.2-2218. Adoption of standard forms for motor vehicle insurance.

The Commission shall prepare a standard form whenever it believes that any form of policy or any form of rider, endorsement, or other supplemental agreement or provision, for use in connection with any contract of motor vehicle insurance to be issued or delivered upon any motor vehicle principally garaged or principally used in this Commonwealth, is so extensively used that a standard form is desirable. The Commission shall file a copy of the standard form in its office and shall provide by order that, at least 30 days after the order, the form shall become a standard form for use by all insurers unless objection to the proposed form is filed with the Commission within 20 days after the entry of the order. The Commission shall provide notice of its order to all insurers licensed to transact the class of insurance to which the form is applicable, and to all rate service and advisory organizations representing those insurers.

Code 1950, §§ 38-240, 38-551; 1952, c. 317, § 38.1-382; 1986, c. 562; 2022, c. 180.

§ 38.2-2219. Hearing on objections to the form.

If any insurer or rate service organization affected by an order entered pursuant to § 38.2-2218 files objections to a proposed standard form within the time prescribed in the Commission's order, the Commission shall rescind the order and shall provide notice of the rescission to all insurers and rate service organizations affected by the order that on a day specified in the notice, which shall be at least 30 days from the date on which the objections are received, it will hold a public hearing on the adoption of the proposed form, and that at the hearing any person interested may appear and be heard. After the hearing the Commission may by order confirm or amend the proposed form and set a day, at least 30 days after the entry of the order, when the approved form shall become a standard form for use by all insurers. The Commission may by order refuse to adopt the proposed form.

Code 1950, §§ 38-241, 38-552; 1952, c. 317, § 38.1-383; 1986, c. 562; 2022, c. 180.

§ 38.2-2220. Use of form after adoption.

Except as provided in § 38.2-2223, after any standard form is adopted by the Commission, no insurer shall use any form covering substantially the same provisions contained in the standard form unless it is in the precise language of the form filed and adopted by the Commission.

Code 1950, §§ 38-240, 38-551; 1952, c. 317, § 38.1-384; 1981, c. 172; 1986, c. 562.

§ 38.2-2221. Amendment of standard form.

The Commission may amend the provisions of any standard form in the manner provided in this chapter for the adoption of a new standard form.

Code 1950, §§ 38-242, 38-553; 1952, c. 317, § 38.1-385; 1986, c. 562.

§ 38.2-2222. Withdrawal of form.

Whenever the Commission believes there is no further necessity for requiring the use of any standard form adopted under the provisions of this chapter, it may, by order entered of record, withdraw the form, and thereafter its use shall not be required.

Code 1950, §§ 38-243, 38-554; 1952, c. 317, § 38.1-386; 1986, c. 562.

§ 38.2-2223. Variations of, or additions to, form.

For the word "company" appearing in any standard form, there may be substituted a more accurate descriptive term for the type of insurer. Additional provisions, other than those in the standard form, or coverages more favorable than those in the standard form, may be used with a standard form by any insurer with the approval of the Commission. However, the Commission shall first determine that the more favorable coverage or the additional provisions are not in conflict or inconsistent with the standard form, the laws of this Commonwealth or any rules and regulations adopted by the Commission.

Code 1950, §§ 38-244, 38-555; 1952, c. 317, § 38.1-387; 1981, c. 172; 1986, c. 562; 1994, c. 316.

§ 38.2-2224. Commission to establish guidelines for filing readable motor vehicle insurance policy forms.

The Commission may establish guidelines for the filing of simplified and readable motor vehicle insurance policy forms that are acceptable for issuance. Notwithstanding the provisions of §§ 38.2-2218 through 38.2-2223, an insurer may issue a motor vehicle insurance policy that deviates in language, but not in substance or coverage, from the standard policy form provided for in §§ 38.2-2218 through 38.2-2223, if the deviating policy form is (i) in no respect less favorable to the insured than the standard form, and (ii) approved by the Commission prior to issuance.

1977, c. 255, § 38.1-387.1; 1981, c. 172; 1986, c. 562.

§ 38.2-2225. Sending copies of orders to companies affected.

A copy of each order entered by the Commission in accordance with the provisions of this chapter shall be sent to every insurer and rate service organization affected by the order.

Code 1950, §§ 38-245, 38-556; 1952, c. 317, § 38.1-388; 1986, c. 562.

§ 38.2-2226. Insurer to give notice to claimant of intention to rely on certain defenses and of execution of nonwaiver of rights agreement.

Whenever any insurer on a policy of liability insurance discovers a breach of the terms or conditions of the insurance contract by the insured, the insurer shall notify the claimant or the claimant's counsel of the breach. Notification shall be given within forty-five days after discovery by the insurer of the breach or of the claim, whichever is later. Whenever, on account of such breach, a nonwaiver of rights agreement is executed by the insurer and the insured, or a reservation of rights letter is sent by the insurer to the insured, notice of such action shall be given to the claimant or the claimant's counsel within forty-five days after that agreement is executed or the letter is sent, or after notice of the claim is received, whichever is later. Failure to give the notice within forty-five days will result in a waiver of the defense based on such breach to the extent of the claim by operation of law.

Notwithstanding the provisions of this section, in any claim in which a civil action has been filed by the claimant, the insurer shall give notice of reservation of rights in writing to the claimant, or if the claimant is represented by counsel, to claimant's counsel not less than thirty days prior to the date set for trial of the matter. The court, upon motion of the insurer and for good cause shown, may allow such notice to be given fewer than thirty days prior to the trial date. Failure to give the notice within thirty days of the trial date, or such shorter period as the court may have allowed, shall result in a waiver of the defense based on such breach to the extent of the claim by operation of law.

1968, c. 410, § 38.1-389.1; 1986, c. 562; 1997, c. 377; 2001, c. 728.

§ 38.2-2226.1. Insurer to give notice of settlement of claim.

Whenever any insurer on a policy or contract of bodily injury or property damage liability insurance relating to the ownership, maintenance, or use of a motor vehicle compromises, settles and discharges a claim made by a person other than the named insured that arose in connection with a motor vehicle accident involving an automobile covered by such policy or contract, the insurer, upon request by a named insured shall advise every named insured of the compromise, settlement and discharge of the claim.

2002, c. 405.

§ 38.2-2227. Aircraft liability policy not to deny coverage for violation of federal or civil regulations, etc.; permitted exclusions or conditions.

No insurance policy issued or delivered in this Commonwealth covering loss, expense, or liability arising out of the loss, maintenance, or use of an aircraft shall act to exclude or deny coverage because the aircraft is operated in violation of federal or civil regulations or any state or local ordinance. This section does not prohibit the use of specific exclusions or conditions in any policy that relates to any of the following:

1. Certification of an aircraft in a stated category by the Federal Aviation Administration;

2. Certification of a pilot in a stated category by the Federal Aviation Administration;

3. Establishing requirements for pilot experience; or

4. Restricting the use of the aircraft to the purposes stated in the policy.

1970, c. 227, § 38.1-389.2; 1986, c. 562.

§§ 38.2-2228, 38.2-2228.1. Repealed.

Repealed by Acts 1996, c. 31.

§ 38.2-2228.2. Certain medical malpractice claims to be reported to the Commission.

All medical malpractice claims settled or adjudicated to final judgment against a person, corporation, firm, or entity providing health care, and any such claim closed without payment during each calendar year shall be reported annually to the Commission by the insurer of the health care provider. The reports shall not identify the parties. The report shall state the following data, to the extent applicable, in a format prescribed by the Commission:

1. The nature of the claim and damages asserted;

2. The principal medical and legal issues;

3. Attorneys' fees and expenses paid in connection with the claim or defense, to the extent these amounts are known;

4. Attorneys' fees and expenses reserved in connection with the claim or defense;

5. The amount of the settlement or judgment awarded to the claimant to the extent this amount is known;

6. The specialty of each health care provider;

7. The date the claim was reported to the company;

8. The date the loss occurred;

9. The date the claim was closed;

10. The date and amount of the initial reserve;

11. The amount of loss paid by the insurer if different from the amount of settlement or judgment awarded to the claimant; and

12. Any other pertinent information the Commission may require as is consistent with the provisions of this section.

The report shall include a statistical summary of the information collected in addition to an individual report on each claim. The report shall be submitted in an electronic format. Statistical summaries and individual closed claim reports shall be a matter of public record, except that data reported under item 10 shall, at the request of the reporting insurer, not be disclosed in the public record.

The report shall be filed electronically by July 1 of the year following the applicable calendar year; however, a report with data for calendar years 2002, 2003, and 2004 shall be filed by September 1, 2005.

2005, cc. 649, 692.

§ 38.2-2229. Claims-made liability insurance.

Pursuant to the authority granted in § 38.2-223, the Commission may issue regulations regarding claims-made liability insurance policies. These regulations may include, but are not limited to, (i) the pricing of extended reporting period coverage, (ii) provisions for installment payment of premiums for such coverage, and (iii) the providing of such coverage in the event of the death, disability, or retirement of the insured.

1990, c. 241.

§ 38.2-2230. Mandatory offer of rental reimbursement coverage.

Every insurer issuing a new or renewal policy of motor vehicle insurance, as defined in § 38.2-2212, which provides comprehensive or collision coverage, shall offer in writing to the named insured the option of purchasing rental reimbursement coverage.

1994, c. 9.

§ 38.2-2231. Physical damage arbitration between insurers; alternate forums.

A. Except as otherwise provided hereafter, insurers shall arbitrate and settle all disputed claims made for automobile physical damage between them in accordance with the terms of the Nationwide Intercompany Arbitration Agreement, or any successor thereto, as adopted and from time to time amended by its members, and the rules promulgated pursuant to the Agreement, unless the parties mutually agree, on a per case basis, to use another forum, which forum may include a court of competent jurisdiction, in which case the claim shall be arbitrated or tried in that alternate forum. Mandatory arbitration of disputed claims shall be limited solely to the issues of liability and damages.

B. Every automobile liability or physical damage insurer doing business in the Commonwealth shall be a member of the Nationwide Intercompany Arbitration Agreement, or any successor thereto, sponsored by the Committee on Insurance Arbitration. However, if any such insurer is unable to furnish proof of its membership in such agreement, an action may be asserted in a court of competent jurisdiction.

1994, c. 346; 1999, c. 514.

§ 38.2-2232. Liability insurance on private pleasure watercraft; optional coverage.

A. Every insurer issuing a new or renewal policy or contract covering liability arising from the ownership, maintenance or use of a private pleasure watercraft shall offer, in writing, to the named insured the option of purchasing coverage for damages which the insured is legally entitled to recover from the owner or operator of an uninsured private pleasure watercraft arising out of the ownership, maintenance, or use of such uninsured watercraft. Such insurer shall be required to offer limits of liability for uninsured private pleasure watercraft coverage equal to the limits of the liability insurance provided by the policy. However, no insurer shall be required to pay damages for uninsured private pleasure watercraft coverage in excess of the limits of uninsured private pleasure watercraft coverage provided by the policy. Uninsured private pleasure watercraft coverage shall include coverage for bodily injury and property damage liability; provided, however, that such property damage liability coverage shall be

excess over any other valid and collectible insurance of any kind applicable to the property. Insurers issuing or providing liability policies that are of an excess or umbrella type or which provide liability coverage incidental to a policy not related to a specifically insured private pleasure watercraft shall not be required to offer, provide or make available to those policies uninsured private pleasure watercraft coverage.

For purposes of this section, a "new or renewal policy or contract covering liability arising from the ownership, maintenance or use of a private pleasure watercraft" shall mean and include only a policy or contract of marine protection and indemnity insurance, as defined in subsection B of § 38.2-126, written as a separate policy, which is not in combination with any other class of insurance defined in Article 2 (§ 38.2-101 et seq.) of Chapter 1 of this title, to insure a private pleasure watercraft.

For purposes of this section, "uninsured private pleasure watercraft" means a private pleasure watercraft for which there is no valid insurance policy or contract covering liability arising from the ownership, maintenance, or use of such private pleasure watercraft in effect at the time liability is incurred. Such term does not, however, include any watercraft owned by, furnished to, or available for the regular use of any insured, or owned by any governmental unit or agency.

B. If any action is instituted against an owner or operator of an uninsured private pleasure watercraft by any insured intending to rely on the coverage required by this section, then the insured shall serve a copy of the process upon the insurer in the manner prescribed by law, as though the insurer were a party defendant, but the provisions of § 8.01-288 shall not be applicable to service of process under this section. The insurer shall then have the right to file pleadings and take other actions allowable by law in the name of the owner or operator of the uninsured private pleasure watercraft or in its own name.

Any insurer paying a claim under coverage required by this section shall be subrogated to the rights of the insured to the extent of any payment on such claim.

1998, c. 726; 1999, c. 918.

§ 38.2-2233. Installment payments of motor vehicle insurance.

Whenever an insurer who accepts payments of insurance in installments and has a set date for the payment of an installment unilaterally changes the due date for such installment payment, the insurer shall conspicuously disclose the new due date for the installment payment. This section shall apply to all policies of motor vehicle insurance, as defined in § 38.2-2212, issued or renewed on or after October 1, 2002.

2002, c. 629.

§ 38.2-2234. Insurance credit score disclosure; use of credit information.

A. Any insurer issuing or delivering a policy of motor vehicle insurance in this Commonwealth, as defined in § 38.2-2212, that uses credit information contained in a consumer report for underwriting, tier placement or rating an applicant or insured shall meet the following requirements:

1. Disclose, either on the insurance application or at the time the insurance application is taken (i) that it shall obtain credit information in connection with such application, (ii) that the insured may request that his credit information be updated; and (iii) that, if the insured questions the accuracy of the credit information, the insurer will, upon request of the insured, reevaluate the insured based on corrected credit information from a consumer reporting agency. The disclosure may be made by the insurer or its agent. Such disclosure shall be either written or provided to an applicant in the same medium as the application for insurance. The insurer need not provide the disclosure required under this subsection to any insured on a renewal policy, if such insured has previously been provided a disclosure. Use of the following example disclosure constitutes compliance with this subsection: "In connection with this application for insurance, we shall review your credit report or obtain or use an insurance credit score based on the information contained in that credit report. We may use a third party in connection with the development of your insurance credit score. You may request that your credit information be updated and if you question the accuracy of the credit information, we will, upon your request, re-evaluate you based on corrected credit information from a consumer reporting agency."

2. If an insurer takes an adverse action, based in whole or in part, upon credit information, the insurer shall provide notice to the applicant or insured that the adverse action was based, in whole or in part, on credit information. Such notice shall also either include a statement advising the applicant or insured of the primary factors or characteristics that were used as the basis for the adverse action, or notify the applicant or insured that he may request such information. For the purposes of this section, adverse action means a denial, nonrenewal or cancellation of, an increase in any charge for or refusal to apply a discount, or placement in a less favorable tier, or a reduction or other adverse or unfavorable change in the terms of coverage or amount of, any insurance, existing or applied for, in connection with underwriting, tier placement or rating of insurance based on the applicant's or insured's credit information. Adverse action includes circumstances where due to his credit information the applicant or insured (i) receives a higher rate, (ii) is placed in a less favorable tier, and (iii) when there are multiple companies available within a group of insurers, receives coverage in a less favorably priced company of the group. Notice is required when the effect of the credit information would put the applicant or insured in a worse position than if the credit information had not been considered. In the case of renewals, the circumstances listed in clauses (i), (ii), and (iii) shall not be deemed adverse actions if, due to the insured's credit information, the insured is not receiving a less favorable rate or placed in a less favorable tier or company than during the policy period immediately preceding renewal.

B. If an insurer uses credit information from a consumer report for tier placement or rating of its renewal business for a policy of motor vehicle insurance, as defined in § 38.2-2212, issued or delivered in this Commonwealth the insurer shall be required to update the credit information at least once every three years, provided, however, that the insurer shall be required to update an insured's credit information within the three-year period if requested by the insured. If an update request is made by the insured at least 45 days prior to the end of the policy term, any adjustment to the premium required by the update

of the insured's credit information shall take effect at the first renewal following the request for update of the insured's credit information. If an update request is made by the insured within 45 days of the end of the policy term, the insurer shall have the option of applying any adjustment to the premium required by the update of the insured's credit information to the first renewal or the second renewal following the request for update of the insured's credit information. An insurer need not update the credit information more frequently than once every policy term. Notwithstanding the requirements of this subsection, no insurer need obtain updated credit information if the insured has the most favorably priced tier or rate based on his credit information.

C. Notwithstanding the provisions of subdivision A 3 of § 38.2-1904, if an insurer issuing or delivering a policy of motor vehicle insurance, as defined in § 38.2-2212, in this Commonwealth is unable to obtain credit information from a consumer report or when an insured or applicant has insufficient credit to produce an insurance credit score, the insurer shall underwrite, tier, or rate the individual risk in one of the following ways: (i) as if the risk received a neutral or average insurance credit score, as defined by the insurer, (ii) by excluding the use of credit information as a factor and using only other underwriting, tiering, or rating criteria, or (iii) in accordance with established underwriting guidelines or filed tiering or rating rules. Any such established underwriting guidelines or filed tiering or rating rules shall consider other actuarially justified factors associated with the risk in addition to the inability to obtain credit information or the insufficiency of the credit information.

D. The following factors shall not be used as credit criteria or to determine an insurance credit score for underwriting, tier placement, or rating purposes for a policy of motor vehicle insurance, as defined in § 38.2-2212, issued or delivered in this Commonwealth:

1. Information that has been identified by the consumer reporting agency as disputed by the consumer and coded as such, if the use of such disputed information would result in an adverse action;

2. Information that has been identified by the consumer reporting agency as related to insurance inquiries or nonconsumer-initiated inquiries and coded as such;

3. Information that has been identified by the consumer reporting agency as related to collection accounts with a medical industry code;

4. Information that includes multiple lender inquiries, if coded by the consumer reporting agency as being from the home mortgage industry and made within 30 days of one another, unless only one inquiry is considered;

5. Information that includes multiple lender inquiries, if coded by the consumer reporting agency as being from the automobile lending industry and made within 30 days of one another, unless only one inquiry is considered;

6. Income, gender, address, zip code, ethnic group, race, color, religion, marital status, or nationality of the consumer; or

7. The total available line of credit; however, an insurer may consider the total amount of outstanding debt in relation to the total available line of credit.

E. No insurer shall take an adverse action against an applicant for a policy of motor vehicle insurance, as defined in § 38.2-2212, issued or delivered in this Commonwealth, based on credit information, unless an insurer obtains and uses a consumer report procured within 90 days from the date the policy is first written.

F. Notwithstanding anything to the contrary, for a policy of motor vehicle insurance, as defined in § 38.2-2212, issued or delivered in this Commonwealth, an insurer may, upon request, provide reasonable exceptions for an individual whose credit information is directly and adversely impacted by a catastrophic event, as determined by the insurer, including catastrophic illness or injury or the death of a spouse or member of the same household. The insurer may require reasonable documentation of the event prior to granting an exception. No insurer shall be deemed out of compliance with its filed rules and rates as a result of granting an exception pursuant to this subsection.

G. Upon the request of an insured or applicant with respect to a policy of motor vehicle insurance, as defined in § 38.2-2212, issued or delivered in this Commonwealth, for a reevaluation as set forth in this section, the insurer shall reevaluate the individual based on corrected credit information from a consumer reporting agency. If the reevaluation results in a lower premium, the lower premium shall be applied retroactively to the effective date of the current policy term, and the insurer shall either refund or credit the amount to the insured. The insurer may require reasonable documentation of the corrected information from the consumer reporting agency prior to the reevaluation.

H. An insurer shall indemnify, defend, and hold agents harmless from and against all liability, fees, and costs arising out of or relating to the actions, errors, or omissions of an agent who obtains or uses credit information or insurance credit scores for an insurer, provided the agent follows the instructions or procedures established by the insurer and complies with any applicable law. Nothing in this subsection shall be construed to provide an applicant or insured with a cause of action that does not exist in the absence of this subsection.

I. No consumer reporting agency shall provide or sell data or lists that include any information that in whole or in part was submitted in conjunction with an insurance inquiry about an individual's credit information or a request for a consumer report or an insurance credit score. Such information includes the expiration dates of an insurance policy or any other information that may identify time periods during which an individual's insurance may expire and the terms and conditions of the individual's insurance coverage. The restrictions provided in this subsection do not apply to data or lists the consumer reporting agency supplies to the insurance agent from whom information was received or the insurer on whose behalf such agent acted. Nothing in this subsection shall be construed to restrict any insurer from being able to obtain a claims history report or a motor vehicle report.

J. For the purposes of this section, "insurance credit score" means a number or rating that is derived from an algorithm, computer application, model, or other process that is based in whole or in part on

credit information for the purposes of predicting the future insurance loss exposure of an individual applicant or insured for or under a policy of motor vehicle insurance, as defined in § 38.2-2212, issued or delivered in this Commonwealth.

K. The provisions of this section shall apply only to insurance purchased primarily for personal, family, or household purposes.

2003, cc. 543, 553; 2019, c. 704.

Chapter 23 - LEGAL SERVICES INSURANCE

§ 38.2-2300. Conditions; permitted contracts; approval.

A. Legal services insurance may be offered in this Commonwealth subject to the following conditions:

1. Premium rates shall be made in accordance with Chapter 19 (§ 38.2-1900 et seq.) of this title.

2. No policy of legal services insurance may be delivered or issued for delivery in this Commonwealth unless it contains a provision that the insurer shall issue to the person in whose name the policy is issued, for delivery to each insured, a certificate summarizing the essential features of the insurance coverage and to whom benefits under the policy are payable. If dependents are included in the coverage, only one certificate need be issued for each family unit.

B. An insurer authorized to transact legal services insurance in this Commonwealth may, in connection with the implementation and operation of any legal services insurance program, contract with any person that offers and manages a group legal services insurance plan, including a state, city, county, or circuit bar association; or any person permitted to practice law in this Commonwealth.

C. The Commission shall not approve any legal services insurance contract if, after providing notice and opportunity to be heard, the Commission finds that the contract violates any law of this Commonwealth.

1976, c. 636, § 38.1-389.4; 1986, c. 562.

Chapter 24 - FIDELITY AND SURETY INSURANCE

Article 1 - General Provisions

§ 38.2-2400. Class of insurance to which chapter applies.

This chapter applies to fidelity and surety insurance as defined in §§ 38.2-120 and 38.2-121.

1952, c. 317, § 38.1-639; 1986, c. 562.

§ 38.2-2401. Fidelity and surety insurer defined.

The term "fidelity and surety insurer" means any company licensed to transact fidelity or surety insurance in this Commonwealth, and includes any company elsewhere designated or referred to in this Code as a guaranty, indemnity, fidelity, surety or security company.

1952, c. 317, § 38.1-640; 1986, c. 562.

§ 38.2-2402. Fidelity and surety insurer not to transact insurance without appropriate license.

No fidelity and surety insurer shall transact the business of fidelity insurance or surety insurance without first obtaining a license from the Commission to transact that class of insurance.

1986, c. 562.

§ 38.2-2403. Limitation of liability on risks.

In applying the limitation specified in § 38.2-208 to fidelity and surety risks, the net amount of exposure on any single risk shall be considered to be within the prescribed limit if the fidelity and surety insurer is protected against losses in excess of the limit by:

1. Reinsurance with a fidelity and surety insurer that enables the obligee or beneficiary to maintain an action on the contract against the insurer jointly with the reinsurer;

2. The cosuretyship of any other fidelity and surety insurer;

3. A deposit of property with it in pledge, or conveyance of property to it in trust for its protection;

4. A conveyance or mortgage of property for its protection;

5. A deposit or other disposition of a portion of any property held in trust so that no future sale, mortgage, pledge or other disposition can be made of that portion of the property except with the consent of the fidelity and surety insurer or by decree or order of a competent court whenever the obligation is entered into on behalf or on account of a person holding property in a fiduciary capacity; or

6. A guarantee by the Small Business Administrator that the surety shall not suffer loss as set forth in the Small Business Investment Act of 1958.

Code 1950, §§ 38-343, 38-344; 1952, c. 317, § 38.1-641; 1986, c. 562; 1988, cc. 529, 548.

§ 38.2-2404. Limit when penalty of bond exceeds actual exposure to risk.

When the penalty of a suretyship obligation exceeds (i) the amount of a judgment described on the obligation as appealed from and secured by the obligation, (ii) the amount of the subject matter in controversy, or (iii) the amount of the estate held in trust by the person acting in a fiduciary capacity, the bond may be executed by any fidelity and surety insurer if the actual amount of the judgment or the subject matter in controversy or estate not subject to supervision or control of the surety is not in excess of the limitation specified in § 38.2-208. When the penalty of a suretyship obligation executed for the performance of a contract exceeds the contract price, the contract price shall be taken as the basis for estimating the limit of risk specified in § 38.2-208.

1952, c. 317, § 38.1-642; 1986, c. 562.

§ 38.2-2405. When insurer accepted as surety.

Any fidelity and surety insurer shall be accepted as surety upon any bond required by the laws of this Commonwealth or by any court, judge, public officer, board, or organization upon presentation of evidence satisfactory to the court, judge, or other officer authorized to approve the bond that the insurer is licensed to transact surety insurance.

Code 1950, § 38-332; 1952, c. 317, § 38.1-643; 1986, c. 562.

§ 38.2-2406. Requirements deemed met by insurer.

Whenever a bond, undertaking, recognizance, guaranty, or similar obligation is required, permitted, authorized or allowed by any law of this Commonwealth, or whenever the performance of any act, duty or obligation, or the refraining from any act, is required, permitted, authorized or allowed to be secured or guaranteed by any law of this Commonwealth, the bond or similar obligation, or the security or guaranty, may be executed by any fidelity and surety insurer licensed to execute such instruments. The execution by any fidelity and surety insurer of a bond, undertaking, recognizance, guaranty or similar obligation by its officer, attorney-in-fact, or other authorized representative shall be accepted as fully complying with every law or other requirement, now or hereafter in force, requiring that the bond, undertaking, recognizance, guaranty or similar obligation be given or accepted or that it be executed by one or more sureties, or that the surety or sureties be residents, householders or freeholders, or possess any other qualifications.

1952, c. 317, § 38.1-644; 1986, c. 562.

§§ 38.2-2407, 38.2-2408. Repealed.

Repealed by Acts 2016, c. 250, cl. 2.

§ 38.2-2409. Agreement for joint control of money and assets.

Any person required to execute a bond, undertaking or other obligation may agree with his surety to deposit any or all assets for which he and his surety may be held responsible. The deposit shall be with a bank, savings bank, safe deposit company, or trust company authorized by law to do business as such, or with any other depository approved by the court or a judge of the court, if the deposit is otherwise proper. Assets shall be deposited for safekeeping and held in a manner that prevents the withdrawal of the whole or any part of the deposit without the written consent of the surety, or without an order of a court or a judge, made on any notice to the surety which the court or judge directs. The agreement shall not in any manner release or change the liability of the principal or sureties as established by the terms of the bond.

Code 1950, § 38-345; 1952, c. 317, § 38.1-645; 1986, c. 562.

§ 38.2-2410. Expense of securing bond to be allowed in settlements; exceptions.

Any court, judge or other officer whose duty it is to approve the account of any person required to execute a bond with surety shall, whenever a fidelity and surety insurer has become surety on the bond, allow a sum for the expense of obtaining the surety in the settlement of the account. The sum allowed shall accord with the applicable rate filing in effect for the insurer under the provisions of this title. The allowance shall not be made to any state, county or municipal officer.

Code 1950, § 38-347; 1952, c. 317, § 38.1-646; 1986, c. 562.

§ 38.2-2411. Repealed.

Repealed by Acts 2012, c. 802, cl. 2.

§ 38.2-2412. Notice to clerks of revocation of licenses.

Whenever the Commission revokes, suspends or otherwise terminates the license of any fidelity and surety insurer it shall immediately give notice of the revocation, suspension or termination to the Clerk of the Supreme Court of Virginia and each circuit court in the Commonwealth.

Code 1950, § 38-335; 1952, c. 317, § 38.1-648; 1986, c. 562; 2003, c. 979; 2004, c. 460.

§ 38.2-2412.1. Notice to Department of Criminal Justice Services of revocation of property and casualty insurance license.

Whenever the Commission revokes, suspends or otherwise terminates the license of any property and casualty agent who is also a licensed surety bail bondsman, it shall immediately give notice of the revocation, suspension or termination to the Department of Criminal Justice Services.

2004, c. 460.

§ 38.2-2412.2. Surety bail bondsman; notice to Department of Criminal Justice Services of violations.

A. The Commission shall notify the Department of Criminal Justice Services of any action taken or investigation concerning any violation by a property and casualty agent who is also licensed as a surety bail bondsman of the prohibitions listed in this section within 30 days from the receipt of the initial report of a violation. The Commission and the Department of Criminal Justice Services may conduct a joint investigation of any alleged violation.

1. Providing materially incorrect, misleading, incomplete or untrue information in the license application or any other document filed with the Commission;

2. Violating any subpoena of the Commission;

3. Obtaining or attempting to obtain a license through misrepresentation or fraud;

4. Engaging in the practice of rebating;

5. Engaging in twisting or any form thereof, where "twisting" means inducing an insured to terminate an existing policy and purchase a new policy through misrepresentation;

6. Improperly withholding, misappropriating or converting any moneys or properties received in the course of doing business;

7. Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance;

8. Having admitted or been found to have committed any insurance unfair trade practice or fraud;

9. Having been convicted of a felony;

10. Using fraudulent, coercive, or dishonest practices, or demonstrating incompetence or untrustworthiness in the conduct of business in the Commonwealth or elsewhere, or demonstrating financial irresponsibility in the handling of applicant, policyholder, agency, or insurance company funds;

11. Forging another's name to an application for insurance or to any document related to an insurance transaction;

12. Improperly using notes or any other reference material to complete an examination for an insurance license;

13. Knowingly accepting insurance business from an individual who is not licensed;

14. Having an insurance producer, surplus lines broker, or consultant license, or its equivalent, denied, suspended or revoked in any other state, province, district or territory;

15. Failing to comply with an administrative or court order imposing a child support obligation;

16. Failing to pay state income tax or comply with any administrative or court order directing payment of state income tax; or

17. Violating any insurance laws, or violating any regulation or order of the Commission or of another state's insurance regulatory authority.

2004, c. 460.

§ 38.2-2413. Release of insurers from liability; rights and remedies.

Any fidelity and surety insurer shall be released from its liability on the same terms and conditions as are prescribed by law for the release of individuals. Any fidelity and surety insurer shall have all the rights, remedies and relief to which an individual guarantor, indemnitor, or surety is entitled.

Code 1950, § 38-333; 1952, c. 317, § 38.1-649; 1986, c. 562.

§ 38.2-2414. Insurer estopped to deny power to assume liability.

Any fidelity and surety insurer that executes any bond as surety under the provisions of this chapter shall be estopped, in any proceedings to enforce the liability it has assumed, to deny its power to execute the bond or assume the liability.

Code 1950, § 38-348; 1952, c. 317, § 38.1-650; 1986, c. 562.

§ 38.2-2415. Where civil proceedings may be instituted.

Any suit or other civil proceeding may be instituted against any fidelity and surety insurer (i) at the place where it became surety or assumed any duty or obligation that may be the subject of suit or other civil proceeding; or (ii) at the place where the principal obligor for whom it has become surety may be sued. When the Commonwealth is a party, plaintiff or defendant, the suit or proceeding shall be in the Circuit Court of the City of Richmond.

Code 1950, § 38-346; 1952, c. 317, § 38.1-651; 1986, c. 562.

Article 2 - POWER OF ATTORNEY TO EXECUTE BONDS

§ 38.2-2416. Power of attorney to be recorded or attached; filing with the Department of Criminal Justice Services.

A. Each power of attorney from a fidelity and surety insurer to an agent making the agent an attorney-in-fact to execute any bail bond as defined in § 19.2-119 in the name and on behalf of the insurer as surety, shall, unless the power of attorney is special and limited to one transaction or to definitely stated transactions, be filed with the Department of Criminal Justice Services allowing the powers delegated by it to be exercised in any city or county in the Commonwealth.

B. Each power of attorney, or a copy or facsimile thereof, which may include a printed or facsimile signature or corporate seal, from a fidelity and surety insurer to an agent making the agent an attorney-in-fact to execute any bond or other obligation, other than a bail bond as defined in § 19.2-119, in the name and on behalf of the insurer as surety, shall be duly attached to the bond or other obligation.

Code 1950, § 38-339; 1952, c. 317, § 38.1-653; 1986, c. 562; 2004, c. 357; 2006, c. 296.

§ 38.2-2417. Continuance of power; revocation.

The power of an attorney-in-fact to bind the fidelity and surety insurer as surety within the authority conferred by a power of attorney recorded pursuant to subsection A of § 38.2-2416, shall, unless the power of attorney is otherwise limited, continue for the agency until the expiration of the power of attorney or until the power is revoked by the insurer's sealed written instrument duly acknowledged for recordation and admitted to record in the county or corporation in which the power of attorney is recorded.

Code 1950, § 38-340; 1952, c. 317, § 38.1-654; 1986, c. 562; 2004, c. 357.

§ 38.2-2418. Recordation of instrument of revocation.

Any instrument of revocation issued pursuant to § 38.2-2417 shall be recorded in the deed book in the office of the clerk in which the power of attorney was recorded, upon the acknowledgment prescribed by law for the acknowledgment of deeds for recordation. The admission to record the instrument of revocation shall constitute notice to all concerned of the revocation of the power previously conferred.

Code 1950, § 38-341; 1952, c. 317, § 38.1-655; 1986, c. 562; 2004, c. 357.

§ 38.2-2419. Notation of revocation; indexing.

When the power of attorney has been revoked in accordance with § 38.2-2417, the clerk in whose office the power of attorney is recorded shall record its revocation in the deed book where the power of attorney is recorded. The revocation shall reference the book and page where the original power of attorney is recorded. The clerk shall index the instrument of revocation both in the name of the fidelity and surety insurer and of its attorney-in-fact.

Code 1950, § 38-342; 1952, c. 317, § 38.1-656; 1986, c. 562; 2004, c. 357; 2011, c. 470; 2014, c. 330.

§ 38.2-2420. Bonds executed under power of attorney binding on insurer.

Any bond or obligation executed in the name and on behalf of the insurer as surety under the authority of the power of attorney shall have the same force, effect and validity, and shall be as binding upon the insurer in the name and on behalf of which it is executed as if it were properly executed by the

insurer itself through its officers under its common seal. For the purpose of this section, the seal of the insurer or the seal of the attorney-in-fact shall not be required to be affixed to the bond or obligation.

Code 1950, § 38-338; 1952, c. 317, § 38.1-657; 1986, c. 562.

Chapter 25 - MUTUAL ASSESSMENT PROPERTY AND CASUALTY INSURERS

Article 1 - General Provisions

§ 38.2-2500. Scope of chapter.

This chapter applies to mutual assessment property and casualty insurers as defined in this chapter, and to insurance written by those insurers.

1952, c. 317, § 38.1-658; 1986, c. 562.

§ 38.2-2501. Definitions.

As used in this chapter:

"Mutual assessment insurance" means property and casualty insurance written by an insurer which has a right to assess its members for contributions and which is licensed pursuant to this chapter.

"Mutual assessment property and casualty insurer" means a company without capital stock that writes only mutual assessment insurance insuring property located in or protecting against losses of members who are residents of this Commonwealth.

Code 1950, §§ 38-523, 38-526, 38-529; 1952, c. 317, § 38.1-659; 1954, c. 161; 1960, c. 292; 1962, c. 172; 1974, c. 244; 1986, c. 562.

§ 38.2-2502. Mutual assessment insurance authorized.

Mutual assessment property and casualty insurers licensed pursuant to this chapter may write mutual assessment insurance.

1952, c. 317, § 38.1-660; 1986, c. 562.

§ 38.2-2503. Classes of insurance that may be written by mutual assessment property and casualty insurers; minimum surplus to policyholders required.

A. Any mutual assessment property and casualty insurer with surplus to policyholders of at least $25,000 may write the following classes:

1. Fire insurance as defined in § 38.2-110;

2. Miscellaneous property damage insurance as defined in § 38.2-111; and

3. Animal insurance as defined in § 38.2-116.

B. Any mutual assessment property and casualty insurer with surplus to policyholders of at least $100,000 may write the following classes of insurance, in addition to those classes enumerated in subsection A of this section:

1. Water damage insurance as defined in § 38.2-112;

2. Burglary and theft insurance as defined in § 38.2-113;

3. Glass insurance as defined in § 38.2-114;

4. Boiler and machinery insurance as defined in § 38.2-115;

5. Personal injury liability insurance as defined in § 38.2-117;

6. Property damage liability insurance as defined in § 38.2-118;

7. Marine insurance as defined in § 38.2-126;

8. Home protection insurance as defined in § 38.2-129;

9. Homeowners insurance as defined in § 38.2-130;

10. Farmowners insurance as defined in § 38.2-131;

11. Commercial multi-peril insurance as defined in § 38.2-132; and

12. Contingent and consequential losses insurance as defined in § 38.2-133.

The liability coverages specified in this subsection may be written only by insurers having a surplus to policyholders of at least $300,000 unless the coverages are fully reinsured.

C. Any mutual assessment property and casualty insurer with surplus to policyholders of at least $800,000 may write the following classes of insurance, in addition to those classes enumerated in sub-sections A and B of this section:

1. Workers' compensation and employers' liability insurance as defined in § 38.2-119;

2. Fidelity insurance as defined in § 38.2-120;

3. Surety insurance as defined in § 38.2-121;

4. Credit insurance as defined in § 38.2-122;

5. Motor vehicle insurance as defined in § 38.2-124;

6. Aircraft insurance as defined in § 38.2-125;

7. Legal services insurance as defined in § 38.2-127; and

8. Mortgage guaranty insurance as defined in § 38.2-128.

Code 1950, §§ 38-523, 38-526, 38-529; 1952, c. 317, § 38.1-659; 1954, c. 161; 1960, c. 292; 1962, c. 172; 1974, c. 244; 1986, c. 562.

§ 38.2-2504. Property beyond authorized territory.

A mutual assessment property and casualty insurer shall not insure real property outside the limits of the territory for which it is authorized to write insurance as specified in its charter or bylaws. However, members may be provided liability or other insurance on risks other than real property insurable under this chapter, wherever located. When members own real property near the border of the territory which

extends in a contiguous manner beyond the territory, all of the property may be insured if otherwise insurable under this chapter, whether the property is within or without the territory.

Code 1950, §§ 38-526, 38-529; 1952, c. 317, § 38.1-661; 1986, c. 562.

§ 38.2-2505. Risks limited to those specified in this chapter; personal liability for loss.

No mutual assessment property and casualty insurer shall insure against any losses except as specified in this chapter. Any officer or agent who knowingly or willfully violates or who causes the insurer to violate this provision shall be fined in accordance with § 38.2-218.

Code 1950, § 38-541; 1952, c. 317, § 38.1-687; 1986, c. 562.

§ 38.2-2506. What laws applicable.

Except as otherwise provided in this chapter, and except when the context otherwise requires, all the provisions of this title relating to insurers generally, and those relating to insurers writing the same class of insurance that mutual assessment property and casualty insurers are authorized to write under this chapter, are applicable to these insurers.

The provisions of §§ 38.2-1032 and 38.2-1035 shall not apply to mutual assessment property and casualty insurers.

Code 1950, §§ 38-505, 38-525; 1952, c. 317, §§ 38.1-91, 38.1-662; 1960, c. 289; 1966, c. 580; 1986, c. 562.

§ 38.2-2507. Conversion of mutual assessment property and casualty insurers.

A. Any mutual assessment property and casualty insurer desiring to remove itself from the provisions of this chapter and desiring to become an insurer under the provisions of Chapter 10 (§ 38.2-1000 et seq.) of this title may do so by meeting the requirements of Chapter 10. The mutual assessment property and casualty insurer shall submit an application to the Commission showing that each requirement of Chapter 10 has been met. If the applicant does not meet the requirements of Chapter 10, the applicant may submit a plan that includes a schedule for meeting the requirements of Chapter 10. The schedule shall provide for compliance with those requirements within ten years of the approval of the application. For good cause shown, the Commission may grant, after informal hearing, an additional period in order to achieve compliance with the requirements of Chapter 10.

B. If the Commission approves the application, the insurer shall have all the rights, privileges and responsibilities of an insurer licensed under the provisions of Chapter 10 of this title.

C. Upon failure of the applicant to comply with the terms of the approved schedule, the Commission may require the applicant to adhere to the provisions of this chapter.

1986, c. 562.

Article 2 - ORGANIZATION AND LICENSING OF INSURERS

§ 38.2-2508. Incorporation of insurers.

Mutual assessment property and casualty insurers formed after July 1, 1986, shall be incorporated under the provisions of Article 3 (§ 13.1-818 et seq.) of Chapter 10 of Title 13.1, as modified by the provisions of this title. Except as otherwise provided in this title, mutual assessment property and casualty insurers shall be subject to all the general restrictions and have all the general powers imposed and conferred upon those corporations by law. Mutual assessment property and casualty insurers formed prior to July 1, 1986, may continue to operate as organized.

Code 1950, § 38-523; 1952, c. 317, § 38.1-666; 1956, c. 431; 1986, c. 562.

§ 38.2-2509. Directors; terms; annual meetings; voting; executive committee.

As provided in the certificate or articles of incorporation and the bylaws, the management of any mutual assessment property and casualty insurer shall be vested in a board of at least five directors, each of whom shall be a member of the insurer. Each director shall hold office for one year or for a longer term if specified in the bylaws, and thereafter until his successor is elected and has qualified. Vacancies in the board may be filled for the unexpired term by the remaining directors. The annual meeting of the members of the insurer shall be held as provided by the certificate or articles of incorporation or the bylaws. A quorum shall consist of (i) ten members or (ii) the number of members specified by either the certificate or articles of incorporation or the bylaws, whichever number is larger. In all meetings of members, each member of the insurer shall be entitled to one vote, or a number of votes based upon insurance in force, the number of policies held or the amount of premiums paid as provided by the bylaws of the insurer. Votes by proxy may be received in accordance with the certificate or articles of incorporation or the bylaws. The date of the annual meeting shall be stated in the policy, or notice of the date and location of the annual meeting shall be provided annually. Notwithstanding the provisions of the charter of any insurer, upon a resolution adopted by the board of directors and approved by a majority of its members present in person or by proxy, the directors may be divided into classes and a portion only elected each year. Pursuant to the provisions of § 13.1-869, the directors may appoint an executive committee to exercise the powers and perform the duties set out in that section.

1952, c. 317, § 38.1-667; 1956, c. 431; 1986, c. 562.

§ 38.2-2510. Officers.

Unless the certificate or articles of incorporation provides otherwise, the directors shall elect from their number a president. The directors shall also elect a secretary, treasurer, and any additional officers they consider necessary, who may or may not be members. The offices of secretary and treasurer may be held by one person. Unless otherwise provided in the certificate or articles of incorporation, the term of those officers shall be not less than one year nor more than three years or until their successors are elected or selected and qualified.

1952, c. 317, § 38.1-667.1; 1986, c. 562.

§ 38.2-2511. How license obtained.

The applicant insurer shall file with and have approved by the Commission its application for the license required by § 38.2-1024 prior to transacting the business of insurance in this Commonwealth. The Commission shall not grant a license to any insurer until it is satisfied that the insurer has complied with the requirements of § 38.2-1024 and has filed with the Commission a statement signed by its president and secretary or two of its directors subject to § 38.2-1304, setting forth:

1. That the corporation holds bona fide applications for insurance of the classes proposed to be issued from 100 or more persons who own property insurable by the insurer under the provisions of this chapter and who desire to become members of the insurer;

2. The names of the proposed members and the amount of insurance subscribed for by each;

3. A statement that the insurer has received from each proposed member the initial fees and assessments required for the insurance requested;

4. The names and addresses of the officers and directors of the insurer;

5. The location of the insurer's principal office in this Commonwealth;

6. The classes of insurance proposed to be written; and

7. The territory within which the insurer proposes to transact insurance.

Code 1950, § 38-524; 1952, c. 317, § 38.1-668; 1986, c. 562.

Article 3 - MEMBERS

§ 38.2-2512. Who may become members.

Any person having a risk insurable under this chapter who resides in the territory in which the insurer operates or who owns property located in the territory may become a member of a mutual assessment property and casualty insurer and shall be entitled to all the rights and privileges pertaining to membership. Any officer, trustee, board member or legal representative of a corporation, board, estate or association may be recognized as acting for or on its behalf for the purpose of the membership, but shall not be personally liable under the contract of insurance by reason of acting in such representative capacity.

1952, c. 317, § 38.1-669; 1986, c. 562.

§ 38.2-2513. Withdrawal and exclusion of members.

A. Any member of a mutual assessment property and casualty insurer may withdraw as a member at any time by giving at least thirty days' written notice to the insurer and paying his share of all losses against the insurer that have occurred prior to the member's withdrawal and which have not been fully reserved or for which surplus is inadequate. Upon this withdrawal the member shall be paid by the insurer any unearned premium, unearned fee or unearned assessment paid in advance.

B. Any member who neglects or refuses to pay an assessment or premium when due may be excluded from membership for that or any other reason satisfactory to a majority of the directors or the executive committee, or as the bylaws prescribe. The member shall remain liable for the payment of

any assessments made for losses that have occurred prior to his exclusion, and also for the amounts provided for in § 38.2-2522, if action is instituted within twelve months after the time the assessments become due.

Code 1950, §§ 38-527, 38-537; 1952, c. 317, §§ 38.1-669.1, 38.1-670; 1986, c. 562.

§ 38.2-2514. Procedure upon exclusion of member.

If any member is excluded from the insurer as provided in this article, the insurer shall note upon its records the exclusion of the member, the cancellation of his insurance policies, and the date of the exclusion. The insurer shall notify the member by mail of the exclusion and cancellation, and after at least five days have elapsed from the mailing of the notice, the policy shall no longer be effective and all further liability of the insurer under the policy shall cease. Proper notification shall be deemed to have been effected if the notice is deposited with the United States Postal Service and mailed to the member at his address as shown on the records of the insurer. If the bylaws or the policy provide that a member's policy shall be void without any notice if the member neglects or refuses to pay any assessment, that provision shall be valid and the notice required in this section need not be given. Upon the cancellation of the insurance or upon the policy becoming void, the member shall be entitled to receive from the insurer a repayment of an equitable portion of any premium, fee or assessment which was paid in advance.

Code 1950, §§ 38-537, 38-538; 1952, c. 317, § 38.1-671; 1986, c. 562.

§ 38.2-2515. Insurers to maintain membership of 100 or more; license suspended or revoked if membership not maintained; rehabilitation or liquidation.

Every mutual assessment property and casualty insurer shall maintain a membership of at least 100 persons at all times. Whenever the number of members falls below 100, the insurer shall notify the Commission immediately of that fact. Upon receipt of that notice, or upon information from any source that the membership of the insurer is less than 100, the Commission may revoke the insurer's license, or may issue an order requiring the insurer to increase its membership to at least 100 within a designated period not exceeding 90 days.

If at the expiration of the designated period the membership has not been increased to at least 100, the Commission shall revoke the insurer's license. Upon the revocation of its license as authorized in this section, delinquency proceedings against the insurer may be instituted and conducted as provided in Chapter 15 of this title.

1952, c. 317, § 38.1-672; 1986, c. 562.

Article 4 - INSURANCE TRANSACTIONS

§ 38.2-2516. Issuance of policies; bylaws as part of contract.

The directors of every mutual assessment property and casualty insurer shall issue insurance policies requiring the insurer to pay all losses or damages caused by the risk insured against during the time the policy is in force. Payment shall not exceed the amount insured. There shall be attached to or

included in each of those policies the portion of the bylaws that constitute a part of the policy contract. Bylaws or their amendments that are not a part of the policy contract shall not affect the policy contract unless they are included as a suitable endorsement mailed or delivered to the policyholder.

Code 1950, § 38-529; 1952, c. 317, § 38.1-673; 1954, c. 161; 1986, c. 562.

§ 38.2-2517. Policy forms to be filed.

Every mutual assessment property and casualty insurer shall file with the Commission a copy of all policy forms and standard endorsements which the insurer intends to use in the transaction of its business. Mutual assessment property and casualty insurers shall be exempt from the filing requirements of Chapter 3 (§ 38.2-300 et seq.) of this title except for those classes of insurance enumerated in subsection C of § 38.2-2503, where full compliance with Chapter 3 shall be required.

1986, c. 562.

§ 38.2-2518. Assessment contract.

Each person insured by a mutual assessment property and casualty insurer shall be issued a contract prescribed by the insurer, that shall be uniform among members of the respective classes of insurance written by the insurer. Each member shall agree to pay his pro rata share of all losses or damages sustained, expenses of operation of the insurer, and the maintenance of an adequate surplus to policyholders as determined by the board of directors. Periodic assessments may be collected as advance premiums or post assessments or by both methods. The amount of assessments shall be established by the directors of the insurer.

Code 1950, § 38-530; 1952, c. 317, § 38.1-677; 1954, c. 161; 1986, c. 562.

§ 38.2-2519. Classification of risks; rates.

Any insurer writing mutual assessment property and casualty insurance may classify the property or risk insured in accordance with the risk or hazard to which the property is subject, and fix the rate of assessment or premium for that insurance in accordance with the classification.

Code 1950, § 38-531; 1952, c. 317, § 38.1-676; 1974, c. 244; 1986, c. 562.

§ 38.2-2520. Right to limit assessment liability.

Any mutual assessment property and casualty insurer having a surplus to policyholders equal to at least 3 times the average annual losses and expenses of the insurer during the last 5-year period or a surplus to policyholders of at least $800,000 may limit the assessment liability of members. The liability of members for assessment may be limited during any one year to an amount not less than one additional current annual assessment.

1952, c. 317, § 38.1-683.1; 1986, c. 562.

§ 38.2-2521. Notice of assessment; how given.

After an assessment is made, the insurer shall give every member subject to the assessment written notice stating the amount of the member's assessment and the date when payment is due. Except where the provisions of the bylaws or the policy provide otherwise, the time of payment shall be at

least thirty days and no more than sixty days from the service of the notice. That notice may be served personally, by mail, or by electronic delivery pursuant to § 38.2-325. If mailed, the notice shall be deposited with the United States Postal Service and addressed to the member at his residence or place of business as shown on the company records.

Code 1950, § 38-535; 1952, c. 317, § 38.1-684; 1986, c. 562; 2020, c. 216.

§ 38.2-2522. Action to recover assessments; penalty.

Within twelve months after an assessment becomes due, a mutual assessment property and casualty insurer may institute suit against any member to recover any assessment that the member fails to pay. The insurer shall be entitled to recover (i) the amount shown to be due, (ii) lawful interest, and (iii) fifty percent of the principal amount as liquidated damages for neglect or refusal to pay within the time required.

Code 1950, § 38-536; 1952, c. 317, § 38.1-685; 1986, c. 562.

§ 38.2-2523. Notice of loss and adjustment.

Each policyholder after sustaining loss or damage from any cause specified in the policy shall notify the mutual assessment property and casualty insurer within the time prescribed in the policy. The insurer shall promptly proceed to ascertain and adjust the loss or damage in the manner provided by the policy, law and bylaws of the company.

Code 1950, § 38-530; 1952, c. 317, § 38.1-678; 1986, c. 562.

§ 38.2-2524. Proceeding when loss or damage exceeds cash on hand.

If at any time any loss or damage to property insured by a mutual assessment property and casualty insurer exceeds the insurer's cash available to pay the loss or damage, the insurer may borrow money in an amount sufficient to pay the loss or damage. This shall be approved by the board of directors or the executive committee. The board of directors or the executive committee may levy an assessment sufficient to repay the loan or to pay the loss or damage, or any portion that is in excess of the cash on hand.

Code 1950, § 38-532; 1952, c. 317, § 38.1-681; 1986, c. 562.

§ 38.2-2525. Agents licenses required.

Agents representing a mutual assessment property and casualty insurer shall be licensed by the Commission and appointed by the insurer in accordance with Chapter 18 of this title. However, agents whose licenses are limited to those classes of insurance referred to in subsections A and B of § 38.2-2503 shall not be required to take a written examination from the Commission in accordance with § 38.2-1814.

1986, c. 562.

Article 5 - FINANCIAL PROVISIONS

§ 38.2-2526. Surplus to policyholders.

A. Surplus to policyholders in addition to the required surplus specified in subsections A and B of § 38.2-2503 may be accumulated in amounts as determined by the board of directors. The surplus may be used for the payment of losses and operating expenses of the insurer.

B. Income earned on any surplus to policyholders may be used to pay losses, operating expenses, or added to surplus.

C. The provisions of this section shall become effective July 1, 1986.

D. Any mutual assessment property and casualty insurer already licensed on July 1, 1986, shall comply with the minimum surplus requirements of § 38.2-2503 by July 1, 1991. Any mutual assessment property and casualty insurer that does not meet the surplus requirements of this section as of July 1, 1986, and is not writing any of the classes authorized in subsections B and C of § 38.2-2503 on July 1, 1986, shall not write any of those classes until the specified surplus requirement is met.

1986, c. 562.

§ 38.2-2527. Limitation on single risk to be assumed.

A. No single risk shall be assumed by a mutual assessment property and casualty insurer in an amount exceeding ten percent of its surplus to policyholders. Any risk or portion of any risk which has been reinsured in accordance with § 38.2-2528 shall be deducted in determining the limitation of risk prescribed by this section. For the purposes of this section the amount of surplus to policyholders shall be determined on the basis of the last financial statement of the insurer, or the last report of examination filed with the Commission, whichever is more recent, at the time the risk is assumed. Mutual assessment property and casualty insurers licensed on or before July 1, 1986, shall conform to this limitation by July 1, 1991.

B. Until July 1, 1991, the following single risk limits after deducting for reinsurance will apply:

1. No insurer having less than $2 million insurance in force shall insure any 1 risk for more than $10,000;

2. No insurer having more than $2 million but less than $5 million insurance in force shall insure any 1 risk for more than $12,000;

3. No insurer having more than $5 million but less than $10 million insurance in force shall insure any 1 risk for more than $20,000;

4. No insurer having more than $10 million insurance in force shall insure any 1 risk for a sum in excess of 15 cent(s) for each $100 insurance it has in force; and

5. An insurer may insure any one risk in larger sums than prescribed in this section if (i) the excess over such prescribed maximum is reinsured as authorized in this chapter or (ii) the excess may be increased by the extent of twenty-five percent of the surplus of the insurer as of the time the insurance is written.

1986, c. 562.

§ 38.2-2528. Reinsurance.

Any mutual assessment property and casualty insurer may reinsure the whole or any part of its risks with any solvent insurer licensed in this Commonwealth or licensed or approved in any other state and meeting standards of solvency at least equal to those required in this Commonwealth if the reinsurance is ceded without contingent liability on the part of the reinsured insurer. Any mutual assessment property and casualty insurer having a surplus in excess of $800,000 may accept or assume reinsurance from any licensed property and casualty insurer. Any of those companies may accept or assume reinsurance on risks located within or without the territory in which it is authorized to transact insurance.

Nothing in this section shall be construed to prohibit the participation of a mutual assessment property and casualty insurer in a pool or other plan among similar companies approved by the Commission for the purpose of spreading losses or providing reinsurance or catastrophe coverage for participants. The acceptance of reinsurance by any insurer outside the territory in which it is authorized to transact the business of insurance shall not be construed to enlarge its territory so as to affect any tax exemption to which it may be entitled.

1952, c. 317, § 38.1-675; 1986, c. 562.

§ 38.2-2529. Unearned premium reserves required.

A. Advance assessments received by mutual assessment property and casualty insurers shall be considered premiums and, except as provided in subsection B of this section, shall be subject to the requirement of an unearned premium reserve computed in accordance with § 38.2-1312. The reserves may be reduced for applicable reinsurance in accordance with the provisions of Article 3.1 (§ 38.2-1316.1 et seq.) of Chapter 13 of this title.

B. The amount each insurer shall maintain in reserves for unearned premium reserves shall be as follows:

1. For calendar year 1987, at least ten percent of the unearned premium reserve as calculated in subsection A of this section; and

2. For each subsequent year, at least an additional ten percent as calculated in subsection A for that subsequent year in order that the full amount of unearned premium reserves shall be established by December 31, 1996.

1986, c. 562; 1994, c. 316.

Chapter 26 - Home Protection Companies

§ 38.2-2600. Definitions.

As used in this chapter:

"Fronting company" means a licensed insurer or licensed home protection company which generally transfers to one or more unlicensed insurers or unlicensed home protection companies by reinsurance

or otherwise all or substantially all of the risk of loss under all of the home protection contracts written by it in this Commonwealth.

"Home protection company" means any person who performs, or arranges to perform, services pursuant to a home protection insurance contract.

"Home protection insurance contract" or "contract" means any insurance contract or agreement whereby a person undertakes for a specified period of time and for a predetermined fee to furnish, arrange for or indemnify for service, repair, or replacement of any and all of the structural components, parts, appliances, or systems of any covered residential dwelling necessitated by wear and tear, deterioration, inherent defect, or by the failure of an inspection to detect the likelihood of failure.

The contract shall provide for a system to effect repair or replacement if the contract undertakes to provide for repair or replacement services. The contract shall not include protection against consequential damage from the failure of any structural component, part, appliance or system.

"Structural component" means the roof, foundation, basement, walls, ceilings, or floors of a home.

1981, c. 530, §§ 38.1-932, 38.1-944; 1982, c. 132; 1986, c. 562; 2006, c. 634; 2017, c. 727.

§ 38.2-2601. Exemptions.

This chapter shall not apply to:

1. Performance guarantees given by either (i) the builder of a home or (ii) the manufacturer, seller, or lessor of the property that is the subject of the contract if no identifiable charge is made for the guarantee.

2. Any service contract, guarantee, or warranty intending to guarantee or warrant the repairs or service of a home appliance, component, part, or system that is issued (i) by a person who has sold, serviced, repaired, or provided replacement of the appliance, component, part, or system at the time of or prior to issuance of the service contract, guarantee or warranty if such person does not engage in the business of a home protection company or (ii) by a home protection company which sells such service contracts, guarantees or warranties in the Commonwealth of Virginia and which has net worth in excess of $100 million.

1981, c. 530, § 38.1-933; 1986, c. 562; 1992, c. 21; 2006, c. 634; 2017, c. 727.

§ 38.2-2602. Limited applicability to certain insurers.

A property and casualty insurer may be licensed to transact home protection insurance as defined in § 38.2-129. An insurer licensed in this Commonwealth to transact the class of insurance defined by § 38.2-111 on July 1, 1986, may also transact home protection insurance without additional authority. No other provision of this chapter, except § 38.2-2606 and §§ 38.2-2608 through 38.2-2614, shall be applicable to the insurers, their businesses, or their home protection contracts.

1981, c. 530, §§ 38.1-933, 38.1-945; 1986, c. 562; 2006, c. 634; 2017, c. 727.

§ 38.2-2603. License required; application; fee.

Except as provided in § 38.2-2602, no home protection company shall issue or offer to issue home protection contracts in this Commonwealth until a home protection company license has been granted by the Commission. Application for a license shall be made in writing, in the form prescribed by the Commission, and shall be accompanied by a nonrefundable application fee of $500.

1981, c. 530, § 38.1-933; 1986, c. 562.

§ 38.2-2604. Qualification for license; net worth; deposit of securities with State Treasurer.

A. No license shall be issued to any home protection company unless the applicant:

1. Is a Virginia corporation formed under the provisions of Article 3 (§ 13.1-618 et seq.) of Chapter 9 of Title 13.1, or Article 3 (§ 13.1-818 et seq.) of Chapter 10 of Title 13.1; or

2. Is a foreign corporation subject to regulation and licensing under the laws of its domiciliary jurisdiction which are substantially similar to those provided in this chapter, and has obtained a certificate of authority to transact business in this Commonwealth;

3. Furnishes the Commission with evidence satisfactory to it that the management of the home protection company is competent and trustworthy, and can be reasonably expected to successfully manage the company's affairs in compliance with law;

4. Establishes to the satisfaction of the Commission that it (i) maintains employees or has contractual arrangements sufficient to provide the services or indemnity undertaken by it, and (ii) agrees to accept requests for heating, electrical and plumbing services contracted for twenty-four hours per day, seven days per week;

5. Makes the deposit of bonds or other securities required by this section;

6. Is otherwise in compliance with this chapter;

7. Has filed the required application and paid the required fee;

8. Has paid all fees, taxes, and charges required by law;

9. Has the minimum net worth prescribed by this section;

10. Has filed any financial statement and any reports, certificates, or other documents as the Commission deems necessary to secure a full and accurate knowledge of its affairs and financial condition; and

11. Keeps adequate, correct and complete books and records of accounts and maintains proper accounting controls.

B. The Commission shall not issue a license to or renew the license of a home protection company unless it is satisfied that the financial condition, the method of operation, and the manner of doing business enable the home protection company to meet its obligations to all contract holders and that the home protection company has otherwise complied with all the requirements of law.

C. A home protection company shall maintain a net worth in an amount not less than 20% of the premiums charged on its contracts currently in force; however, the minimum required net worth shall be not less than $100,000, and the maximum required net worth shall be that amount required of insurers under the provisions of Article 5 (§ 38.2-1024 et seq.) of Chapter 10 of this title.

D. No license shall be granted to any home protection company until it presents to the Commission a certificate of the State Treasurer that bonds or other securities have been deposited with him to be held in accordance with the provisions of and upon the terms and conditions and in the amount as provided in Article 7 (§ 38.2-1045 et seq.) of Chapter 10 of this title.

1981, c. 530, § 38.1-934; 1982, c. 132; 1984, c. 640; 1986, c. 562; 2006, c. 634; 2017, c. 727.

§ 38.2-2605. Expiration and renewal of license.

Every home protection company licensed under this chapter shall obtain a renewal of its license annually from the Commission. Every license issued under this chapter shall expire at midnight on June 30 immediately following the date of issuance. No renewal license shall be issued unless the home protection company has paid all taxes, fees, assessments and other charges imposed upon it, and has complied with all the other requirements of law. The Commission shall not fail or refuse to renew the license of any home protection company without giving the home protection company ten days' notice of the failure or refusal to renew and providing it an opportunity to be heard and to introduce evidence in its behalf. Any such hearing may be informal, and the required notice may be waived by the Commission and the home protection company.

1981, c. 530, § 38.1-935; 1986, c. 562; 2006, c. 634; 2017, c. 727.

§ 38.2-2606. Reserves required.

A home protection company licensed in this Commonwealth shall maintain reserves in an amount sufficient to provide for its liability to furnish appropriate indemnity, repairs, and replacement services under its issued and outstanding contracts. The reserve account shall be calculated according to sound actuarial principles, but shall equal at a minimum fifty percent of the premiums received from all contracts in force in this Commonwealth, net of applicable reinsurance and any amounts paid on account of liabilities incurred under the contracts. To receive credit for reinsurance on home protection contracts, the reinsurance contract or policy shall be issued by a solvent insurer licensed in this Commonwealth or any other state having standards of solvency at least equal to those required in this Commonwealth.

1981, c. 530, § 38.1-936; 1986, c. 562.

§ 38.2-2607. Annual statements.

On or before March 1 of each year, each home protection company shall file with the Commission its annual statement pursuant to the provisions of § 38.2-1300, in the form prescribed by the Commission. The annual statement may be based on accounting principles common to the home protection business, provided that they enable the Commission to ascertain whether the reserves required by § 38.2-2606 have been established. However, the Commission may prescribe a uniform accounting system

to be used by home protection companies. The Commission may also require the uniform reporting of statistical information under a plan prescribed or approved by the Commission.

1981, c. 530, § 38.1-937; 1986, c. 562.

§ 38.2-2608. Home protection contracts; filing; form and contents; application or agreement to purchase; regulation of rates and charges.

A. No home protection contract shall be issued or used in this Commonwealth unless it has been filed with and approved by the Commission.

B. No home protection contract shall be issued in this Commonwealth unless it:

1. Is written in simple and readable words with common meanings and is understandable without special insurance knowledge or training;

2. Specifically sets forth:

a. The services to be performed by the home protection company and the terms and conditions of the performance;

b. Any service fee or deductible amount applicable per claim or per occurrence;

c. Each of the systems, appliances, and structural components covered by the contract;

d. All exclusions and limitations respecting the extent of coverage;

e. The period during which the contract will remain in effect and the cancellation provision;

f. All limitations regarding the performance of services, including any restrictions as to the time periods when services will be performed;

3. Provides for the initiation of covered services contracted for upon telephonic request without first requiring the filing of written claim forms or written applications; and

4. Provides for the initiation of covered services contracted for by or under the direction of the home protection company within seventy-two hours of the request for the service by the contract holder, and provides for the completion of the services as soon as reasonably possible. For malfunctions of furnace or heating systems during the winter months, the contract must provide for the initiation of services immediately.

C. Every application for or agreement to purchase a home protection contract shall include a statement that the purchase of the contract is not mandatory and may be waived, and shall include a statement of the premium.

D. 1. Chapter 20 (§ 38.2-2000 et seq.) of this title shall apply to the rates charged by home protection companies until such time as the Commission determines, after proper notice and hearing, that sufficient competition exists in the home protection industry to justify its regulation under Chapter 19 (§ 38.2-1900 et seq.) of this title. Upon this determination, Chapter 19 of this title shall apply to the rates charged by home protection companies.

2. No home protection company shall make or issue a contract except in accordance with the filings that are in effect for that company. No home protection company or any of its representatives shall charge or receive any fee, compensation or consideration for the contract that is not included in the rate in effect for that company.

3. The rates charged shall be based on sound actuarial principles and shall not be excessive, inadequate, or unfairly discriminatory as defined in § 38.2-1904.

1981, c. 530, § 38.1-938; 1984, c. 640; 1986, c. 562.

§ 38.2-2609. Qualifications of agents.

No person shall sell, solicit, or negotiate home protection contracts in this Commonwealth unless (i) he has a valid license granting the authority to transact such insurance in this Commonwealth, (ii) he has a valid license to sell real estate in this Commonwealth, issued pursuant to Chapter 21 (§ 54.1-2100 et seq.) of Title 54.1, or (iii) he is the builder of the home or one of his authorized agents.

1981, c. 530, § 38.1-939; 1984, c. 640; 1986, c. 562; 2001, c. 706.

§ 38.2-2610. Cancellation of home protection contracts.

A. No home protection contract shall be cancelable by the home protection company during the initial term for which it is issued, except for:

1. Nonpayment of premium;

2. Fraud or misrepresentation of facts material to the issuance of the contract; or

3. Contracts providing coverage prior to the time the residential property is purchased, provided that purchase of the property does not occur.

B. Nothing in this section establishes the right of a contract holder to renew any contract.

1981, c. 530, § 38.1-940; 1986, c. 562.

§ 38.2-2611. Unfair discrimination.

No person shall make or permit any unfair discrimination between individuals in the rates or fees charged for any contract, in the performance of services or payments for services, or in any other terms or conditions of the contract.

1981, c. 530, § 38.1-941; 1986, c. 562.

§ 38.2-2612. Unfair trade practices.

In addition to the provisions of Chapter 5 (§ 38.2-500) of this title, the Commission may order any home protection company or its representatives to cease and desist from engaging in the following unfair trade practices:

1. The making of any false or misleading statements, either oral or written, in connection with the sale, offer to sell, or advertisement of a home protection contract;

2. The omission of any material statement in connection with the sale, offer to sell, or advertisement of a contract that under the circumstances should have been made in order to make the statements that were made not misleading;

3. The making of any statement that the purchase of a home protection contract is mandatory;

4. The making of any false or misleading statements, either oral or written, about the benefits or services available under the contract;

5. The failure to perform the services promised under the contract in a timely, competent, or workmanlike manner; or

6. Any statement or practice which has the effect of creating or maintaining a fraud.

1981, c. 530, § 38.1-942; 1986, c. 562.

§ 38.2-2613. Application of insurance laws.

Except as otherwise specifically provided in this chapter or where the context requires otherwise, all of the provisions of this title that apply to property and casualty insurers shall apply in every respect to home protection companies licensed under this chapter. In addition, Article 1 (§ 58.1-2500 et seq.) and Article 2 (§ 58.1-2520 et seq.) of Chapter 25 of Title 58.1 shall apply to the operation of a home protection company.

1981, c. 530, § 38.1-943; 1986, c. 562; 2006, c. 634; 2017, c. 727.

§ 38.2-2614. Fronting not permitted.

No licensed insurer or licensed home protection company shall act as a fronting company for any unlicensed insurer or unlicensed home protection company.

1981, c. 530, § 38.1-944; 1986, c. 562.

§ 38.2-2615. Other insurance transactions prohibited.

A. A home protection company that engages in any business other than the business of a home protection company is not eligible for the issuance or renewal of a license in this Commonwealth.

B. Nothing in this chapter shall be deemed to authorize any home protection company to transact any business other than that of a home protection company or to transact any other business of insurance, unless the company is authorized by a license issued by the Commission.

1981, c. 530, § 38.1-945; 1986, c. 562; 2006, c. 634; 2017, c. 727.

§ 38.2-2616. Binding arbitration provisions in contract.

Notwithstanding the provisions of § 38.2-312, no home protection company based in this Commonwealth shall be prohibited from including in its contract a provision that requires the contract holder to submit to binding arbitration any dispute between the contract holder and the home protection company.

2003, c. 799.

§§ 38.2-2617 through 38.2-2627. Repealed.

Repealed by Acts 2017, c. 727, cl. 2, effective January 1, 2018.

§ 38.2-2628. Repealed.

Repealed by Acts 2015, c. 709, cl. 2.

Chapter 27 - BASIC PROPERTY INSURANCE RESIDUAL MARKET FACILITY AND JOINT UNDERWRITING ASSOCIATION

§ 38.2-2700. Purposes of chapter.

The purposes of this chapter are:

1. To assure stability in the property insurance market of this Commonwealth;

2. To assure the availability of basic property insurance for qualified property;

3. To encourage maximum use of the voluntary insurance market provided by licensed insurers in obtaining basic property insurance; and

4. To provide for the equitable distribution among licensed insurers of the responsibility for insuring qualified property for which basic property insurance cannot be obtained through the voluntary insurance market.

1968, c. 559, § 38.1-746; 1986, c. 562.

§ 38.2-2701. Definitions.

As used in this chapter:

"Basic property insurance" means insurance against direct loss to any property caused by perils defined and limited in the standard fire policy prescribed in §§ 38.2-2101 through 38.2-2112, and in the extended coverage endorsement approved by the Commission pursuant to § 38.2-2117 and such additional lines of insurance and forms of coverage as may be recommended by the governing body of the residual market facility and approved by the Commission.

"Inspection service" means any organization designated or approved by the Commission to determine the insurability and conditions of the properties for which basic property insurance is sought.

"Net direct premiums written" means gross direct premiums written in this Commonwealth on all policies of basic property insurance and the basic property insurance component of multi-peril policies less (i) all return premiums on those policies, (ii) dividends paid or credited to policyholders, and (iii) the unused or unabsorbed portions of premium deposits.

"Qualified property" means all real property and all tangible personal property at a fixed location in this Commonwealth, whether or not the property is subject to exposure from an external hazard located on property that is neither owned nor controlled by the prospective insured, and whether or not the property is subject to exposure from riot hazard, where the property:

1. Is not used for manufacturing purposes;

2. Complies with applicable state laws and regulations and local building codes and ordinances;

3. Is not commonly owned or controlled, or combinable for rating purposes, with property insured for similar coverages elsewhere; and

4. Has characteristics of ownership, condition or occupancy that do not violate any public policy.

"Residual market facility" means any organization approved by the Commission to equitably distribute the responsibility to provide basic property insurance on qualified property among insurers licensed to write basic property insurance or other insurance containing a basic property insurance component.

1968, c. 559, § 38.1-747; 1980, c. 156; 1982, c. 664; 1986, c. 562; 1987, c. 520; 1995, c. 119.

§ 38.2-2702. Establishment of residual market facility.

A. A residual market facility shall be established and maintained by all insurers licensed to write basic property insurance or other insurance containing a basic property insurance component. The plan of operation of the residual market facility shall be subject to approval by the Commission.

B. The residual market facility shall be governed by a board of fifteen directors. Four directors shall be appointed by the Commissioner, two of whom shall be property and casualty insurance agents and two of whom shall be from the general public.

C. The residual market facility shall have the power to:

1. Employ or retain persons necessary to perform the duties of the residual market facility;

2. Acquire, hold, and dispose of real and personal property, or any interest in real and personal property;

3. Borrow funds necessary to effect the purposes of this chapter in accord with the plan of operation;

4. Negotiate and become a party to those contracts necessary to carry out the purposes of this chapter;

5. Indemnify any director or member of its governing body, officer, employee, or agent in the manner permitted by and subject to the limitations contained in Article 9 (§ 13.1-875 et seq.) of Chapter 10 of Title 13.1; and provide any other or further indemnity to any such person that may be authorized by the plan of operation except an indemnity against his gross negligence or willful misconduct, and purchase and maintain insurance in the manner permitted by § 13.1-882; and

6. Perform any other acts necessary or proper to carry out the purposes of this chapter.

D. The residual market facility shall not be deemed to be an insurer within the provisions of § 38.2-100.

1968, c. 559, § 38.1-748; 1973, c. 451, § 38.1-748.1; 1980, c. 156; 1982, c. 664; 1986, c. 562.

§ 38.2-2703. Rules, rates, policy forms and endorsements subject to the approval of Commission.

The rules, rates, policy forms, and endorsements of the residual market facility shall be subject to the Commission's approval prior to use.

1986, c. 562.

§ 38.2-2704. Inspection of property.

Any person having an insurable interest in real property and tangible personal property at a fixed location in this Commonwealth is entitled, upon request, to an inspection of the property by representatives of the residual market facility to determine whether the property is within the definition of qualified property. A copy of the inspection report shall be made available upon request to the applicant, his agent, or the insurer.

1968, c. 559, § 38.1-748; 1980, c. 156; 1982, c. 664; 1986, c. 562.

§ 38.2-2705. Operation of inspection service.

A. The residual market facility may employ other organizations to perform inspection services to determine whether property is within the definition of qualified property.

B. The plan of operation regarding the inspection service, the experience and qualifications of the organization proposed to conduct the inspection service, the manner and scope of the inspection, and the form of the inspection report shall be set forth by the residual market facility in a written report made to the Commission and shall be subject to approval by the Commission.

1968, c. 559, § 38.1-748; 1980, c. 156; 1982, c. 664; 1986, c. 562.

§ 38.2-2706. Service of process.

Service of any notice, proof of loss, legal process or other communication relating to the policy or any notice or order of the Commission shall be made upon the residual market facility by service upon the residual market facility's manager, or any duly appointed assistant manager.

1973, c. 451, § 38.1-748.1; 1986, c. 562.

§ 38.2-2707. When Commission may order implementation of §§ 38.2-2708 and 38.2-2709.

If the Commission finds, after a reasonable period of time, that the residual market facility established by § 38.2-2702 is not creating a market that meets the purposes of this chapter, the Commission may order the implementation of §§ 38.2-2708 and 38.2-2709.

1968, c. 559, § 38.1-749; 1973, c. 451; 1986, c. 562.

§ 38.2-2708. Creation and plan of operation of joint underwriting association.

A. After providing notice and opportunity to be heard and upon promulgation of an order by the Commission pursuant to § 38.2-2707, a joint underwriting association shall be created consisting of all insurers licensed to write basic property insurance or other insurance that contains a basic property insurance component in this Commonwealth, but excluding insurers exempted from rate regulation by subsection C of § 38.2-1902. Each insurer that is required to be a member of the joint underwriting association shall remain a member as a condition of its license to write basic property insurance and other insurance that contains a basic property insurance component in this Commonwealth.

B. The joint underwriting association shall, pursuant to this chapter and the plan of operation, have the power to (i) cause its members to issue policies of basic property insurance on qualified property to applicants; (ii) assume reinsurance on qualified property from members; and (iii) cede reinsurance.

C. 1. Within ninety days following the effective date of the order of the Commission, the joint underwriting association shall submit to the Commission for its review a proposed plan of operation consistent with this chapter. The plan of operation shall provide for economical, fair and nondiscriminatory administration and for the prompt and efficient provision of basic property insurance to promote orderly community development. The plan of operation shall include, but not be limited to, (i) preliminary assessment of all members for initial expenses necessary to commence operations, (ii) establishment of necessary facilities, (iii) management of the joint underwriting association, (iv) assessment of members to defray losses and expenses, (v) commission arrangements, (vi) reasonable underwriting standards and limits of liability, (vii) acceptance and cession of reinsurance, and (viii) procedures for determining amounts of insurance to be provided.

2. The plan of operation shall be subject to approval by the Commission after consultation with affected individuals and organizations, and shall take effect ten days after its approval. If the Commission disapproves all or any part of the proposed plan of operation, the joint underwriting association shall within thirty days submit for review an appropriately revised plan of operation. If the joint underwriting association fails to submit a revised plan, or if the revised plan is unacceptable, the Commission shall promulgate whatever plan of operation it deems necessary to carry out the purposes of this chapter.

3. The joint underwriting association may, on its own initiative or at the request of the Commission, amend the plan of operation. Any amendment to the plan of operation shall be subject to the Commission's approval.

1968, c. 559, § 38.1-750; 1973, c. 504; 1986, c. 562.

§ 38.2-2709. Ceding basic property insurance to association; participation of members; governing body.

A. Any member of the joint underwriting association may cede to the association basic property insurance written on qualified property, to the extent and on the terms and conditions set forth in the plan of operation.

B. All members of the joint underwriting association shall participate in its writings, expenses, profits and losses, or in any categories thereof that may be separately established by the joint underwriting association, in the proportion that the net direct premiums written by each member during the preceding calendar year bear to the aggregate net direct premiums written in this Commonwealth by all members of the joint underwriting association during the preceding calendar year, but excluding (i) premiums on property used for manufacturing purposes, and (ii) that portion of premiums attributable to the operation of the joint underwriting association.

C. The joint underwriting association shall be governed by a board of fifteen directors. Four directors shall be appointed by the Commissioner, two of whom shall be property and casualty insurance agents and two of whom shall be from the general public. The remaining eleven directors shall be elected annually by a cumulative vote of the joint underwriting association's members, whose votes

shall be weighted in accordance with each member's premiums written during the preceding calendar year. The first board shall be elected at a meeting of the members or their authorized representatives, which shall be held within thirty days after approval of the plan of operation as provided in § 38.2-2708.

1968, c. 559, § 38.1-751; 1982, c. 665; 1986, c. 562.

§ 38.2-2710. Supervision and regulation by Commission.

The residual market facility, any inspection service, and any joint underwriting association shall at all times be subject to the supervision and regulation of the Commission. The Commission, or any person designated by it, shall have the power:

1. To visit and examine the operations of the residual market facility, any inspection service, and any joint underwriting association;

2. To examine directors, officers, agents, employees, or any other person having knowledge of those operations;

3. To summon and qualify witnesses under oath and, pursuant to these powers, to have free access to all books, records, files, papers and documents that relate to those operations; and

4. To require that the association file annually a financial report that is approved by the board of directors and prepared in a form prescribed by the Commission. Unless the Commission provides otherwise, the report shall be filed within 120 days after the end of each fiscal year and shall be for the preceding twelve months.

1968, c. 559, § 38.1-752; 1986, c. 562; 1995, c. 60.

§ 38.2-2711. Immunity from liability; reports, etc., not public documents.

A. There shall be no liability on the part of, and no cause of action shall arise against any insurer, any inspection service, the residual market facility, the joint underwriting association, or their directors, governing committee members, officers, agents or employees, or the Commission or its authorized representatives, for any action taken by them in good faith in the performance of their powers and duties under this chapter, nor for any inspections undertaken or statements made by them (i) in any reports and communications concerning the property insured or to be insured, (ii) at the time of the hearings conducted in connection with the property insured or to be insured, or (iii) in the findings required by this chapter.

B. The reports and communications of an inspection bureau service, the residual market facility, and the joint underwriting association shall not be public documents.

1968, c. 559, § 38.1-753; 1985, c. 401; 1986, c. 562.

§ 38.2-2712. Appeal from decision of inspection service, residual market facility or joint underwriting association.

Any person aggrieved by any action or decision of an inspection service, the residual market facility, or the joint underwriting association may appeal to the Commission within thirty days from the action

or the decision. The Commission shall provide the aggrieved person and the inspection service, the residual market facility, or the joint underwriting association an opportunity to be heard on not less than ten days' written notice. The Commission shall then issue an order (i) approving the action or decision, (ii) disapproving the action or decision, or (iii) directing the inspection service, the residual market facility or the joint underwriting association to reinspect the property, or place the application or cause it to be placed pursuant to its plan of operation, whichever is appropriate.

1968, c. 559, § 38.1-754; 1986, c. 562.

§ 38.2-2713. Obligations not to be impaired in event of repeal of chapter.

If the General Assembly repeals this chapter, (i) the obligations incurred by the residual market facility and the joint underwriting association and policies issued by either organization or by their members shall not be impaired by the repeal, and (ii) the residual market facility and joint underwriting association shall be continued until they have fully performed their respective outstanding obligations.

1970, c. 45, § 38.1-755.1; 1986, c. 562.

Chapter 28 - MEDICAL MALPRACTICE JOINT UNDERWRITING ASSOCIATION

§ 38.2-2800. Definitions.

As used in this chapter:

"Association" means the joint underwriting association established pursuant to the provisions of this chapter.

"Incidental coverage" means any other type of liability insurance covering activities directly related to the continued and efficient delivery of health care that: (i) cannot be obtained in the voluntary market because medical malpractice insurance is being provided pursuant to this chapter; and (ii) cannot be obtained through other involuntary market mechanisms.

"Liability insurance" includes the classes of insurance defined in §§ 38.2-117 through 38.2-119 and the liability portions of the insurance defined in §§ 38.2-124, 38.2-125, and 38.2-130 through 38.2-132.

"Medical malpractice insurance" means insurance coverage against the legal liability of the insured and against loss, damage, or expense incident to a claim arising out of the death or injury of any person as the result of negligence in rendering or failing to render professional service by any provider of health care.

"Net direct premiums written" means gross direct premiums written in this Commonwealth on all policies of liability insurance less, (i) all return premiums on the policy, (ii) dividends paid or credited to policyholders, and (iii) the unused or unabsorbed portions of premium deposits on liability insurance.

"Provider of health care" means any of the following deemed by the Commission to be necessary for the delivery of health care: (i) a physician and any other individual licensed or certified pursuant to Chapter 29 (§ 54.1-2900 et seq.) of Title 54.1; (ii) a nurse, dentist, or pharmacist licensed pursuant to Title 54.1; (iii) any health facility licensed or eligible for licensure pursuant to Chapter 5 (§ 32.1-123 et

seq.) of Title 32.1 or Article 2 (§ 37.2-403 et seq.) of Chapter 4 of Title 37.2; and (iv) any other group, type, or category of individual or health-related facility that the Commission finds to be necessary for the continued delivery of health care after providing notice and opportunity to be heard.

1976, c. 85, § 38.1-775; 1986, c. 562.

§ 38.2-2801. Association activation; members; purpose; determinations by Commission; powers of association.

A. The Commission shall activate a joint underwriting association if, after investigation, notice, and hearing, it finds that medical malpractice insurance cannot be made reasonably available in the voluntary market for a significant number of any class, type, or group of providers of health care. The association shall consist of all insurers licensed to write and engaged in writing liability insurance within this Commonwealth on a direct basis except those exempted from rate regulation by subsection C of § 38.2-1902. Each such insurer shall be a member of the association as a condition of its license to write liability insurance in this Commonwealth.

B. The purpose of the association shall be to provide a market for medical malpractice insurance on a self-supporting basis without subsidy from its members.

C. 1. The association shall not commence underwriting operations for any class, type or group of providers of health care until it is activated by the Commission. At the direction of the Commission, the association shall commence operations in accordance with the provisions of this chapter.

2. If the Commission determines at any time that medical malpractice insurance can be made reasonably available in the voluntary market for any class, type or group of providers of health care, the association shall, at the direction of the Commission, cease its underwriting operations for that class, type or group of providers of health care.

D. The Commission shall also determine after investigation and a hearing whether the association shall be the exclusive source of medical malpractice insurance for any class, type or group of providers of health care and the type of policy or policies that shall be issued to any class, type or group of providers of health care. If the Commission determines that a claims-made policy will be issued to any class, type or group of providers of health care, the Commission shall also provide for the guaranteed availability of insurance that covers claims that (i) result from incidents occurring during periods when the basic claims-made policies are in force, and (ii) are reported after the expiration of the basic claims-made policies. The Commission may from time to time after an investigation and hearing reexamine and reconsider any determination made pursuant to this subsection.

E. Pursuant to this chapter and the plan of operation required by § 38.2-2804, the association shall have the power on behalf of its members to: (i) issue, or cause to be issued, policies of medical malpractice insurance to applicants, including incidental coverages, subject to limits as specified in the plan of operation but not to exceed $2 million for each claimant under any one policy and $6 million for all claimants under one policy in any one year; (ii) underwrite the insurance and adjust and pay losses on the insurance; (iii) appoint a service company or companies to perform the functions

enumerated in this subsection; (iv) assume reinsurance from its members; and (v) reinsure its risks in whole or in part.

1976, c. 85, § 38.1-776; 1980, c. 286, § 38.1-776.2; 1986, c. 562; 2003, cc. 488, 1026.

§ 38.2-2802. Dissolution.

A. When the association has ceased all of its underwriting operations by order of the Commission under subsection C of § 38.2-2801, it shall be subject during its continued existence to the following:

1. The association shall remain in existence for the sole purpose of completing its orderly dissolution;

2. The association shall refund to all of its members all preliminary assessments contributions and other funds paid to the association that have not been reimbursed prior to dissolution; and

3. The board of the association shall satisfy and discharge its obligations and, subject to the approval of the Commission, shall have authority to do all other acts required to conclude its business affairs, including but not limited to, transfer of policies in force to approved carriers.

B. When the Commission finds the association has met its obligations incident to termination of its business affairs, the Commission shall by order issue a certificate of dissolution and the existence of the association shall cease.

1980, c. 286, § 38.1-776.1; 1986, c. 562; 1987, c. 554.

§ 38.2-2803. Directors.

A. The association shall be governed by a board of 14 directors. Two directors shall be appointed by each of the following three insurance industry trade associations: (i) the American Insurance Association; (ii) the Property Casualty Insurers Association of America; and (iii) the National Association of Mutual Insurance Companies. The Commission shall appoint two directors to represent insurers not affiliated with the insurance industry trade associations listed above. One director shall be appointed by each of the following two agent trade associations: (a) the Independent Insurance Agents of Virginia and (b) the Professional Insurance Agents Association of Virginia and the District of Columbia. Two directors shall be appointed by the Medical Society of Virginia, and two directors shall be appointed by the Virginia Hospital and Healthcare Association.

B. If any of the foregoing associations fail to appoint a director or directors within a reasonable period of time, the Commission shall have the power to make the appointments.

1976, c. 85, § 38.1-777; 1986, c. 562; 2014, c. 198.

§ 38.2-2804. Plan of operation.

A. Within forty-five days of the date the Commission makes a determination to activate a joint underwriting association pursuant to subsection A of § 38.2-2801, the directors of the association shall submit to the Commission for review a proposed plan of operation consistent with this chapter.

B. The plan of operation shall provide for economic, fair and nondiscriminatory administration and for the prompt and efficient provision of medical malpractice insurance. The plan shall contain other

provisions including (i) preliminary assessment of all members for initial expenses necessary to commence operations, (ii) establishment of necessary facilities, (iii) management of the association, (iv) assessment of members to defray losses and expenses, (v) reasonable and objective minimum underwriting standards developed in consultation with the medical and hospital advisory committees provided for in § 38.2-2805, (vi) acceptance and cession of reinsurance, (vii) appointment of servicing carriers or other servicing arrangements, (viii) the establishment of premium payment plans, (ix) procedures for determining amounts of insurance to be provided by the association, (x) procedures for the recoupment of preliminary assessments and other assessments of members as authorized by this chapter, and (xi) any other matters necessary for the efficient and equitable operation and termination of the association.

C. The plan of operation shall be subject to approval by the Commission after consultation with the members of the association and representatives of interested individuals and organizations. If the Commission disapproves all or any part of the proposed plan of operation, the directors shall within fifteen days submit for review an appropriate revised plan of operation. If the directors fail to do so, the Commission shall promulgate a plan of operation. The plan of operation approved or promulgated by the Commission shall become effective and operational upon order of the Commission.

D. Amendments to the plan of operation may be made by the directors of the association, subject to the approval of the Commission.

1976, c. 85, § 38.1-778; 1980, c. 286; 1986, c. 562; 1987, c. 554; 1988, c. 341.

§ 38.2-2805. Medical and hospital advisory committees.

The Commission shall appoint a medical advisory committee to the association composed of five physicians licensed to practice medicine in this Commonwealth and a hospital advisory committee composed of five representatives of hospitals licensed in this Commonwealth.

1976, c. 85, § 38.1-779; 1986, c. 562.

§ 38.2-2806. Policy forms; applicants to be issued policies; cancellation of policies; rates; examination of business of association.

A. All policies issued by the association shall be subject to the group retrospective premium adjustment and to the stabilization reserve fund required by § 38.2-2807. No policy form shall be used by the association unless it has been filed with the Commission and either (i) the Commission has approved it or (ii) thirty days have elapsed and the Commission has not disapproved the form or endorsement for one or more of the reasons enumerated in subsection A of § 38.2-317.

B. Policies shall be issued by the association, after receipt of the premium or portion of the premium prescribed by the plan of operation, to applicants that (i) meet the minimum underwriting standards, and (ii) have no unpaid or uncontested premium due as evidenced by the applicant having failed to make written objection to premium charges within thirty days after billing.

C. Any policy issued by the association may be cancelled for any one of the following reasons: (i) nonpayment of premium or portion of the premium; (ii) suspension or revocation of the insured's license;

(iii) failure of the insured to meet the minimum underwriting standards; (iv) failure of the insured to meet other minimum standards prescribed by the plan of operation; and (v) nonpayment of any stabilization reserve fund charge.

D. The rates, rating plans, rating rules, rating classifications, premium payment plans and territories applicable to the insurance written by the association, and related statistics shall be subject to the provisions of Chapter 20 (§ 38.2-2000 et seq.) of this title. Due consideration shall be given to the past and prospective loss and expense experience for medical malpractice insurance written and to be written in this Commonwealth, trends in the frequency and severity of losses, the investment income of the association, and other information the Commission requires. All rates shall be on an actuarially sound basis, giving due consideration to the stabilization reserve fund, and shall be calculated to be self-supporting. The Commission shall take all appropriate steps to make available to the association the loss and expense experience of insurers writing or having written medical malpractice insurance in this Commonwealth.

E. All policies issued by the association shall be subject to a nonprofit group retrospective premium adjustment to be approved by the Commission under which the final premium for all policyholders of the association, as a group, will be calculated based upon the experience of all policyholders. The experience of all policyholders shall be calculated following the end of each fiscal period and shall be based upon earned premiums, administrative expenses, loss and loss adjustment expenses, and taxes, plus a reasonable allowance for contingencies and servicing. Policyholders shall be given full credit for all investment income, net of expenses and a reasonable management fee on policyholder supplied funds. Any final premium resulting from a retrospective premium adjustment will be collected from the stabilization fund set forth in § 38.2-2807. The maximum premium for all policyholders as a group shall be limited as provided in § 38.2-2807.

F. 1. The association shall certify to the Commission the estimated amount of any deficit remaining after the stabilization reserve fund has been exhausted in payment of the maximum final premium for all policyholders of the association. Within sixty days after such certification, the Commission shall authorize the association to recover from the members their respective share of the deficit.

2. Members shall be permitted to recover any assessment made by the association under subdivision 1 by deducting the members' share of the deficit from future premium taxes due the Commonwealth. The amount of premium tax deduction for each member's share of the deficit shall be apportioned by the Commission so that the amount of each member's premium tax deduction in each of the ten calendar years following the payment of the member's assessment is equal to ten percent of the assessment paid by the member.

G. In the event that sufficient funds are not available for the sound financial operation of the association, subject to recoupment as provided in this chapter and the plan of operation, all members shall, on a temporary basis, contribute to the financial requirements of the association in the manner

provided in this chapter. The contribution shall be reimbursed to the members by the procedure set forth in subdivision F 2.

H. The Commission shall examine the business of the association as often as it deems appropriate to make certain that the group retrospective premium adjustments are being calculated and applied in a manner consistent with this section. If the Commission finds that they are not being calculated and applied in a manner consistent with this section, it shall issue an order to the association, specifying (i) how the calculation and application are not consistent and (ii) stating what corrective action shall be taken.

1976, c. 85, § 38.1-780; 1986, c. 562; 1987, cc. 520, 554; 1988, c. 341; 1997, c. 160.

§ 38.2-2807. Stabilization reserve fund.

A. When an association is activated under § 38.2-2801, a stabilization reserve fund shall be created. The fund shall be administered by five directors appointed by the Commission, one of whom shall be a representative of the Commission, two of whom shall be representatives of the association, and two of whom shall be representatives of the association's policyholders.

B. The directors shall act by majority vote with three directors constituting a quorum for the transaction of any business or the exercise of any power of the fund. The directors shall serve without salary, but each director shall be reimbursed for actual and necessary expenses incurred in the performance of his official duties as a director of the fund. The directors shall not be subject to any personal liability with respect to the administration of the fund.

C. Each policyholder shall pay to the association a stabilization reserve fund charge equal to one-third of the annual premium due for medical malpractice insurance through the association until the fund reaches a level deemed appropriate by the Commission. The means of payment shall be set forth in the plan of operation and shall be separately stated in the policy. The association shall cancel the policy of any policyholder who fails to pay the stabilization reserve fund charge. Upon the termination of any policy during the term of the policy, payments made to the stabilization reserve fund shall be returned to the policyholder on a pro rata basis identical to that applied in computing that portion of the premium which is returned to the policyholder.

D. All moneys received by the fund shall be held in a separate restricted cash account under the sole control of an independent fund manager to be selected by the directors. The fund manager may invest the moneys held, subject to the approval of the directors. All investment income shall be credited to the fund. All expenses of administration of the fund shall be charged against the fund. The moneys held shall be used solely for the following purposes: (i) to reimburse the association for any and all expenses, taxes, licenses and fees paid by the association which are properly chargeable or allocable to the stabilization reserve fund; or (ii) to pay any retrospective premium adjustment charge levied by the association. Payment of retrospective premium adjustment charges and other authorized payments shall be made by the directors upon certification to them by the association of the amount due. If all moneys accruing to the fund are exhausted in payment of retrospective premium adjustment

charges, all liability and obligations of the association's policyholders with respect to the payment of retrospective premium adjustment charges shall terminate and shall be conclusively presumed to have been discharged.

E. The association shall promptly pay the fund manager of the fund all stabilization reserve fund charges that it collects from its policyholders.

F. Upon dissolution of the association, all assets remaining in the fund shall be distributed equitably to the policyholders who have contributed to the fund under procedures authorized by the directors. Distribution of assets remaining in the fund shall be made after final disposition of all claims, expenses, and liabilities against the fund, including reimbursement of preliminary organizational assessments made pursuant to subsection B of § 38.2-2804.

1976, c. 85, § 38.1-781; 1977, c. 154; 1986, c. 562; 1987, cc. 526, 554; 1988, c. 341.

§ 38.2-2808. Participation in association by insurers.

Each insurer that is a member of the association shall participate in the temporary contributions to finance the operation of the association in the proportion that the net direct premiums written by each member during the preceding calendar year bears to the aggregate net direct premiums written in this Commonwealth by all members of the association. However, the net direct premiums written by each member shall exclude that portion of premiums attributable to the operation of the association. Each insurer's participation in the association shall be determined annually on the basis of such premiums written during the preceding calendar year in the manner set forth in the plan of operation.

1976, c. 85, § 38.1-782; 1986, c. 562.

§ 38.2-2809. Review of actions or decisions of association.

Any insurer, applicant or other person aggrieved by any action or decision of the association or of any insurer as a result of its participation in the association, may appeal to the board of directors of the association. The decision of the board of directors may be appealed to the Commission within thirty days from the date the aggrieved person received notice of the board's action.

1976, c. 85, § 38.1-783; 1986, c. 562.

§ 38.2-2810. Annual statements.

The association shall file an annual statement with the Commission within three months of the close of each fiscal year. The annual statement shall contain information on its transactions, condition, operations and affairs during the preceding fiscal year. The form and content of the annual statement shall be subject to the Commission's approval. The Commission may at any time require the association to furnish additional information on its transactions, condition or any matter connected with the association considered to be material and of assistance in evaluating the scope, operation and experience of the association.

1976, c. 85, § 38.1-784; 1986, c. 562.

§ 38.2-2811. Examination into affairs of association.

The Commission shall examine the affairs of the association pursuant to § 38.2-1317. The examination shall be performed in the manner prescribed in §§ 38.2-1317 through 38.2-1321.1.

1976, c. 85, § 38.1-785; 1986, c. 562; 1999, c. 61.

§ 38.2-2812. Public officers or employees.

No member of the board of directors of the stabilization reserve fund who is a public officer or employee shall forfeit his office or employment, or incur any loss or diminution in the rights and privileges associated with his office or employment, because of membership on the board.

1976, c. 85, § 38.1-786; 1986, c. 562.

§ 38.2-2813. Commissions for placing and servicing risk with association.

For any medical malpractice insurance or incidental coverage policy issued by the association, the commission payable to the person that places the risk with the joint underwriting association or services the risk shall be limited to 5 percent of the annual premium for the policy or $1,000, whichever is less.

1976, c. 85, § 38.1-787; 1986, c. 562.

§ 38.2-2814. Liability.

There shall be no liability imposed on the part of and no civil cause of action of any nature shall arise against the association or the stabilization reserve fund, their board of directors, their agents, their employees, any service carrier, any participating insurer or its employees, any licensed producer, the Commission or its authorized representatives, the medical and hospital advisory committees, or their members or employees for any statements or actions made by them in good faith in carrying out the provisions of this chapter.

1976, c. 85, § 38.1-788; 1986, c. 562; 1987, c. 519.

Chapter 29 - COMMERCIAL LIABILITY INSURANCE JOINT UNDERWRITING ASSOCIATION

§ 38.2-2900. Definitions.

As used in this chapter:

"Association" means the joint underwriting association established pursuant to the provisions of this chapter.

"Commercial liability insurance" means the commercial classes of insurance defined in §§ 38.2-117 and 38.2-118, but for the purposes of this chapter, does not include medical malpractice insurance as defined in § 38.2-2800, nuclear liability or any risks, lines, or subclassifications that are determined by the Commission to be uninsurable; provided, no such determination shall be based solely upon evidence that no insurers are then insuring such risk, line, or subclassification. The Commission may exclude from this definition any other line, subclassification or type of commercial liability insurance as it deems appropriate.

"Incidental coverage" means any other type of liability insurance covering activities directly related to the continued and efficient delivery of business and professional services that: (i) cannot be separately obtained in the voluntary market because commercial liability insurance is being provided pursuant this chapter; and (ii) cannot be separately obtained through other involuntary market mechanisms.

"Market assistance plan" means a voluntary association of insurers and insurance agents licensed to do business in the Commonwealth that is formed, pursuant to a plan of operation filed with and approved by the Commission, to assist with the individual placement of commercial liability insurance coverage that is not reasonably available on the voluntary market.

"Net direct premiums written" means gross direct premiums written in this Commonwealth on all policies of liability insurance less (i) all return premiums on the policy, (ii) dividends paid or credited to policyholders, and (iii) the unused or unabsorbed portions of premium deposits on liability insurance. For the purposes of this chapter, "liability insurance" means the classes of insurance defined in §§ 38.2-117 through 38.2-119, and the liability portions of the insurance defined in §§ 38.2-124, 38.2-125 and 38.2-130 through 38.2-132.

1988, cc. 769, 783.

§ 38.2-2900.1. Market assistance plan.

The Commission may authorize the formation of a voluntary market assistance plan to assist in the individual placement of coverage for any lines, subclassifications, or types of commercial liability insurance. Such plan shall not be an insurer capable of assuming insurance risks.

1988, cc. 769, 783.

§ 38.2-2901. Association activation; members; purpose; determinations by Commission; powers of Association.

A. After investigation, notice, and hearing, the Commission shall be empowered to activate a Joint Underwriting Association with respect to any line, subclassification or type of commercial liability insurance coverage if it finds that such line, subclassification, or type of commercial liability insurance coverage is not reasonably available for a significant number of any class, type, or group of such risks in the voluntary market or through a market assistance plan. The Association shall consist of all insurers licensed to write and engaged in writing the classes of insurance defined in §§ 38.2-117 through 38.2-119, and the liability portions of the insurance defined in §§ 38.2-124, 38.2-125 and 38.2-130 through 38.2-132 within this Commonwealth on a direct basis except those exempted from rate regulation by subsection C of § 38.2-1902. Each such insurer shall be a member of the Association as a condition of its license to write such insurance in this Commonwealth.

B. The purpose of the Association shall be to provide markets for commercial liability insurance for persons with eligible risks who are unable to obtain commercial liability insurance coverage, including incidental coverage, through the voluntary market. It shall also be the purpose of the Association to do so on a self-supporting basis without subsidy from its members.

C. 1. The Association shall not commence underwriting operations for any line, subclassification or type of commercial liability insurance coverage until so ordered by the Commission. At the direction of the Commission, the Association shall commence operations in accordance with the provisions of this chapter.

2. If the Commission determines at any time that a line, subclassification or type of commercial liability insurance coverage is reasonably available at adequate levels in the voluntary market, the Association shall, at the direction of the Commission, cease its underwriting operations for that line, subclassification, or type of commercial liability insurance coverage.

D. The Commission shall also determine after investigation and a hearing whether the Association shall be the exclusive source of any line, subclassification or type of commercial liability insurance which it finds not to be reasonably available pursuant to subsection A of this section and the type of policy or policies that shall be issued for any line, subclassification or type of commercial liability insurance. If the Commission determines that a claims-made policy will be issued for any line, subclassification or type of coverage, the Commission shall also provide for the guaranteed availability of insurance that covers claims which (i) result from incidents occurring during periods when the basic claims-made policies are in force; and (ii) are reported after the expiration of the basic claims-made policies. The Commission may from time to time after an investigation and hearing reexamine and reconsider any determination made pursuant to this subsection.

E. Pursuant to this chapter and the plan of operation required by § 38.2-2904, the Association shall have the power on behalf of its members to:

1. Issue, or cause to be issued, policies of commercial liability insurance to eligible applicants, including incidental coverages, subject to limits specified in the plan of operation but not to exceed one million dollars for each claimant under any one policy and three million dollars for all claimants under one policy in any one year;

2. Provide a means for establishing eligibility of a risk for obtaining insurance through the plan;

3. Underwrite the insurance and adjust and pay losses on the insurance;

4. Appoint a service company or companies to perform functions enumerated in this subsection;

5. Provide a means for the equitable apportionment of profits or losses and expenses among participating insurers;

6. Develop rules for the classification of risks and rates which reflect the past and prospective loss experience and a rating plan which reasonably reflects the prior claims experience of the insureds;

7. Assume reinsurance from its members;

8. Reinsure its risks in whole or in part; and

9. Take such other action as is necessary for the efficient and equitable operation and termination of the Association.

1988, cc. 769, 783.

§ 38.2-2902. Dissolution.

A. When the Association has ceased all of its underwriting operations by order of the Commission under subdivision 2 of subsection C of § 38.2-2901, it shall be subject during its continued existence to the following:

1. The Association shall remain in existence for the sole purpose of completing its orderly dissolution.

2. The Association shall refund to all of its members all preliminary assessments, contributions and other funds paid to the Association that have not been reimbursed prior to dissolution.

3. The board of the Association shall satisfy and discharge its obligations and, subject to the approval of the Commission, shall have authority to do all other acts required to conclude its business affairs, including but not limited to, transfer of policies in force to approved carriers.

B. When the Commission finds the Association has met its obligations incident to termination of its business affairs, the Commission shall by order issue a certificate of dissolution and the existence of the Association shall cease.

1988, cc. 769, 783.

§ 38.2-2903. Directors.

A. The Association shall be governed by a board of 11 directors, including one who shall be elected chairman. Two directors shall be appointed by each of the following three insurance industry trade associations: (i) the American Insurance Association; (ii) the Property Casualty Insurers Association of America; and (iii) the National Association of Mutual Insurance Companies. One director shall be appointed by each of the following two insurance agents' trade associations: (a) the Independent Insurance Agents of Virginia and (b) the Professional Insurance Agents Association of Virginia and the District of Columbia. The Commission shall appoint three directors not affiliated with the aforementioned trade associations. If, for any reason, any of the trade associations fail to appoint a director or directors within a reasonable period of time, the Commission shall have the power to make the appointment.

B. All board members, including the chairman, shall be appointed to serve for two-year terms beginning on a date designated by the plan.

C. Six directors shall constitute a quorum for the transaction of any business or exercise of any power of the Association. The directors of the Association shall act by vote of a majority of those present. The directors shall serve without salary, but each director shall be reimbursed for actual and necessary expenses incurred in the performance of his or her official duties as a director of the Association.

1988, cc. 769, 783; 2014, c. 198.

§ 38.2-2904. Plan of operation.

A. Within forty-five days after appointment of the members of the board, the directors of the Association shall submit to the Commission for review a proposed plan of operation consistent with this chapter.

B. The plan of operation shall provide for economic, fair and nondiscriminatory administration and for the prompt and efficient provision of commercial liability insurance. The plan shall contain other provisions governing:

1. Preliminary assessment of all members for initial expenses necessary to commence operations;

2. Establishment of necessary facilities;

3. Management of the Association;

4. Assessment of members to defray losses and expenses;

5. Reasonable and objective minimum underwriting standards;

6. Acceptance and cession of reinsurance;

7. Appointment of servicing carriers or other servicing arrangements;

8. The establishment of premium payment plans;

9. Procedures for determining amounts of insurance to be provided by the Association;

10. Procedures for the recoupment of preliminary assessments and other assessments of members as authorized by this chapter; and

11. Any other matters necessary for the efficient and equitable operation and termination of the Association.

C. The plan of operation shall be subject to approval by the Commission after consultation with the members of the Association and representatives of interested individuals and organizations. If the Commission disapproves all or any part of the proposed plan of operation, the directors shall within fifteen days submit for review an appropriate revised plan of operation. If the directors fail to do so, the Commission shall promulgate a plan of operation. The plan of operation approved or promulgated by the Commission shall become effective and operational upon order of the Commission.

D. At any time after the Association is activated, and after investigation, notice, and hearing, the Commission may order the submission of a supplemental plan of operation if it finds that any line, subclassification or type of commercial liability insurance not covered by the existing plan of operation is not reasonably available according to the terms of subsection A of § 38.2-2901. Such supplemental plan of operation shall be submitted within forty-five days of the Commission's order and shall be subject to all other provisions of this chapter governing the plan of operation.

E. Amendments to the plan of operation may be made by the directors of the Association, subject to the approval of the Commission.

1988, cc. 769, 783.

§ 38.2-2905. Policy forms; applicants to be issued policies; cancellation of policies; rates; group retrospective rating plan; examination of business of Association.

A. All policies issued by the Association shall be subject to the group retrospective premium adjustment and to the stabilization reserve fund required by § 38.2-2906. No policy form shall be used by the Association unless it has been filed with the Commission and either (i) the Commission has approved it or (ii) thirty days have elapsed and the Commission has not disapproved the form or endorsement for one or more of the reasons enumerated in subsection A of § 38.2-317.

B. Policies shall be issued by the Association, after receipt of the premium or portion of the premium prescribed by the plan of operation, to applicants that (i) meet the minimum underwriting standards of the Association, and (ii) have no unpaid or uncontested premium due as evidenced by the applicant having failed to make written objection to premium charges within thirty days after billing.

C. Any policy issued by the Association may be cancelled for any one of the following reasons:

1. Nonpayment of premium or portion of the premium;

2. Suspension or revocation of the insured's license to conduct business;

3. Failure of the insured to meet the minimum underwriting standards;

4. Failure of the insured to meet other minimum standards prescribed by the plan of operation; or

5. Nonpayment of any stabilization reserve fund charge.

D. The rates, rating plans, rating rules, rating classifications, premium payment plans and territories applicable to the insurance written by the Association, and related supplementary rate information shall be subject to the provisions of Chapter 20 (§ 38.2-2000 et seq.) of this title. Due consideration shall be given to the past and prospective loss and expense experience for the line, subclassification or type of commercial liability insurance written in this Commonwealth, trends in the frequency and severity of losses, the investment income of the Association, and other information the Commission requires. All rates shall be on an actuarially sound basis, giving due consideration to the stabilization reserve fund, and shall be calculated to be self-supporting. The Commission shall take all appropriate steps to make available to the Association the loss and expense experience of insurers writing or having written the same line, subclassification or type of commercial liability insurance in this Commonwealth.

E. All policies issued by the Association shall be subject to a nonprofit group retrospective premium adjustment to be approved by the Commission under which the final total premium for all policyholders for each line, subclassification or type of commercial liability insurance issued each year by the Association, as a group, will be calculated based upon the experience of all such policyholders. The experience of all such policyholders shall be calculated following the end of each year and shall be based upon earned premiums, administrative expenses, loss and loss adjustment expenses, and taxes, plus a reasonable allowance for contingencies and servicing, for each line, subclassification or type of commercial liability insurance. Policyholders shall be given full credit for all investment income, net of expenses and a reasonable management fee on policyholder supplied funds. Any final premium resulting from a retrospective premium adjustment will be collected from those moneys in the

stabilization reserve fund set forth in § 38.2-2906 that are attributable to the policies written for the particular line, subclassification or type of commercial liability insurance or group of such risks for which activation occurred pursuant to § 38.2-2901. The maximum premium for all policyholders as a group shall be limited as provided in § 38.2-2906.

F. 1. If the stabilization reserve fund account for one or more lines, subclassifications or types of commercial liability insurance is exhausted in the payment of the maximum final premium for all such policies issued during the year for which a deficit exists, the Association shall certify to the Commission the estimated amount of any remaining deficit for any year's policies. Within sixty days after such certification, the Commission shall authorize the Association to recover from the members their respective share of such deficit. No member insurer may be assessed in any year an amount greater than two percent of the member's direct gross premium income as defined in § 58.1-2500 from liability insurance for the calendar year preceding the assessment. If an assessment in any year is not sufficient to eliminate such deficit, a like assessment may be made the ensuing year but not thereafter.

2. A member shall be permitted to recover any assessment made by the Association under subdivision 1 of this subsection by deducting the member's share of the deficit from future premium taxes due the Commonwealth. The amount of premium tax deduction for each member's share of the deficit shall be apportioned by the Commission so that in the aggregate, the total premium tax deduction permitted for all members in any one taxable year shall not exceed 0.05 of one percent of the direct gross premium income for the liability insurance written by member insurers defined in subsection A of § 38.2-2901. To the extent that the said 0.05 of one percent is reached in any one taxable year, any amount not so offset may be carried over to a subsequent year or years.

G. In the event that sufficient funds are not available for the sound financial operation of the Association, subject to recoupment as provided in this chapter and the plan of operation, all members shall, on a temporary basis, contribute to the financial requirements of the Association in the manner provided in this chapter. The contribution shall be reimbursed to the members by the procedure set forth in subdivision 2 of subsection F of this section.

H. The Commission shall examine the business of the Association as often as it deems appropriate to make certain that the group retrospective premium adjustments are being calculated and applied in a manner consistent with this section. If the Commission finds that the group retrospective premium adjustments are not being made in a manner consistent with this section, it shall issue an order to the Association, specifying (i) how such calculation and application are not consistent and (ii) stating what corrective action shall be taken.

1988, cc. 769, 783.

§ 38.2-2906. Stabilization reserve fund.

A. When an Association is activated under this chapter, a stabilization reserve fund shall be created for the lines, subclassifications and types of commercial liability insurance for which such activation occurred. The fund shall be administered by five directors appointed by the Commission, one of whom

shall be a representative of the Commission, two of whom shall be representatives of the Association, and two of whom shall be representatives of the Association's policyholders.

B. The directors of the fund shall act by majority vote of those present with three directors constituting a quorum for the transaction of any business or the exercise of any power of the fund. The directors shall serve without salary, but each director shall be reimbursed for actual and necessary expenses incurred in the performance of his or her official duties as a director of the fund. The directors shall not be subject to any personal liability with respect to the administration of the fund.

C. Each policyholder shall pay to the Association a stabilization reserve fund charge equal to one-third of the annual premium due for commercial liability insurance obtained through the Association. The means of payment shall be set forth in the plan of operation and shall be separately stated in the policy. The Association shall cancel the policy of any policyholder who fails to pay the stabilization reserve fund charge. Upon the termination of any policy during the term of the policy, payments made to the stabilization reserve fund shall be returned to the policyholder on a pro rata basis identical to that applied in computing that portion of the premium which is returned to the policyholder.

D. All moneys received by the fund shall be held in a separate restricted cash account or accounts under the sole control of an independent fund manager to be selected by the directors of the fund. The fund manager shall account separately for the moneys paid to the fund for each year's policies written for a given line, subclassification or type of commercial liability insurance. The fund manager may invest the moneys held, subject to the approval of the directors. All investment income shall be credited to the fund. All expenses of administration of the fund shall be charged against the fund. The moneys held shall be used solely for the following purposes: (i) to reimburse the Association for any and all expenses, taxes, licenses and fees paid by the Association which are properly chargeable or allocable to the stabilization reserve fund, and (ii) to pay any retrospective premium adjustment charge levied by the Association. Payment of retrospective premium adjustment charges and other authorized payments shall be made by the directors of the fund upon certification to them by the Association of the amount due. If all moneys accruing to the fund for a particular year's policies for a given line, subclassification or type of commercial liability insurance are exhausted in payment of retrospective premium adjustment charges for the particular year, all liability and obligations of the holders of said policies with respect to the payment of retrospective premium adjustment charges shall terminate and shall be conclusively presumed to have been discharged.

E. The Association shall promptly pay the fund manager all stabilization reserve fund charges that it collects from its policyholders under subsection C of this section.

F. Upon dissolution of the Association, all assets remaining in the fund shall be distributed equitably to the policyholders who have contributed to the fund under procedures authorized by the directors. Distribution of assets remaining in the fund shall be made after final disposition of all claims, expenses, and liabilities against the fund, including reimbursement of preliminary organizational assessments made pursuant to subsection B of § 38.2-2904.

1988, cc. 769, 783.

§ 38.2-2907. Participation in Association by insurers.

Each insurer that is a member of the Association shall participate in the contributions to finance the operation of the Association in the proportion that the net direct premiums written by each member during the preceding calendar year bears to the aggregate net direct premiums written in this Commonwealth by all members of the Association. However, the net direct premiums written by each member shall exclude that portion of premiums attributable to the operation of the Association. Each insurer's participation in the Association shall be determined annually on the basis of such premiums written during the preceding calendar year in the manner set forth in the plan of operation.

1988, cc. 769, 783.

§ 38.2-2908. Review of actions or decisions of Association.

Any insurer, applicant or other person aggrieved by any action or decision of the Association or of any insurer as a result of its participation in the Association, may appeal to the board of directors of the Association. The decision of the board of directors may be appealed to the Commission within thirty days from the date the aggrieved person received notice of the board's action.

1988, cc. 769, 783.

§ 38.2-2909. Annual statements.

The Association shall file an annual statement with the Commission within three months of the close of each fiscal year. The annual statement shall contain information on its transactions, conditions, operations and affairs during the preceding fiscal year. The form and content of the annual statement shall be subject to the Commission's approval. The Commission may at any time require the Association to furnish additional information on its transactions, condition or any matter connected with the Association considered to be material and of assistance in evaluating the scope, operation and experience of the Association.

1988, cc. 769, 783.

§ 38.2-2910. Annual examination into affairs of Association.

The Commission shall examine the affairs of the Association at least annually. The examination shall be conducted and the report of the examination filed in the manner prescribed in §§ 38.2-1317 through 38.2-1321. The expenses of each examination shall be borne and paid by the Association.

1988, cc. 769, 783.

§ 38.2-2911. Public officers or employees.

No member of the board of directors of the Association or of the board of directors of the stabilization reserve fund who is a public officer or employee shall forfeit his office or employment, or incur any loss or diminution in the rights and privileges associated with his office or employment, because of membership on either board.

1988, cc. 769, 783.

§ 38.2-2912. Commissions for placing and servicing risk with Association.

For any policy issued by the Association, the commission payable to the person that places the risk with the Joint Underwriting Association or services the risk shall be limited to five percent of the annual premium for the policy or $1,000, whichever is less.

1988, cc. 769, 783.

§ 38.2-2913. Liability.

There shall be no liability imposed on the part of, and no civil cause of action of any nature shall arise against, the Association or the stabilization reserve fund, their boards of directors, agents, and employees; any service carrier or its employees; any participating insurer or its employees; any licensed producer; the Commission, its authorized representatives, members or employees; or any committee established by the Association's board of directors or its members or employees for any statements or actions made in good faith in carrying out the provisions of this chapter.

1988, cc. 769, 783.

Chapter 30 - UNINSURED MOTORISTS FUND

§ 38.2-3000. Supervision and control of Fund by Commission; payments from Fund.

The Uninsured Motorists Fund, referred to in this chapter as the Fund, shall be under the supervision and control of the Commission. Payments from the Fund shall be made on warrants of the Comptroller issued on vouchers signed by a person designated by the Commission. The purpose of the Fund is to reduce the cost of the insurance required by subsection A of § 38.2-2206.

Code 1950, § 12-65; 1958, c. 455, § 38.1-379.1; 1962, c. 253; 1971, Ex. Sess., c. 44; 1986, c. 562.

§ 38.2-3001. Distribution to insurers; records of loss experience as prerequisite to payment.

The Commission shall distribute moneys annually from the Fund among the several insurers writing motor vehicle bodily injury and property damage liability insurance on motor vehicles registered in this Commonwealth. Moneys shall be distributed in the proportion that each insurer's reported written car years bear to the total number of written car years reported for the preceding year by all insurers in this Commonwealth who have elected to participate in the distribution of the Fund. For purposes of this section, "written car years" means the number of motor vehicles insured by policies providing uninsured motorist coverage as required by subsection A of § 38.2-2206 during a twelve-month period. Only insurers that maintain records satisfactory to the Commission shall receive any payment from the Fund.

Code 1950, § 12-66; 1958, c. 455, § 38.1-379.2; 1962, c. 253; 1971, Ex. Sess., c. 44; 1986, c. 562; 2002, c. 145.

Chapter 31 - LIFE INSURANCE

Article 1 - General Provisions

§ 38.2-3100. Scope of chapter.

Except as otherwise provided, this chapter applies to insurers transacting life insurance and the granting of annuities, and to life insurance and annuities as defined in §§ 38.2-102 through 38.2-107.1.

1952, c. 317, § 38.1-431; 1986, c. 562; 1994, c. 316.

§ 38.2-3100.1. Forms of insurance authorized.

A. Life insurance and annuities shall be issued only in the following forms:

1. Individual life insurance and annuities; or

2. Group life insurance and annuities.

B. Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such regulations as may be necessary or appropriate to govern insurers' practices with regard to Acquired Immunodeficiency Syndrome (AIDS) or presence of the Human Immunodeficiency Virus (HIV), including advertising practices, underwriting practices, policy provisions, claim practices, or other practices with regard to individual or group life insurance and annuities, delivered or issued for delivery in the Commonwealth of Virginia and certificates or evidences of coverage, issued under any contract delivered or issued for delivery in the Commonwealth of Virginia.

1989, c. 653.

§ 38.2-3100.2. Funding agreements.

A. Any insurer that is licensed to write life insurance or annuities in the Commonwealth may deliver, or issue for delivery, funding agreements in the Commonwealth.

B. As used in this section "funding agreement" is inclusive but not limited to guaranteed investment contracts, guaranteed interest contracts, unallocated group contracts, investment contracts, or other similar instrument by whatever name, and means an agreement that authorizes the insurer to accept funds and that provides for an accumulation of funds for the purpose of making one or more payments in fixed or variable amounts, or in both, that are not based on mortality or morbidity contingencies.

C. Funding agreements may be issued to persons to fund (i) benefits under any employee benefit plan as defined in the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (3)) maintained in the United States or a foreign country; (ii) the activities of any organization exempt from taxation under section 501(c) of the Internal Revenue Code or any similar organization in any foreign country; (iii) any program of the government of the United States, the government of any state, foreign country, or political subdivision thereof; (iv) any agreement providing for one or more payments in satisfaction of a claim; (v) any program of any individual or entity that has assets in excess of $25,000,000; or (vi) any program of any individual or entity that is registered with the federal Securities and Exchange Commission.

D. Amounts paid to the insurer and proceeds applied under optional modes of settlement under a funding agreement may be allocated by the insurer to its general account and to one or more separate accounts. The assets of any such separate account shall not be chargeable with liabilities arising out of any other business that the insurer conducts. Where separate accounts are not chargeable with

liabilities arising out of any other business of the insurer, a risk charge shall be paid on not less than a quarterly basis from the respective separate account to the general account to provide appropriate compensation and to fund an appropriate reserve, if any, for the risks to the general account.

E. No licensed insurer shall make an agreement in the Commonwealth providing for the allocation of funding agreement amounts to a separate account until such insurer has filed with the Commission a statement as to its methods of operation of such separate account and the Commission has approved such statement. Subject to the approval of the Commission, any such statement may apply to one or more groups of separate accounts classified by investment policy, number or kinds of separate account participants, methods of distribution of such agreements or otherwise. In determining whether or not to approve any such statement, the Commission shall consider, among other things, the history, reputation and financial stability of the insurer and the character, experience, responsibility, competence, and general fitness of the officers and directors of the insurer. An amendment of any such statement that changes the investment policy of a separate account shall be treated as an original filing.

F. A funding agreement delivered or issued for delivery in the Commonwealth shall not qualify as or be considered to be life insurance, an annuity, or any other form of insurance defined and classified in Article 2 (§ 38.2-101 et seq.) of Chapter 1 of this title, but shall constitute transacting an insurance business in the Commonwealth.

G. For any funding agreement assets held in the insurer's general account, or for any other obligations due under the funding agreement from the insurer's general account, the funding agreement shall be treated as an insurance contract, and the holder of the funding agreement shall be entitled to the same priority of distribution as other policyholders for the purposes of clause (ii) of subdivision B 1 of § 38.2-1509.

H. Any domestic insurer that has established separate accounts in connection with funding agreements and has allocated funds to such separate accounts shall file with the Commission, in addition to the annual statement required by § 38.2-1300, any other periodic or special reports the Commission prescribes.

I. An insurer that has established a separate account pursuant to this section shall not transfer any assets to such separate account from any of its other accounts, including its general account, unless the transfer to such separate account is authorized by the Commission.

2004, c. 254; 2008, c. 216.

§ 38.2-3100.3. Requirements of life insurance or annuity contracts used to fund preneed funeral contracts.

A. For purposes of this section, "preneed funeral contract" means any agreement where payment is made by the insured prior to the receipt of services or supplies contracted for, which evidences arrangements prior to death for (i) the providing of funeral services or (ii) the sale of funeral supplies.

B. Each individual and group life insurance policy issued or issued for delivery in Virginia, each individual and group annuity contract issued or issued for delivery in Virginia, and each certificate issued in connection with a group life insurance policy or group annuity contract issued or issued for delivery in Virginia shall include a provision specifying the means by which face amount adjustments will be made and benefits payable upon death will be adjusted when such a policy or contract will be used to fund a preneed funeral contract.

C. Each insurer proposing to issue individual or group life insurance policies or individual or group annuity contracts in Virginia for purposes of funding preneed funeral contracts shall clearly disclose the intended purpose and market for such policies and contracts when submitting the forms with the Commission for approval, in accordance with § 38.2-316.

2009, c. 653; 2022, cc. 18, 641.

§ 38.2-3101. Legal reserve insurers.

Any life insurer, association or society whose policies or certificates are required to contain any provision that a person insured shall, upon surrender of the policy during his lifetime, receive a surrender value, either in cash, paid-up insurance, or extended insurance, shall be regarded as a "legal reserve insurer," and shall maintain a reserve calculated in accordance with the provisions of Article 10 (§ 38.2-1365 et seq.) of Chapter 13. Nothing in this section shall be construed to apply to any insurer in the transaction of industrial sick benefit insurance as defined in § 38.2-3544, nor to fraternal benefit societies.

Code 1950, § 38-389; 1952, c. 317, § 38.1-432; 1986, c. 562; 2014, c. 571.

§ 38.2-3102. Domestic insurers prohibited from insuring lives and persons of residents of "reciprocal states.".

A. As used in this section, "reciprocal state" means a state whose laws prohibit its domestic insurers from insuring the lives or persons of residents of this Commonwealth unless the insurer is licensed in this Commonwealth. The prohibition may be subject to exceptions similar to those set forth in subsection C of this section.

B. Subject to the exceptions set forth in subsection C of this section, a domestic insurer shall not enter into an insurance contract upon the life or person of a resident of a reciprocal state unless the insurer is licensed in that state.

C. The following are exceptions to the provisions of subsection B of this section:

1. Contracts entered into when the person insured, or proposed to be insured, is, at the time he signs the application, personally present in a state where the insurer is licensed;

2. Certificates issued under any lawfully issued group life or group accident and sickness policy, when the group policy is entered into in a state where the insurer is licensed;

3. Contracts made pursuant to a pension or retirement plan of an employer, when the contracts are applied for in a state where the employer is personally present or doing business and where the insurer is also licensed; or

4. Contracts renewed, reinstated, converted, or continued in force, with or without modification, that are otherwise lawful and that were not originally executed in violation of this section.

Code 1950, § 38-364; 1952, c. 317, § 38.1-433; 1986, c. 562.

§ 38.2-3103. Fraudulent procurement of policy; penalty.

A. No person shall knowingly secure, attempt to secure or cause to be secured a life insurance policy on any person who is not in an insurable condition by means of misrepresentations or false or fraudulent statements.

B. An insurance agent who violates this section shall be subject to penalties under § 38.2-1831 in addition to the penalties of § 38.2-218.

Code 1950, § 38-369; 1952, c. 317, § 38.1-434; 1986, c. 562.

§ 38.2-3104. No policy to be issued purporting to take effect more than six months before application made; conversion permitted.

A. No life insurance policy delivered or issued for delivery in this Commonwealth shall be backdated more than six months from the date the written application for the insurance was made if the premium on the policy is less than the premium that would be payable on the policy, as determined by the nearest birthday of the insured when the application was made.

B. Neither the provisions of subsection A of this section nor any other provision of general law shall prohibit the conversion or exchange to some form of life insurance dated back to become effective at an age not less than the insured's age at his nearest birthday on the date of issue of the existing contract for:

1. A policy insuring one person for a policy insuring another person dated not earlier than the original policy exchanged;

2. The conversion of any existing life insurance policy; or

3. Any deferred annuity contract purchased by a consideration payable in annual or more frequent installments, and under which no annuity payments have yet been made.

The exchanged or converted form of life insurance shall not exceed the greater of (i) the amount of insurance under the existing policy or (ii) the amount of insurance that the premium or consideration paid for the existing policy or contract would have purchased at the insured's age on his nearest birthday at the date of issue of the existing policy or contract.

Code 1950, § 38-363; 1952, c. 317, § 38.1-435; 1956, c. 417; 1980, c. 205; 1986, c. 562.

§ 38.2-3105. What contracts with respect to life insurance may be made by minors.

A. A minor who is at least fifteen years of age:

1. Shall be competent to contract for life insurance upon his own life for his own benefit or for the benefit of his ascending or descending kindred, spouse, brothers or sisters;

2. May exercise every right, privilege and benefit provided by any life insurance policy on his own life, subject to the foregoing limitations as to designation of beneficiary; and

3. Shall not be permitted to recover any premiums paid on the policy solely because he is a minor.

B. If the minor resides with at least one of his parents, the application for the policy shall be approved in writing by the parent with whom he resides. No promissory note or other evidence of debt given by a minor in payment of any first year premium on a policy shall be validated by this section.

C. Any such minor shall be competent to give a valid discharge for any benefit accruing or money payable under the policy, and to create liens on the policy in favor of the insurer issuing the policy for money borrowed or for unpaid premiums and interest on the policy. However, any beneficiary or beneficiaries named in the policy who are then at least fifteen years of age shall unite in the discharge or in the instrument creating the lien.

Code 1950, § 38-10; 1952, c. 317, § 38.1-436; 1960, c. 31; 1986, c. 562.

§ 38.2-3106. Suicide and execution not grounds of defense; exception.

A. Except as provided in subsection B of this section, the fact that an insured committed suicide, or was executed under law, shall not be a defense in any action, motion or other proceeding on a life insurance policy that (i) was issued to any person residing in this Commonwealth at the time of issuance, or (ii) is otherwise subject to the laws of this Commonwealth, to recover for the death of that person.

B. An express provision in the body of the policy limiting the liability of the insurer to an insured who, whether sane or insane, dies by his own act within two years from the date of the policy shall be valid but the insurer shall be obligated to return or pay at the least the amount of the premium paid for the policy.

Code 1950, § 38-365; 1952, c. 317, § 38.1-437; 1986, c. 562.

§ 38.2-3107. Incontestability of certain policies.

A. No life insurance policy shall be contestable after it has been in force during the lifetime of the insured for two years from its date, except for nonpayment of premiums.

B. Provisions relating to benefits in event of disability, and provisions granting additional insurance specifically against death by accident or accidental means may be exempted in an incontestability provision.

Code 1950, § 38-366; 1952, c. 317, § 38.1-438; 1962, c. 139; 1986, c. 562.

§ 38.2-3108. Misstatement of age.

Each life insurance policy shall contain a provision that, if at any time before final settlement under the policy the age of the insured, or the age of any other person if considered in determining the premium,

is found to have been misstated, the amount payable under the policy shall be the amount that the premium would have purchased at the correct age at the time the policy was issued.

Code 1950, § 38-366; 1952, c. 317, § 38.1-439; 1986, c. 562.

§ 38.2-3109. Contestability of reinstated policy.

Reinstatement of a life insurance policy shall not affect the running of the contestable period except as provided in this section. A life insurance policy reinstated after July 1, 1986, regardless of whether the original policy was issued before or after July 1, 1986, shall be contestable on account of fraud or misrepresentation of any material fact pertaining to the reinstatement contained in a written application for reinstatement, or in any written statement supplemental to the application for reinstatement, only for the same period after reinstatement as the policy provides for contestability after original issue.

Code 1950, § 38-366.1; 1950, p. 181; 1952, c. 317, § 38.1-440; 1986, c. 562.

§ 38.2-3110. Incontestability not applicable to excluded or restricted coverage.

Any life insurance policy provision stating that the policy shall be incontestable after a specified period shall preclude only a contest of the validity of the policy, and shall not preclude the assertion at any time of defenses based upon provisions in the policy that exclude or restrict coverages, whether or not those restrictions or exclusions are excepted in the incontestability provision.

1952, c. 317, § 38.1-441; 1986, c. 562.

§ 38.2-3111. Assignment of life insurance policies.

No life insurance policy shall be taken out by the insured or by a person having an insurable interest in the insured's life for the mere purpose of assignment. A policy may be assigned whether or not the assignee has an insurable interest in the life insured unless the policy provides otherwise.

Code 1950, § 38-367; 1952, c. 317, § 38.1-442; 1962, c. 590; 1986, c. 562.

§ 38.2-3111.1. Annuity contract purchased to fund retirement benefits; transfer subject to Commission approval.

A. As used in this section:

"Employer" means a person doing business in or operating within the Commonwealth who employs a resident of the Commonwealth to work for wages or a salary or on commission and includes any similar entity acting directly or indirectly in the interest of an employer in relation to an employee. "Employer" does not include the Commonwealth or any of its agencies, institutions, or political subdivisions or any public body.

"Pension plan" has the same meaning ascribed to that term in § 3(2) of ERISA.

"Retirement annuity contract" means an allocated or unallocated group annuity contract that is issued or issued for delivery by an insurer to an employer or a pension plan, pension plan sponsor, or affiliate of such employer, pension plan, or pension plan sponsor, for the purpose of providing retirement benefits to employees or retirees of the employer under a defined benefit plan and that (i) is issued or issued for delivery in the Commonwealth or (ii) affects retired employees residing in the

Commonwealth who are certificate holders or beneficiaries of a contract if the Commission has jurisdiction over the insurer issuing the contract.

B. On or after July 1, 2018, no retirement annuity contract shall be transferred to or assumed by another insurer unless:

1. The transfer is made to an assuming insurer that has a rating equivalent of A or better from two or more nationally recognized rating agencies; or

2. The transfer to the assuming insurer is approved by the Commission, which approval shall not be granted unless the assuming insurer meets all of the requirements of § 38.2-1024.

C. If the Commission determines that an insurer has violated this section or any order or regulation adopted hereunder, the Commission, after notice and opportunity to be heard, may impose a penalty in accordance with §§ 38.2-218 and 38.2-219.

2018, c. 847.

§ 38.2-3112. Designation of testamentary trustee as beneficiary.

A. A life insurance policy may designate as beneficiary a trustee or trustees named or to be named by will if the designation is made in accordance with the provisions of the policy and the requirements of the insurer issuing the policy.

B. A trustee may qualify immediately after probate of the will. Upon appointment and qualification of a trustee, the proceeds of the insurance shall be paid to the trustee to be held and disposed of under the terms of the will. If there is no valid will appointing a trustee or if the trust provided by the will is invalid for any other cause, the designation of a trustee as beneficiary of the policy shall be void. If no qualified trustee makes claim to the proceeds from the insurer within one year after the death of the insured, or if satisfactory evidence is furnished to the insurer within the one-year period showing that no trustee can qualify to receive the proceeds, payment shall be made by the insurer to the executors, administrators or assigns of the insured, unless otherwise provided for by the owner of the policy, if the owner is other than the insured, or by the insured by agreement with the insurer.

C. The proceeds of the insurance as collected by a trustee shall not be subject to debts of the insured nor to estate taxes to any greater extent than if the proceeds were payable to any other named beneficiary other than the estate of the insured.

D. For purposes of trust administration, the proceeds shall be subject to the court's jurisdiction over the trust as in any other testamentary trust, but the proceeds shall not be considered as payable to the estate of the insured.

E. This section does not authorize payment of policy proceeds to any testamentary trustee who is not otherwise qualified to act as a testamentary trustee. A qualified substitute trustee may be appointed to perform the trust provided by the will.

F. Enactment of this section shall not be construed as casting any doubt upon the validity of any previous life insurance policy beneficiary designations naming trustees of a trust established or to be established by will.

G. As used in this section, "life insurance policy" shall include other types of contracts under which proceeds become payable on the death of the testator to the end that interests other than those described as "life insurance" may be made payable or transferred to a trustee named or to be named in a will in the same manner and to the same extent they could be made payable to or transferable to any other person.

1968, c. 524, § 38.1-408.1; 1968, c. 553, § 38.1-442.1; 1986, c. 562.

§ 38.2-3113. Variable life insurance and variable annuities; separate accounts to be established; authority to issue; reports; special voting rights and procedures for owners.

A. Each domestic insurer that issues life insurance or annuities providing for payments that vary directly according to investment experience shall establish one or more separate accounts in connection with these types of life insurance or annuities. All amounts received by the insurer that are required by contract to be applied to provide for variable payments shall be added to the appropriate separate account. The assets of any such separate account shall not be chargeable with liabilities arising out of any other business the insurer may conduct. Any surplus or deficit that may arise in any separate account by virtue of mortality experience shall be adjusted by withdrawals from or additions to the account so that the assets of the account shall always at least equal the assets required to satisfy the insurer's obligations for the variable payments.

B. A foreign or alien insurer licensed to do business in this Commonwealth may be licensed to deliver or issue for delivery life insurance or annuity contracts in this Commonwealth providing for payments which vary directly according to investment experience only if authorized to issue such life insurance or annuity contracts under the laws of its domicile.

C. No domestic, foreign, or alien insurer shall be licensed to deliver or issue for delivery variable life insurance or variable annuity contracts in this Commonwealth, until the insurer has satisfied the Commission that its condition and methods of operation in connection with the issuance of variable life insurance or variable annuity contracts will not render its operation hazardous to the public or to its policyholders in this Commonwealth. In determining the qualification of an insurer to deliver or issue for delivery such variable life insurance or variable annuity contracts in this Commonwealth, the Commission shall consider, but shall not be limited to considering, the following: (i) the history and financial condition of the insurer; (ii) the character, responsibility, and general fitness of the officers and directors of the insurer; and, (iii) in the case of a foreign or alien insurer, whether the regulation provided by the laws of its domicile provides a degree of protection to policyholders and the public substantially equal to that provided by this section and any rules and regulations issued by the Commission.

D. Each insurer that delivers or issues for delivery variable life insurance or variable annuity contracts in this Commonwealth shall file with the Commission, in addition to the annual statement required by § 38.2-1300, any other periodic or special reports the Commission prescribes.

E. The provisions of this section shall not apply to any contracts or policies which do not provide for payments which vary directly according to investment experience.

F. Any domestic life insurer that establishes one or more separate accounts pursuant to this section may amend its charter to provide for special voting rights and procedures for the owners of variable life insurance or variable annuity contracts relating to investment policy, investment advisory services and selection of certified public accountants, in relation to the administration of the assets in any such separate account. This subsection shall not in any way affect existing laws pertaining to the voting rights of the insurer's policyholders.

1966, c. 289, § 38.1-443; 1976, c. 562; 1986, c. 562.

§ 38.2-3113.1. Modified guaranteed life insurance and modified guaranteed annuities; separate accounts; authority to issue; statements required; regulations to be issued; approval expenses.

A. For purposes of this section, "modified guaranteed contracts" means modified guaranteed life insurance or modified guaranteed annuity contracts. The provisions of this section apply only to such contracts.

B. A domestic insurer that issues modified guaranteed contracts may establish one or more separate accounts in connection with these types of contracts. All amounts received by the insurer to provide benefits under contracts for which separate accounts have been established shall be added to the appropriate separate account. Unless provided otherwise in the contract and approved by the Commission in its discretion, the assets of any such separate account shall be chargeable with liabilities arising out of any other business the insurer may conduct.

C. A foreign or alien insurer licensed to do business in this Commonwealth may be licensed to deliver or issue for delivery modified guaranteed contracts in this Commonwealth only if authorized to issue such contracts under the laws of its domicile.

D. No domestic, foreign, or alien insurer shall be licensed to deliver or issue for delivery modified guaranteed contracts in this Commonwealth, until the insurer has satisfied the Commission that its condition and methods of operation in connection with the issuance of modified guaranteed contracts will not render its operation hazardous to the public or to its policyholders in this Commonwealth. In determining the qualifications of an insurer to deliver or issue for delivery such modified guaranteed contracts in this Commonwealth, the Commission shall consider, but shall not be limited to considering, the following: (i) the history and financial condition of the insurer; (ii) the character, responsibility, and general fitness of the officers and directors of the insurer; and (iii) in the case of a foreign or alien insurer, whether the regulation provided by the laws of its domicile provides a degree of protection to policyholders and the public substantially equal to that provided by this section and any rules and regulations issued by the Commission.

E. Each insurer that has established any separate accounts in connection with modified guaranteed contracts, and delivers or issues for delivery modified guaranteed contracts in this Commonwealth shall file with the Commission, in addition to the annual statement required by § 38.2-1300, any other periodic or special reports the Commission prescribes.

F. Any modified guaranteed contract delivered or issued for delivery in this Commonwealth, and any certificate evidencing nonforfeiture benefits that vary according to a market-value adjustment formula issued pursuant to any life insurance or annuity contract issued on a group basis shall (i) contain, on its first page, a prominent statement that the nonforfeiture values may increase or decrease, based on the market-value adjustment formula in the contract, and (ii) for modified guaranteed life insurance only, be accompanied by a written disclosure to the purchaser of the policy's "interest adjusted net cost index" in compliance with regulations or forms approved by the Commission.

G. The Commission may promulgate reasonable regulations applicable to modified guaranteed contracts and to any separate accounts that may be established in connection with such contracts.

H. Reasonable actuarial expenses incurred in connection with approval of a modified contract shall be paid by the person seeking approval of such a contract.

1992, c. 210.

§ 38.2-3113.2. Qualified charitable gift annuities; issuance not business of insurance; disclosures to donors; unfair trade practices provisions not applicable.

A. The issuance of a qualified charitable gift annuity does not constitute engaging in the business of insurance in this Commonwealth. A charitable gift annuity issued before the effective date of this section is a qualified charitable gift annuity for purposes of this title if it meets the requirements of § 501 (m) (5) of the Internal Revenue Code of 1986 (26 U.S.C. § 501 (m) (5)) and § 514 (c) (5) of the Internal Revenue Code of 1986 (26 U.S.C. § 514 (c) (5)), and the issuance of that charitable gift annuity does not constitute engaging in the business of insurance in this Commonwealth.

B. When entering into an agreement for a qualified charitable gift annuity, the charitable organization shall disclose to the donor in writing in the annuity agreement that a qualified charitable gift annuity is not insurance under the laws of this Commonwealth and is neither subject to regulation by the Commission nor protected by the Virginia Life, Accident and Sickness Insurance Guaranty Association. The notice provisions required by this subsection shall be in a separate paragraph in a print size no smaller than that employed in the annuity agreement generally.

C. The solicitation or issuance of a qualified charitable gift annuity does not constitute a violation of the unfair trade practices provisions of Chapter 5 (§ 38.2-500 et seq.) of this title.

1996, c. 425.

§ 38.2-3113.3. Educational loan provisions in life insurance policies.

Educational loan provisions may be included as additional benefits, as part of the policy, or as a rider or as a separate agreement, subject to the following requirements:

1. Any and all necessary eligibility qualifications for an educational loan shall be specified in the life insurance policy, rider or separate agreement. The policy, rider or separate agreement shall also state clearly that the loan will be granted provided the covered individual applying for such loan has satisfied the stated qualifications. Loan eligibility qualifications shall not be more restrictive than the following:

a. The loan applicant is a covered individual under the life insurance policy;

b. The purpose of the loan is to provide funds for a covered individual under the policy, rider or separate agreement, or the dependent of a covered individual under the policy, rider or separate agreement to attend an institution of higher education, a trade school, or a technical school. As used in this section, an "institution of higher education" shall not be defined more restrictively than an accredited institution of higher education that is approved by the U.S. Department of Education. Age eligibility of the individual for whom the educational loan will be used may be limited to an age range no less restrictive than age 15 to age 25, subject to continued life insurance coverage of the covered individual during this duration; and

c. The individual for whose education the loan will be used must attend a qualifying institution at least halftime, determined in a manner consistent with the institution's standards for establishing full-time and half-time attendance, and must maintain an academic record sufficient to demonstrate reasonable progression or advancement.

2. The amount of funds available for an educational loan shall be specified in the policy, rider or separate agreement, and shall be further limited to an amount not to exceed the actual cost of the school or institution during any given year of attendance less other aid received. If the amount available for the educational loan varies by the year of attendance in the school or institution, this shall be so stated and a schedule of annual loan availability by dollar amount shall be included in the policy, rider or separate agreement.

3. The terms of the loan shall be clearly stated in the policy or rider, or the policy or rider shall refer to the availability of a separate document specifying all loan terms upon request of any insured individual. If the terms of the loan are included in a separate document, such document must be filed with the Commission for review. For purposes of this section, "terms of the loan" include, but are not limited to, (i) any and all fees, charges, and interest rates applied to borrowed funds, including a clear statement concerning possible fluctuation of such fees and charges depending upon the applicant's credit worthiness and/or depending upon any sources or indices used to determine such fees, charges or interest rates, (ii) minimum monthly payments, (iii) maximum amount of years for loan repayment, and (iv) policy assignment, if applicable.

4. Any life insurance policy, rider or separate agreement providing for educational loans shall include a prominent disclosure advising the reader of the prudence of obtaining information about educational loans from a variety of sources before making any decision about borrowing funds for financing higher education.

5. No policy, rider or separate agreement providing for educational loans shall be delivered or issued for delivery in this Commonwealth unless a copy of the form has been filed with and approved by the Commission in accordance with § 38.2-316. No advertising material shall be used in the solicitation or promotion of the educational loan feature of a life insurance policy, rider or separate agreement until such material has been filed with and approved by the Commission in the same manner as is required for forms pursuant to § 38.2-316.

2000, c. 173.

§ 38.2-3114. Statements required in variable life insurance and variable annuity contracts and certificates issued pursuant to group variable life insurance and group variable annuity contracts.

Any variable life insurance or variable annuity contract delivered or issued for delivery in this Commonwealth, and any certificate evidencing variable benefits issued pursuant to any life insurance or annuity contract issued on a group basis shall:

1. State the essential features of the procedure to be followed by the insurer in determining the value of benefits or other contractual payments under the contract;

2. State clearly that the benefits may decrease or increase according to the procedure; and

3. State clearly on its first page that the benefits or other contractual payments are on a variable basis.

1966, c. 289, § 38.1-408; 1976, c. 562; 1986, c. 562.

§ 38.2-3115. Interest on life insurance and annuity contract proceeds.

A. If an action to recover the proceeds due under a life insurance policy or annuity contract results in a judgment against the insurer, interest on the judgment at the legal rate of interest shall be paid from (i) the date of presentation to the insurer of proof of death on a life insurance policy or annuity contract or (ii) the date of maturity of an endowment policy to the date judgment is entered.

B. If no action is brought, interest upon the principal sum paid to the beneficiary or policyowner shall be computed daily at an annual rate of two and one-half percent or at the annual rate currently paid by the insurer on proceeds left under the interest settlement option, whichever is greater, commencing (i) from the date of death on a life insurance policy or annuity contract claim; (ii) from the date of receipt of a completed claim form on a variable annuity contract claim; or (iii) from the date of maturity of an endowment contract to the date of payment. The interest shall be added to and become a part of the total sum payable.

C. No insurer shall be required to pay interest computed under this section if the total interest is less than five dollars.

D. This section shall not apply to (i) credit life insurance for which the premium is paid wholly from funds of the creditor with no specific identifiable charge being made to insureds for the insurance and upon which post-death interest on the indebtedness is waived by the creditor in an amount at least equal to the amount of interest that would otherwise be payable under this section; (ii) credit life insurance payable in whole or in part to a creditor that is an affiliate, as defined in § 13.1-725, of the insurer

and that does not charge interest on the indebtedness from the date of death of the insured; or (iii) policies or contracts issued prior to July 1, 1977, but shall apply to any renewals or reissues of group life insurance policies or contracts occurring after that date.

1977, c. 264, § 38.1-443.1; 1986, c. 562; 1991, c. 368; 2006, c. 209; 2014, cc. 155, 411.

§ 38.2-3115.1. Accelerated payment of benefits.

A. Except as set forth in subsection C of this section, each insurer issuing a life insurance policy in the Commonwealth may include a policy provision for accelerated payment of benefits to the insured during the lifetime of the insured:

1. If a qualified health care provider or court of competent jurisdiction has determined that the insured is no longer able to perform two of the following activities of daily living: (i) bathing, (ii) dressing, (iii) continence, (iv) eating, (v) toileting, or (vi) transferring; or

2. If a qualified health care provider or court of competent jurisdiction has determined that the insured requires substantial supervision by another person to protect the health and safety of the insured or any other person.

B. The Commission shall adopt appropriate rules and regulations to carry out the intent of this section, and such rules and regulations may also provide for additional options for the accelerated payment of benefits under any other conditions deemed appropriate by the Commission.

C. This section shall not apply to (i) credit life insurance issued pursuant to Chapter 37.1 (§ 38.2-3717 et seq.) of this title, or (ii) policies or contracts issued prior to July 1, 2002, but shall apply to any renewals or reissues of group life insurance policies or contracts occurring after that date.

2002, c. 343.

§ 38.2-3116. Commission to establish standards for simplified and readable life insurance and annuity policies.

A. Pursuant to the authority granted under § 38.2-223, the Commission may issue rules and regulations establishing standards for simplified and readable life insurance policies and annuity contracts. The standards shall apply to all policy forms for annuities as defined in §§ 38.2-106 and 38.2-107 and life insurance as defined in §§ 38.2-102 through 38.2-105.

B. As used in this section, "policy form" means:

1. Any individual life insurance policy, plan or agreement, and any annuity contract delivered or issued for delivery in this Commonwealth;

2. Any policy, certificate or contract, including any riders, endorsements or amendments providing death benefits, delivered or issued for delivery in this Commonwealth by a fraternal benefit society;

3. Any group life insurance policy, contract, plan or agreement, including any riders, endorsements or amendments, delivered or issued for delivery in this Commonwealth, to a group with ten or fewer members; or

4. Any certificate, including any riders, endorsements or amendments, issued under a group life insurance policy delivered or issued for delivery in this Commonwealth.

C. No insurer shall issue a life insurance policy that has been filed with the Commission unless the Commission has determined that the policy form satisfies the readability standards established by the rules and regulations and complies with other statutory requirements.

1986, c. 562.

§ 38.2-3117. Standards for certain policies; prohibited policies.

A. Pursuant to the authority granted under § 38.2-223, the Commission may issue rules and regulations that may include but shall not be limited to policy provisions, definitions, standards for full and fair disclosure and standards for minimum benefits, for variable life insurance policies, universal life insurance policies or other nontraditional types of life insurance policies, annuities and variable annuities.

B. The Commission may prescribe the method of identification of policies and contracts based upon coverage provided.

C. The Commission may issue rules and regulations that specify prohibited policies or policy provisions not otherwise specifically authorized by statute which in the opinion of the Commission are unjust, unfair or unfairly discriminatory to the policyholder, beneficiary, owner, or any other person insured under the policy.

1986, c. 562.

§ 38.2-3117.01. Provision of life insurance information upon notification of insured's death.

Upon receipt of a request for information regarding a deceased person's life insurance policy from a funeral service provider that complies with § 54.1-2818.5, a life insurer doing business in the Commonwealth may provide certain information to the funeral service provider regarding the existence of any life insurance policy issued by the insurer or any affiliated insurer insuring the life of the deceased person identified in the request. The information may include the names and contact information, if available, of any beneficiaries on record under any such policy insuring such life. Nothing in this section shall require a life insurer to provide information that is confidential or protected from disclosure under applicable state or federal law. A life insurer may respond to such a request for information in a manner that is consistent with the terms of any applicable life insurance policy and the life insurer's administrative practices and procedures.

2017, c. 482.

Article 1.1 - USE OF RETAINED ASSET ACCOUNTS

§ 38.2-3117.1. Definitions.

As used in this article, unless the context requires a different meaning:

"Insurer" means an insurance company licensed in the Commonwealth that offers retained asset accounts for death benefits.

"Policy" means any policy or certificate of insurance that provides a death benefit.

"Retained asset account" means any mechanism whereby the settlement of proceeds payable under a life insurance policy is accomplished by the insurer or an entity acting on behalf of the insurer depositing the proceeds into an account with check or draft writing privileges where those proceeds are retained by the insurer pursuant to a supplementary contract not involving annuity benefits.

2011, cc. 194, 227.

§ 38.2-3117.2. Explanation of settlement options.

The insurer shall provide the beneficiary, at the time a claim is made, written information describing the settlement options available under the policy and how to obtain specific details relevant to the options.

2011, cc. 194, 227.

§ 38.2-3117.3. Supplemental contract.

If the insurer settles benefits through a retained asset account, the insurer shall provide the beneficiary with a supplemental contract that clearly discloses the rights of the beneficiary and the obligations of the insurer under the supplemental contract.

2011, cc. 194, 227.

§ 38.2-3117.4. Disclosures for retained asset accounts to beneficiaries.

The insurer shall provide the following written disclosures to the beneficiary of a policy before the retained asset account is selected, if optional, or established, if not optional:

1. Payment of the full benefit amount is accomplished by delivery of the draft book or check book;

2. One draft or check may be written to access the entire amount, including interest, of the retained asset account at any time;

3. Whether other available settlement options are preserved until the entire balance is withdrawn or the balance drops below the insurer's minimum balance requirements;

4. A statement identifying the account as either a checking account or a draft account and an explanation of how the account works;

5. Information about the account services provided and contact information where the beneficiary may request and obtain more details about such services;

6. A description of fees charged, if applicable;

7. The frequency of statements showing the current account balance, the interest credited, drafts or checks written, and any other account activity;

8. The minimum interest rate to be credited to the account and how the actual interest rate will be determined;

9. The interest earned on the account may be taxable;

10. Retained asset account funds held by insurance companies are not insured by the Federal Deposit Insurance Corporation but are guaranteed by the state guaranty association. The beneficiary should be advised to contact the National Organization of Life and Health Insurance Guaranty Associations via the association's website to learn more about the coverage limitations to the account under a state guaranty association; and

11. A description of the insurer's policy regarding retained asset accounts that become inactive.

2011, cc. 194, 227.

Article 2 - PROCEEDS OF CERTAIN POLICIES

§ 38.2-3118. Spendthrift trusts created under life insurance policies.

If, under the terms of any life insurance policy or of any written agreement supplemental to a life insurance policy, the proceeds are retained by the insurer at maturity or otherwise, no person entitled to any part of the proceeds, or to any installment of interest due or becoming due, may commute, anticipate, encumber, alienate or assign the proceeds or any part of the proceeds or interest if permission is expressly withheld by the terms of the policy or supplemental agreement. If the life insurance policy or supplemental agreement provides, no payments of interest or principal shall be in any way subject to the person's debts, contracts or engagements, nor to any judicial process to levy upon or attach the interest or principal for payment of those debts, contracts, or engagements.

Code 1950, § 38-115; 1952, c. 317, § 38.1-444; 1986, c. 562.

§ 38.2-3119. Limitation on § 38.2-3118.

A. The provisions of § 38.2-3118 shall not apply to any proportionate part of the proceeds of any such policy or supplemental contract mentioned in § 38.2-3118 arising or resulting from premiums paid by the beneficiary. The proportionate part of the proceeds shall be determined by comparing the total premiums paid for the policy, without interest, with the premiums for the policy, without interest, paid by the beneficiary.

B. Notwithstanding the other provisions of this section, an insurer who (i) has no written notice of any claim that premiums have been paid by the beneficiary and (ii) has no written notice of an adverse claim of any other character under this section, shall be protected in making or withholding payments pursuant to the terms of a policy or supplemental agreement.

C. Notwithstanding the other provisions of this section, upon an insurer's acceptance of proof that premiums have been paid by the beneficiary and the insurer's payment of the corresponding proportionate part of the proceeds of the policy or supplemental agreement, the insurer's payment shall constitute full release of the insurer from all liability with respect to the proportionate part of the proceeds of the policy or supplemental agreement.

Code 1950, § 38-116; 1952, c. 317, § 38.1-445; 1986, c. 562.

§ 38.2-3120. Repealed.

Repealed by Acts 2005, c. 935, cl. 3, effective July 1, 2006.

§ 38.2-3121. Segregation of proceeds not required.

No insurer holding the proceeds of any policy mentioned in § 38.2-3118 shall be required to segregate the proceeds but may hold them as a part of its general corporate funds.

Code 1950, § 38-118; 1952, c. 317, § 38.1-447; 1986, c. 562.

§ 38.2-3122. Proceeds and avails of life insurance policies and annuity contracts free of certain claims.

A. As used in this section, "protected insurance item" means, with respect to a policy of life insurance or annuity issued or issued for delivery in the Commonwealth:

1. The cash surrender value of any such policy;

2. The proceeds of any such policy;

3. The withdrawal value of any optional settlement or deposit with any company made pursuant to the terms of such policy; or

4. All other benefits, indemnities, payments, and privileges of every kind from any such policy.

B. In no case whatsoever shall any protected insurance item be liable to execution, attachment, garnishment, or other legal process in favor of any creditor of:

1. The person whose life is insured by the related policy or contract;

2. The person who can, may, or will receive the benefit of that protected insurance item, provided that such person is the insured or owner of the contract, deposit, indemnity, policy, or settlement or the spouse or intended spouse of, a dependent child of, or any other person dependent on, the insured or owner of the contract, deposit, indemnity, policy, or settlement;

3. The person who owns the related contract, deposit, or policy; or

4. The person who effected the related contract, deposit, or policy.

C. The provisions of subsection B shall not apply to any claim by a creditor with respect to a life insurance policy, annuity contract, or deposit with an insurance company that was taken out, made, or assigned in writing for the benefit of the creditor.

D. Notwithstanding the provisions of subsection B and subject to the applicable statute of limitations, the amount of any premiums or other amounts paid for the related life insurance policy, annuity contract, or deposit with an insurance company that were paid with the intent to defraud creditors, with the interest thereon, shall inure to the benefit of the creditors from the proceeds of the policy, contract, or deposit.

E. The exemption provided by this section shall not apply to any protected insurance item issued or effected during the six months preceding the date that the person claiming the exemption (i) files a voluntary petition in bankruptcy; (ii) becomes the subject of an order for relief or is declared insolvent in any federal or state bankruptcy or insolvency proceeding; or (iii) files a petition or answer seeking for himself any reorganization, arrangement, composition, readjustment, liquidation, dissolution, or similar relief under any statute, law, or regulation.

F. The exemption established by this section shall apply to a protected insurance item regardless of whether (i) the right to change the beneficiary thereof is reserved or permitted or (ii) any of the following persons or any of their estates is a contingent beneficiary thereof:

1. The person insured by the related life insurance policy;

2. The person effecting the related life insurance policy or annuity contract;

3. The annuitant of the related annuity contract; or

4. The owner of the related life insurance policy or annuity contract.

Code 1950, § 38-119; 1952, c. 317, § 38.1-448; 1986, c. 562; 2016, c. 274.

§ 38.2-3122.1. Annuity contract purchased to fund retirement benefits; protection from creditor's claims.

A. As used in this section:

"Employer" means a person doing business in or operating within the Commonwealth who employs another to work for wages or a salary or on commission and includes any similar entity acting directly or indirectly in the interest of an employer in relation to an employee. "Employer" does not include the Commonwealth or any of its agencies, institutions, or political subdivisions or any public body.

"ERISA" means the federal Employee Retirement Income Security Act of 1974 (P.L. 93-406, 88 Stat. 829), as amended.

"Pension plan" has the same meaning ascribed to that term in § 3(2) of ERISA.

B. Any interest in or amounts payable to a participant or beneficiary from any allocated or unallocated group annuity contract issued or issued for delivery in the Commonwealth to an employer or a pension plan for the purpose of providing retirement benefits to employees or retirees of the employer under a defined benefit plan, which retirement benefits were protected under ERISA or the Federal Pension Benefit Guaranty Corporation prior to the effective date of the group annuity contract and will not be protected under ERISA or the Federal Pension Benefit Guaranty Corporation on and after the effective date of the group annuity contract, shall be exempt from the claims of all creditors of such participant or beneficiary.

C. The exemption from the claims of creditors provided under subsection B shall not apply to claims arising under a qualified domestic relations order.

D. The exemption from the claims of creditors provided under subsection B shall not apply to any claim by a creditor with respect to an annuity contract that was taken out, made, or assigned in writing for the benefit of the creditor.

E. Notwithstanding the provisions of subsection B and subject to the applicable statute of limitations, the amount of any premiums or other amounts paid for the related annuity contract that were paid with the intent to defraud creditors, with the interest thereon, shall inure to the benefit of the creditors from the proceeds of the policy, contract, or deposit.

F. The exemption provided by this section shall not apply to any protected annuity contract issued or effected during the six months preceding the date that the person claiming the exemption (i) files a voluntary petition in bankruptcy; (ii) becomes the subject of an order for relief or is declared insolvent in any federal or state bankruptcy or insolvency proceeding; or (iii) files a petition or answer seeking for himself any reorganization, arrangement, composition, readjustment, liquidation, dissolution, or similar relief under any statute, law, or regulation.

2018, c. 847.

§ 38.2-3123. Repealed.

Repealed by Acts 2018, c. 304, cl. 2.

§ 38.2-3124. Protection of insurers from creditor's claims.

Notwithstanding § 38.2-3122, any insurer issuing any insurance policy shall be discharged of all liability on that policy by payment of its proceeds in accordance with its terms, unless before payment the insurer receives written notice by or on behalf of a creditor of a claim, stating the amount claimed and the nature of the claim.

Code 1950, § 38-121; 1952, c. 317, § 38.1-450; 1986, c. 562; 2018, c. 304.

§ 38.2-3125. Other rights of beneficiaries and assignees protected.

Since the purpose of §§ 38.2-3122 and 38.2-3122.1 is to confer additional rights, privileges, and benefits upon beneficiaries and assignees of policies, no beneficiary or assignee shall by reason of these sections be divested or deprived of or prohibited from exercising or enjoying any right, privilege, or benefit that he would have or could exercise or enjoy had §§ 38.2-3122 and 38.2-3122.1 not been enacted.

Code 1950, § 38-119; 1952, c. 317, § 38.1-451; 1986, c. 562; 2018, cc. 304, 847.

Article 3 - RESERVES [Repealed]

§§ 38.2-3126 through 38.2-3144. Repealed.

Repealed by Acts 2014, c. 571, cl. 2, effective January 1, 2015.

Chapter 32 - Standard Nonforfeiture Provisions for Life Insurance

§ 38.2-3200. Nonforfeiture benefits and cash surrender values in life policies issued prior to operative date stated in § 38.2-3214.

A. This section shall apply only to life insurance policies issued prior to the operative date stated in § 38.2-3214.

B. The nonforfeiture benefit referred to in § 38.2-3309 shall be available to the insured in the event of default in premium payments, after premiums have been paid for three full years. The premium paid for the insured under any policy provision shall not be considered in default. The nonforfeiture benefit shall be a stipulated form of insurance, effective from the due date of the defaulted premium, the net value of which shall at least equal the reserve at the date of default on the policy and on any dividend additions to the policy, exclusive of the reserve on account of return premium insurance and on total and permanent disability and additional accidental death benefits, less a sum not more than 2 1/2 percent of the amount insured by the policy and of any dividend additions to the policy and less any existing indebtedness to the insurer on or secured by the policy. The policy shall specify the mortality table and rate of interest used in computing these reserves. Instead of allowing a deduction from the reserve of a sum not more than 2 1/2 percent of the amount insured by the policy, and of any dividend additions to the policy, the insurer may insert in the policy a provision that one-fifth of the reserve may be deducted, or may provide in the policy that a deduction may be made of 2 1/2 percent of the amount insured by the policy or one-fifth of the reserve, at the insurer's option. The cash surrender value referred to in § 38.2-3309 shall be available upon surrender of the policy to the insurer within one month of the due date of the defaulted premium and shall at least equal the sum which would otherwise be available for the purchase of insurance. The insurer may defer payment for not more than three months after the application for the cash surrender value is made.

C. If more than one option is provided, the policy shall stipulate which of the options shall be effective if the insured does not elect any option on or before the expiration of the grace period allowed for the payment of the premium.

D. A provision may also be inserted in the policy that in the event of default in a premium payment before the options become available, the reserve on any dividend additions then in force may, at the insurer's option, be paid in cash or applied as a net premium to the purchase of paid-up term insurance for any amount not exceeding the face amount of the original policy.

E. This section shall apply to term insurance policies only if the term is for more than twenty years.

Code 1950, § 38-374; 1952, c. 317, § 38.1-459; 1986, c. 562.

§ 38.2-3201. Same; for industrial life policies.

A. This section shall apply only to industrial life insurance policies issued prior to the operative date stated in § 38.2-3214.

B. The nonforfeiture benefits referred to in § 38.2-3347 shall be available in the event of default in premium payments after premiums have been paid for five full years, without action on the part of the insured. The nonforfeiture benefit shall be a stipulated form of insurance, effective from the due date of the defaulted premium, the net value of which at least equals the reserve on the policy, excluding any reserves for provisions (i) relating to benefits for specific types of disability, (ii) granting additional

insurance specifically against accidental death, and (iii) granting other benefits in addition to life insurance, at the end of the last completed policy year for which premiums have been paid, and on any dividend additions to the policy, less a specified maximum percentage, not more than 2 1/2 percent, of the maximum face amount insured by the policy and of any dividend additions to the policy and less any existing indebtedness to the insurer on or secured by the policy. The policy shall specify the mortality table, rate of interest and method of valuation used for computing these reserves. The policy shall also specify the percentage or other rule of calculation so as to permit determination of the values for each year for which required values are not included in the policy. Instead of allowing for the deduction from the reserve of a sum not more than 2 1/2 percent of the maximum face amount insured by the policy and of any dividend additions to the policy, the insurer may insert in the policy a provision that one-fifth of the reserve may be deducted, or may provide in the policy that a deduction may be made of 2 1/2 percent of the maximum face amount insured by the policy or one-fifth of the reserve at the insurer's option.

C. If more than one option is provided, the policy shall stipulate which of the options shall apply if the insured fails to notify the insurer of his selection of an option.

D. The cash surrender value referred to in § 38.2-3347 shall be available after premiums have been paid for ten full years upon surrender of the policy to the insurer within three months of the due date of the defaulted premium and shall be at least equal to the sum which would otherwise be available for the purchase of insurance. The insurer may defer payment for not more than three months after the application for the cash surrender value is made. This section shall not apply to term insurance policies of twenty years or less, but such term policy shall specify the mortality table, rate of interest and method of valuation adopted for computing reserves.

Code 1950, § 38-375; 1952, c. 317, § 38.1-460; 1986, c. 562.

§ 38.2-3202. Standard nonforfeiture law; required policy provisions.

A. On and after the operative date stated in § 38.2-3214, no life insurance policy, except as stated in § 38.2-3213, shall be delivered or issued for delivery in this Commonwealth unless it contains in substance the following provisions and statements, or corresponding provisions and statements that in the opinion of the Commission (i) are at least as favorable to the defaulting or surrendering policyholder and (ii) essentially comply with § 38.2-3212:

1. That in the event of default in any premium payment, the insurer will grant, upon proper request not later than sixty days after the due date of the premium in default, a paid-up nonforfeiture benefit on a plan stipulated in the policy, effective as of the due date, in the amount specified in this article. Instead of the stipulated paid-up nonforfeiture benefit, the insurer may substitute, upon proper request not later than sixty days after the due date of the premium in default, an actuarially equivalent alternative paid-up nonforfeiture benefit that provides a greater amount or longer period of death benefits or, if applicable, a greater amount or earlier payment of endowment benefits.

2. That upon surrender of the policy within sixty days after the due date of any premium payment in default, after premiums have been paid for at least three full years for ordinary insurance or five full years for industrial insurance, the insurer will pay, instead of any paid-up nonforfeiture benefit, a cash surrender value in the amount specified in this chapter.

3. That a specified paid-up nonforfeiture benefit shall become effective as specified in the policy unless the person entitled to make an election selects another available option not later than sixty days after the due date of the premium in default.

4. That for a policy paid up by completion of all premium payments or continued under any paid-up nonforfeiture benefit that became effective on or after the third policy anniversary for ordinary insurance or the fifth policy anniversary for industrial insurance, the insurer will pay, upon surrender of the policy within thirty days after any policy anniversary, a cash surrender value in the amount specified in this article.

5. For policies that provide on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or both, or that provide an option for changes in benefits or premiums, or both, other than a change to a new policy, a statement of the mortality table, interest rate, and method used in calculating cash surrender values and the paid-up nonforfeiture benefits available under the policy. All other policies shall include a statement of the mortality table and interest rate used in calculating the cash surrender values and the paid-up nonforfeiture benefits available under the policy, together with a table showing any cash surrender value and any paid-up nonforfeiture benefit available under the policy on each policy anniversary either during the first twenty policy years or during the term of the policy, whichever is shorter. The values and benefits referred to in this subdivision shall be calculated upon the assumption that there are no dividends or paid-up additions credited to the policy and that there is no indebtedness to the insurer on the policy.

6. A brief and general statement of the method to be used in calculating the cash surrender value and the paid-up nonforfeiture benefits available under the policy on any policy anniversary beyond the last anniversary for which the values and benefits are consecutively shown in the policy, with an explanation of how the existence of any paid-up additions credited to the policy or any indebtedness to the insurer on the policy affects the cash surrender values and the paid-up nonforfeiture benefits.

B. To the extent that any of the foregoing provisions are not applicable to the plan of insurance, they may be omitted from the policy with the approval of the Commission.

C. The insurer shall reserve the right to defer the payment of any cash surrender value for no more than six months after demand for the cash surrender value and surrender of the policy.

Code 1950, § 38-376; 1952, c. 317, § 38.1-461; 1982, c. 228; 1986, c. 562.

§ 38.2-3203. Same; cash surrender value in case of default.

A. Any cash surrender value available under any life insurance policy issued on or after the operative date stated in § 38.2-3214 in the event of default in a premium payment due on any policy

anniversary, whether or not required by § 38.2-3202, shall at least equal any excess of the present value, on that anniversary, of the future guaranteed benefits that would have been provided for by the policy, including any existing paid-up additions had there been no default, over the sum of (i) the then present value of the adjusted premiums as defined in §§ 38.2-3205 through 38.2-3209, corresponding to premiums that would have fallen due on and after that anniversary, and (ii) the amount of any indebtedness to the insurer on the policy.

B. For any policy issued on or after the operative date of § 38.2-3209 and providing at the option of the insured supplemental life insurance or annuity benefits for an identifiable additional premium by rider or supplemental policy provision, the cash surrender value referred to in subsection A of this section shall at least equal the sum of (i) the cash surrender value defined in subsection A for an otherwise similar policy issued at the same age without the rider or supplemental policy provision and (ii) the cash surrender value defined in subsection A for a policy providing only the benefits provided by the rider or supplemental policy provision.

C. For any family policy issued on or after the operative date of § 38.2-3209, defining a primary insured and providing term insurance on the life of the spouse of the primary insured expiring before the spouse achieves the age of seventy-one, the cash surrender value referred to in subsection A of this section shall at least equal the sum of (i) the cash surrender value defined in subsection A for an otherwise similar policy issued at the same age without the term insurance on the life of the spouse and (ii) the cash surrender value defined in subsection A for a policy providing only the benefits provided by the term insurance on the life of the spouse.

D. Any cash surrender value available within thirty days after any policy anniversary under any policy paid-up by completion of all premium payments or any policy continued under any paid-up non-forfeiture benefit, whether or not required by § 38.2-3202, shall at least equal the present value, on that anniversary, of the future guaranteed benefits provided for by the policy, including any existing paid-up additions, decreased by any indebtedness to the insurer on the policy.

Code 1950, § 38-377; 1952, c. 317, § 38.1-462; 1982, c. 228; 1986, c. 562.

§ 38.2-3204. Same; present value of paid-up nonforfeiture benefits on default.

Any paid-up nonforfeiture benefit available under a life insurance policy issued on or after the operative date stated in § 38.2-3214 in the event of default in a premium payment due on any policy anniversary shall be such that its present value as of that anniversary shall at least equal the cash surrender value then provided for by the policy or, if none is provided for, shall equal the cash surrender value that would have been required by § 38.2-3203 in the absence of the condition that premiums have been paid for a specified period.

Code 1950, § 38-378; 1952, c. 317, § 38.1-463; 1986, c. 562.

§ 38.2-3205. Same; calculation of adjusted premiums.

A. The provisions of this section shall not apply to policies issued on or after the operative date as defined in § 38.2-3209. Except as provided in subsection C of this section, the adjusted premium for

any life insurance policy issued on or after the operative date stated in § 38.2-3214 shall be calculated on an annual basis and shall be a uniform percentage of the respective premiums specified in the policy for each policy year, excluding any extra premiums charged because of impairments or special hazards, so that the present value at the date of issue of the policy of all adjusted premiums is equal to the sum of: (i) the then present value of the future guaranteed benefits provided for by the policy; (ii) two percent of the amount of insurance, if the insurance is uniform in amount, or of the equivalent uniform amount as defined in subsection B of this section if the amount of insurance varies with the duration of the policy; (iii) forty percent of the adjusted premium for the first policy year; and (iv) twenty-five percent of either the adjusted premium for the first policy year or the adjusted premium for a whole life policy of the same uniform or equivalent uniform amount with uniform premiums for the whole of life issued at the same age for the same amount of insurance, whichever is less. However, in applying the percentages specified in (iii) and (iv) of this subsection, no adjusted premium shall be deemed to exceed four percent of the amount of insurance or level amount equivalent to the amount of insurance. The date of issue of a policy for the purpose of this section shall be the date as of which the rated age of the insured is determined.

B. The equivalent uniform amount of a policy providing an amount of insurance varying with the duration of the policy is the level amount of insurance provided by an otherwise similar policy, containing the same endowment benefit or benefits, if any, issued at the same age and for the same term, the amount of which does not vary with duration and the benefits under which have the same present value at the date of issue as the benefits under the policy. However, for a policy providing a varying amount of insurance issued on the life of a child under age ten, the equivalent uniform amount may be computed as though the amount of insurance provided by the policy prior to the attainment of age ten were the amount provided by the policy at age ten.

C. The adjusted premiums for any policy providing term insurance benefits by a rider or a supplemental policy provision shall equal (i) the adjusted premiums for an otherwise similar policy issued at the same age without the term insurance benefits, increased, during the period for which premiums for the term insurance benefits are payable by (ii) the adjusted premiums for the term insurance. Items (i) and (ii) of this subsection shall be calculated separately and as specified in subsections A and B of this section. For the purposes of items (ii), (iii), and (iv) of subsection A of this section, the amount of insurance or equivalent uniform amount of insurance used in the calculation of the adjusted premiums referred to in item (ii) of this subsection shall equal the excess of the corresponding amount determined for the entire policy over the amount used in the calculation of the adjusted premiums in item (i) of this subsection.

Code 1950, § 38-379; 1952, c. 317, § 38.1-464; 1962, c. 562; 1982, c. 228; 1986, c. 562.

§ 38.2-3206. Same; tables used for calculations.

Except as otherwise provided in §§ 38.2-3207 and 38.2-3208, all adjusted premiums and present values referred to in §§ 38.2-3202 through 38.2-3205 shall for all policies of ordinary insurance be calculated on the basis of the Commissioners 1941 Standard Ordinary Mortality Table. However, for any

category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than three years younger than the actual age of the insured and the calculations for all policies of industrial insurance shall be made on the basis of the 1941 Standard Industrial Mortality Table. All calculations shall be made on the basis of the rate of interest, not exceeding 3 1/2 percent per year, specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits. However, in calculating the present value of any paid-up term insurance with any accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than 130 percent of the rates of mortality according to the applicable table. For insurance issued on a substandard basis, the calculation of any adjusted premiums and present values may be based on any other table of mortality specified by the insurer and approved by the Commission.

Code 1950, § 38-380; 1952, c. 317, § 38.1-465; 1959, Ex. Sess., c. 43; 1962, c. 562; 1982, c. 228; 1986, c. 562.

§ 38.2-3207. Same; use of new mortality table; ordinary policies.

The provisions of this section shall not apply to ordinary policies issued on or after the operative date as defined in § 38.2-3209. In the case of ordinary policies issued on or after the operative date of § 38.2-3215, all adjusted premiums and present values referred to in §§ 38.2-3202 through 38.2-3205 shall be calculated on the basis of the Commissioners 1958 Standard Ordinary Mortality Table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits. However, the rate of interest shall not exceed (i) 3 1/2 percent per year for policies issued before July 1, 1975, (ii) four percent per year for policies issued on or after July 1, 1975, and prior to July 1, 1979, and (iii) 5 1/2 percent per year for policies issued on or after July 1, 1979. Notwithstanding the foregoing provisions of this section, the rate of interest for any single premium whole life or endowment insurance policy issued on or after July 1, 1979, may be a rate not exceeding 6 1/2 percent per year. For any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than six years younger than the actual age of the insured. In calculating the present value of any paid-up term insurance with any accompanying pure endowment offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1958 Extended Term Insurance Table. For insurance issued on a substandard basis the calculation of any adjusted premiums and present values may be based on any other table of mortality specified by the insurer and approved by the Commission.

1959, Ex. Sess., c. 43, § 38.1-465.1; 1975, c. 215; 1979, c. 437; 1982, c. 228; 1986, c. 562.

§ 38.2-3208. Same; industrial policies.

The provisions of this section shall not apply to industrial policies issued on or after the operative date as defined in § 38.2-3209. For industrial policies issued on or after the operative date of § 38.2-3216, all adjusted premiums and present values referred to in §§ 38.2-3202 through 38.2-3205 shall be calculated on the basis of the Commissioners 1961 Standard Industrial Mortality Table and the rate of

interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits. However, the rate of interest shall not exceed (i) 3 1/2 percent per year for policies issued before July 1, 1975, (ii) four percent per year for policies issued on or after July 1, 1975, and prior to July 1, 1979, and (iii) 5 1/2 percent per year for policies issued on or after July 1, 1979. Notwithstanding the foregoing provisions of this section, the rate of interest for any single premium whole life or endowment insurance policy issued on or after July 1, 1979, may be a rate not exceeding 6 1/2 percent per year. In calculating the present value of any paid-up term insurance with any accompanying pure endowment offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1961 Industrial Extended Term Insurance Table. For insurance issued on a substandard basis, the calculations of any adjusted premiums and present values may be based on any other table of mortality specified by the insurer and approved by the Commission.

1962, c. 562, § 38.1-465.2; 1975, c. 215; 1979, c. 437; 1982, c. 228; 1986, c. 562.

§ 38.2-3209. Same; adjusted premiums for policies.

A. This section shall apply to all policies issued on or after the operative date as defined in this section. Except as provided in subsection G of this section, the adjusted premiums for any policy shall be calculated on an annual basis and shall be a uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments or special hazards and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, so that the present value at the date of issue of the policy of all adjusted premiums shall equal the sum of (i) the then present value of the future guaranteed benefits provided for by the policy; (ii) 1 percent of either the amount of insurance, if the insurance is uniform in amount, or the average amount of insurance at the beginning of each of the first 10 policy years; and (iii) 125 percent of the nonforfeiture net level premium as defined in subsection B of this section. However, in applying the percentage specified in (iii) of this subsection no nonforfeiture net level premium shall be deemed to exceed four percent of either the amount of insurance, if the insurance is uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years. The date of issue of a policy for the purpose of this section shall be the date as of which the rated age of the insured is determined.

B. The nonforfeiture net level premium shall equal the present value, at the date of issue of the policy, of the guaranteed benefits provided for by the policy divided by the present value, at the date of issue of the policy, of an annual annuity of one dollar payable on the date of issue of the policy and on each anniversary of the policy on which a premium falls due.

C. For a policy that provides, on a basis guaranteed in the policy, unscheduled changes in benefits or premiums, or both, or that provides an option for changes in benefits or premiums, or both, other than a change to a new policy, the adjusted premiums and present values shall initially be calculated on the assumption that future benefits and premiums do not change from those stipulated at the date of issue of the policy. At the time of any change in the benefits or premiums, the future adjusted premiums,

nonforfeiture net level premiums and present values shall be recalculated on the assumption that future benefits and premiums do not change from those stipulated by the policy immediately after the change.

D. Except as otherwise provided in subsection G of this section, the recalculated future adjusted premiums for any policy referred to in subsection C of this section shall be a uniform percentage of the respective future premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments and special hazards, and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, so that the present value at the time of change to the newly defined benefits or premiums of all future adjusted premiums shall equal the excess of (1) over (2), where (1) is (i) the then present value of the then future guaranteed benefits provided for by the policy plus (ii) any additional expense allowance and (2) is the then cash surrender value, if any, or present value of any paid-up nonforfeiture benefit under the policy.

E. The additional expense allowance, at the time of the change to the newly defined benefits or premiums, shall be the sum of (i) 1 percent of the excess, if positive, of the average amount of insurance at the beginning of each of the first 10 policy years after the change over the average amount of insurance before the change at the beginning of each of the first 10 policy years after the time of the most recent previous change, or, if there has been no previous change, the date of issue of the policy and (ii) 125 percent of the increase, if positive, in the nonforfeiture net level premium.

F. The recalculated nonforfeiture net level premium shall equal (1) divided by (2), where (1) is the sum of (i) the nonforfeiture net level premium applicable before the change times the present value of an annual annuity of one dollar payable on each anniversary of the policy on or after the date of the change on which a premium would have fallen due had the change not occurred, and (ii) the present value of the increase in future guaranteed benefits provided by the policy, and (2) is the present value of an annual annuity of one dollar payable on each anniversary of the policy on or after the date of change on which a premium falls due.

G. Notwithstanding any other provisions of this section, for a policy issued on a substandard basis that provides reduced graded amounts of insurance so that, in each policy year, the policy has the same tabular mortality cost as an otherwise similar policy issued on the standard basis that provides higher uniform amounts of insurance, adjusted premiums and present values for the substandard policy may be calculated as if it were issued to provide the higher uniform amounts of insurance on the standard basis.

H. All adjusted premiums and present values referred to in §§ 38.2-3202 through 38.2-3213 shall for all policies of ordinary insurance be calculated on the basis of (i) the Commissioners 1980 Standard Ordinary Mortality Table or (ii) at the election of the insurer for any one or more specified plans of life insurance, the Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors. The premiums and values shall for all policies of industrial insurance be calculated on the

basis of the Commissioners 1961 Standard Industrial Mortality Table. The premiums and values shall for all policies issued in a particular calendar year be calculated on the basis of a rate of interest not exceeding the nonforfeiture interest rate as defined in this section for policies issued in that calendar year, provided that:

1. At the insurer's option, calculations for all policies issued in a particular calendar year may be made on the basis of a rate of interest not exceeding the nonforfeiture interest rate, as defined in this section, for policies issued in the immediately preceding calendar year;

2. Under any paid-up nonforfeiture benefit, including any paid-up dividend additions, any cash surrender value available, whether or not required by § 38.2-3202, shall be calculated on the basis of the mortality table and rate of interest used in determining the amount of the paid-up nonforfeiture benefit and any paid-up dividend additions;

3. An insurer may calculate the amount of any guaranteed paid-up nonforfeiture benefit, including any paid-up additions, under the policy on the basis of an interest rate no lower than that specified in the policy for calculating cash surrender values;

4. In calculating the present value of any paid-up term insurance with any accompanying pure endowment offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1980 Extended Term Insurance Table for policies of ordinary insurance and not more than the Commissioners 1961 Industrial Extended Term Insurance Table for policies of industrial insurance;

5. For insurance issued on a substandard basis, the calculation of any adjusted premiums and present values may be based on appropriate modifications of the tables referred to in this section;

6. For policies issued prior to the operative date of the valuation manual, any Commissioners Standard ordinary mortality tables adopted after 1980 by the National Association of Insurance Commissioners (NAIC) and approved by the Commission for use in determining the minimum nonforfeiture standard may be substituted for the Commissioners 1980 Standard Ordinary Mortality Table with or without Ten-Year Select Mortality Factors or for the Commissioners 1980 Extended Term Insurance Table. "Operative date of the valuation manual" means the January 1 of the first calendar year that the valuation manual as defined in § 38.2-1365 is effective.

For policies issued on or after the operative date of the valuation manual, the valuation manual shall provide the Commissioners Standard mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the Commissioners 1980 Standard Ordinary Mortality Table with or without Ten-Year Select Mortality Factors or for the Commissioners 1980 Extended Term Insurance Table. If the Commission approves by regulation any Commissioners Standard ordinary mortality table adopted by the NAIC for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, then that minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual; and

7. For policies issued prior to the operative date of the valuation manual, any Commissioners Standard industrial mortality tables adopted after 1980 by the National Association of Insurance Commissioners and approved by the Commission for use in determining the minimum nonforfeiture standard may be substituted for the Commissioners 1961 Standard Industrial Mortality Table or the Commissioners 1961 Industrial Extended Term Insurance Table.

For policies issued on or after the operative date of the valuation manual, the valuation manual shall provide the Commissioners Standard mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the Commissioners 1961 Standard Industrial Mortality Table or the Commissioners 1961 Industrial Extended Term Insurance Table. If the Commission approves by regulation any Commissioners Standard industrial mortality table adopted by the NAIC for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, then that minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual.

I. The nonforfeiture annual interest rate for any policy issued in a particular calendar year:

1. For policies issued prior to the operative date of the valuation manual, shall equal 125 percent of the calendar year statutory valuation interest rate for the policy as defined in Article 10 (§ 38.2-1365 et seq.) of Chapter 13, rounded to the nearest one-quarter percent, provided, however, that the nonforfeiture annual interest rate shall not be less than four percent; and

2. For policies issued on or after the operative date of the valuation manual, shall be provided by the valuation manual.

J. Any refiling of nonforfeiture values or their methods of computation for any previously approved policy form that involves only a change in the interest rate or mortality table used to compute nonforfeiture values shall not require refiling of any other provisions of that policy form.

K. After July 1, 1982, any insurer may file with the Commission a written notice of its election to comply with the provisions of this section after a specified date before January 1, 1989, which shall be the operative date of this section for that insurer. If an insurer makes no election, the operative date of this section for that insurer shall be January 1, 1989.

1982, c. 228, § 38.1-465.3; 1986, c. 562; 2014, c. 571.

§ 38.2-3210. Same; life insurance providing future premium determination.

For any plan of life insurance providing for future premium determination, the amounts of which are to be determined by the insurer based on then estimates of future experience, or for any plan of life insurance for which minimum values cannot be determined by the methods described in §§ 38.2-3202 through 38.2-3209, then:

1. The Commission shall be satisfied that the benefits provided under the plan are substantially as favorable to policyholders and insureds as the minimum benefits otherwise required by §§ 38.2-3202 through 38.2-3209;

2. The Commission shall be satisfied that the benefits and the pattern of premiums of the plan are not misleading to prospective policyholders or insureds; and

3. The cash surrender values and paid-up nonforfeiture benefits provided by the plan shall not be less than the minimum values and benefits required for the plan computed by a method consistent with the principles of §§ 38.2-3202 through 38.2-3213, as determined by the Commission.

1982, c. 228, § 38.1-465.4; 1986, c. 562.

§ 38.2-3211. Same; other factors in calculations.

A. Any cash surrender value and any paid-up nonforfeiture benefit available under any life insurance policy issued on or after the operative date stated in § 38.2-3214 in the event of default in a premium payment due at any time other than on the policy anniversary, shall be calculated with allowance for the lapse of time and the payment of fractional premiums beyond the last preceding policy anniversary. All values referred to in §§ 38.2-3203 through 38.2-3209 may be calculated upon the assumption that any death benefit is payable at the end of the policy year of death. The net value of any paid-up additions, other than paid-up term additions, shall at least equal the amounts used to provide these additions.

B. 1. Notwithstanding the provisions of § 38.2-3203, additional benefits payable in the following cases and premiums for them shall be disregarded in ascertaining cash surrender values and nonforfeiture benefits required by §§ 38.2-3202 through 38.2-3216:

a. Death or dismemberment by accident or accidental means;

b. Total and permanent disability;

c. Reversionary annuity or deferred reversionary annuity benefits;

d. Term insurance benefits provided by a rider or supplemental policy provision to which, if issued as a separate policy, this section would not apply;

e. Term insurance on the life of a child or on the lives of children provided in a policy on the life of a parent of the child, if the term insurance expires before the child's age is twenty-six, is uniform in amount after the child's age is one, and has not become paid-up by reason of the death of a parent of the child; and

f. Other policy benefits additional to life insurance and endowment benefits.

2. No additional benefits shall be required to be included in any paid-up nonforfeiture benefits.

Code 1950, § 38-381; 1952, c. 317, § 38.1-466; 1959, Ex. Sess., c. 43; 1962, c. 562; 1982, c. 228; 1986, c. 562.

§ 38.2-3212. Same; policies issued on or after January 1, 1986.

A. This section, in addition to all other applicable sections of law, shall apply to all policies issued on or after January 1, 1986. Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary shall not differ by more than two-tenths percent of

either (i) the amount of insurance, if the insurance is uniform in amount, or (ii) the average amount of insurance at the beginning of each of the first ten policy years, from the sum of (i) the greater of zero and the basic cash value specified in this section and (ii) the present value of any existing paid-up additions less the amount of any indebtedness to the insurer under the policy.

B. The basic cash value shall equal the present value on that anniversary of the future guaranteed benefits that would have been provided for by the policy, excluding any existing paid-up additions and before deduction of any indebtedness to the insurer, if there had been no default, less the then present value of the nonforfeiture factors, as defined in this section, corresponding to premiums that would have fallen due on and after that anniversary. However, the effects on the basic cash value of supplemental life insurance or annuity benefits or of family coverage, as described in § 38.2-3203 or § 38.2-3205, whichever applies, shall be the same as the effects specified in § 38.2-3203 or § 38.2-3205, whichever applies, on the cash surrender values defined in those sections.

C. 1. The nonforfeiture factor for each policy year shall equal a percentage of the adjusted premium for the policy year, as defined in § 38.2-3205 or § 38.2-3209, whichever applies. Except as required by subdivision 2 of this subsection, such percentage:

a. Shall be the same percentage for each policy year between the second policy anniversary and the later of (i) the fifth policy anniversary and (ii) the first policy anniversary at which there is available under the policy a cash surrender value in an amount, before including any paid-up additions and before deducting any indebtedness, of at least two-tenths percent of either the amount of insurance, if the insurance is uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years; and

b. Shall be such that no percentage after the later of the two policy anniversaries specified in subdivision 1 a of this subsection may apply to fewer than five consecutive policy years.

2. No basic cash value shall be less than the value that would be obtained if the adjusted premiums for the policy, as defined in § 38.2-3205 or § 38.2-3209, whichever applies, were substituted for the nonforfeiture factors in the calculation of the basic cash value.

D. All adjusted premiums and present values referred to in this section shall for a particular policy be calculated on the same mortality and interest bases used in demonstrating the policy's compliance with the other sections of this article. The cash surrender values referred to in this section shall include any endowment benefits provided for by the policy.

E. Any cash surrender value available other than in the event of default in a premium payment due on a policy anniversary, and the amount of any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment, shall be determined by a method consistent with the methods specified for determining the analogous minimum amounts in §§ 38.2-3202 through 38.2-3204, 38.2-3209 and 38.2-3211. The amounts of any cash surrender values and of any paid-up nonforfeiture benefits granted in connection with additional benefits, such as those listed as B1 a through B1 f in § 38.2-3211, shall conform with the principles of this section.

1982, c. 228, § 38.1-466.1; 1986, c. 562.

§ 38.2-3213. Same; exemptions from application of certain sections.

A. Sections 38.2-3202 through 38.2-3212 shall not apply to any:

1. Certificates of fraternal benefit societies;

2. Reinsurance;

3. Group insurance;

4. Pure endowments;

5. Annuities or reversionary annuity contracts;

6. Term policies of uniform amount (i) that provide no guaranteed nonforfeiture or endowment benefits, or renewal thereof; (ii) that are of twenty years or less expiring before age seventy-one; and (iii) for which uniform premiums are payable during the entire term of the policy;

7. Term policies of decreasing amount (i) that provide no guaranteed nonforfeiture or endowment benefits; (ii) on which each adjusted premium calculated as specified in §§ 38.2-3205 through 38.2-3209 is less than the adjusted premium calculated on term policies of uniform amount, or renewal thereof; (iii) that provide no guaranteed nonforfeiture or endowment benefits; (iv) that are issued at the same age and for the same initial amounts of insurance and for terms of twenty years or less expiring before age seventy-one; and (v) for which uniform premiums are payable during the entire term of the policy;

8. Policies (i) that provide no guaranteed nonforfeiture or endowment benefits and (ii) for which any cash surrender value or present value of any paid-up nonforfeiture benefit at the beginning of any policy year, calculated as specified in §§ 38.2-3203 through 38.2-3209, does not exceed 2 1/2% of the amount of insurance at the beginning of the same policy year; or

9. Policies delivered outside this Commonwealth through an agent or other representative of the insurer issuing the policy.

B. For purposes of determining the applicability of §§ 38.2-3202 through 38.2-3216, the age at expiry for a joint term life insurance policy shall be the age at expiry of the oldest life.

Code 1950, § 38-382; 1952, c. 317, § 38.1-467; 1962, c. 562; 1982, c. 228; 1986, c. 562.

§ 38.2-3214. Same; operative date.

After March 17, 1948, any insurer may file with the Commission a written notice of its election to comply with the provisions of §§ 38.2-3202 through 38.2-3213 after a specified date before April 1, 1948. After the filing of the notice upon the specified date, which shall be the operative date for that insurer, the sections shall become operative with respect to the policies thereafter issued by that insurer. If an insurer makes no election, the operative date for the insurer shall be April 1, 1948. The Commission, for good cause shown by any insurer, may extend the operative date for that insurer to not later than January 1, 1949.

Code 1950, § 38-383; 1952, c. 317, § 38.1-468; 1986, c. 562.

§ 38.2-3215. Same; operative date for § 38.2-3207.

After July 1, 1959, any insurer may file with the Commission a written notice of its election to comply with the provisions of § 38.2-3207 after a specified date before January 1, 1966. After the filing of the notice, then upon the specified date, which shall be the operative date of this section for the insurer, § 38.2-3207 shall become operative with respect to the ordinary policies thereafter issued by that insurer. If an insurer makes no such election, the operative date of § 38.2-3207 for the insurer shall be January 1, 1966.

1959, Ex. Sess., c. 43, § 38.1-468.1; 1986, c. 562.

§ 38.2-3216. Same; operative date for § 38.2-3208.

After July 1, 1962, any insurer may file with the Commission a written notice of its election to comply with the provisions of § 38.2-3208 after a specified date before January 1, 1968. After the filing of the notice, then upon the specified date, which shall be the operative date of this section for the insurer, § 38.2-3208 shall become operative with respect to the industrial policies thereafter issued by that insurer. If an insurer makes no election, the operative date of § 38.2-3208 for the insurer shall be January 1, 1968.

1962, c. 562, § 38.1-468.2; 1986, c. 562.

§ 38.2-3217. Loan provisions in policies issued prior to operative date stated in § 38.2-3214.

For those policies issued prior to the operative date stated in § 38.2-3214, the loan value referred to in former § 38.1-397 shall be the reserve at the end of the current policy year on the policy and on any dividend additions to the policy, exclusive of the reserve on account of return premium insurance and of total and permanent disability and additional accidental death benefits, less a sum not more than 2 1/2 percent of the amount insured by the policy and of any dividend additions to the policy. The policy shall specify the mortality table and rates of interest adopted for computing the reserve. The policy may further provide that the loan may be deferred for up to three months after the application for the loan is made. Instead of permitting the deduction from a loan on the policy of a sum not more than 2 1/2 percent of the amount insured by the policy and of any dividend additions to the policy, an insurer may insert in the policy a provision that one-fifth of the reserve may be deducted in case of a loan under the policy, or may provide in the policy that the deduction may be 2 1/2 percent of the amount insured by the policy or one-fifth of the reserve, at the insurer's option.

Code 1950, § 38-384; 1952, c. 317, § 38.1-469; 1986, c. 562.

§ 38.2-3218. Same; in policies subsequently issued.

For policies issued on or after the operative date stated in § 38.2-3214, the loan value referred to in former § 38.1-397 or § 38.2-3308, whichever applies, shall be the cash surrender value at the end of the current policy year required by § 38.2-3202. The insurer shall have the right to defer for up to six months after application for the loan is made a loan on the policy, except when made to pay premiums to the insurer.

Code 1950, § 38-385; 1952, c. 317, § 38.1-470; 1986, c. 562.

§ 38.2-3219. Applicability.

Sections 38.2-3220 through 38.2-3229 shall not apply to any (i) reinsurance; (ii) group annuity purchased under a retirement plan or plan of deferred compensation established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under § 408 of the Internal Revenue Code, as amended; (iii) premium deposit fund; (iv) variable annuity; (v) investment annuity; (vi) immediate annuity; (vii) deferred annuity contract after annuity payments have commenced; (viii) reversionary annuity; (ix) modified guaranteed annuity; or (x) contract delivered outside this Commonwealth through an agent or other representative of the insurer issuing the contract.

1979, c. 437, § 38.1-470.1; 1986, c. 562; 1992, c. 210.

§ 38.2-3220. Nonforfeiture requirements.

A. For contracts issued on or after the operative date as defined in § 38.2-3229, no contract of annuity, except as stated in § 38.2-3219, shall be delivered or issued for delivery in this Commonwealth unless it contains in substance the following provisions and statements, or corresponding provisions and statements that in the opinion of the Commission are at least as favorable to the contract holder, upon cessation of payment of consideration under the contract:

1. That upon cessation of payment of considerations under a contract, or upon the written request of the contract holder, the insurer shall grant a paid-up annuity benefit on a plan stipulated in the contract of the value specified in §§ 38.2-3222 through 38.2-3225 and 38.2-3227.

2. If a contract provides for a lump sum settlement at maturity or at any other time, a provision that upon surrender of the contract at or before the beginning of any annuity payments, the insurer shall pay instead of any paid-up annuity benefits a cash surrender benefit of the amount specified in §§ 38.2-3222, 38.2-3223, 38.2-3225 and 38.2-3227. The insurer may reserve the right to defer the payment of the cash surrender benefit for up to six months after demand for payment with surrender of the contract after making written request and receiving the written approval of the Commission. The request shall address the necessity and equitability to all contract holders of the deferral.

3. A statement of the mortality table and interest rates used in calculating any minimum paid-up annuity, cash surrender or death benefits that are guaranteed under the contract, together with sufficient information to determine the amounts of those benefits.

4. That any paid-up annuity, cash surrender or death benefits that may be available under the contract are not less than the minimum benefits required by any statute of the state in which the contract is delivered and an explanation of how the existence of any additional amounts credited by the insurer to the contract, any indebtedness to the insurer on the contract or any prior withdrawals from or partial surrenders of the contract affects the benefits.

B. Notwithstanding the requirements of this subsection, any deferred annuity contract may provide that if no considerations have been received under a contract for a period of two full years and the portion

of the paid-up annuity benefit at maturity on the plan stipulated in the contract arising from considerations paid prior to that period would be less than $20 monthly, the insurer may at its option terminate the contract by payment in cash of the then present value of the portion of the paid-up annuity benefit, calculated on the basis of the mortality table, if any, and interest rate specified in the contract for determining the paid-up annuity benefit. This payment shall relieve the insurer of any further obligation under the contract.

1979, c. 437, § 38.1-470.1; 1986, c. 562; 2004, c. 313.

§ 38.2-3221. Minimum values.

A. The minimum values specified in §§ 38.2-3222 through 38.2-3225 and 38.2-3227 of any paid-up annuity, cash surrender or death benefits available under an annuity contract shall be based upon the minimum nonforfeiture amounts defined in this section and applied as follows:

1. For contracts issued before April 1, 2003, the amounts shall be determined in accordance with subsections B, C, and D.

2. For contracts issued on or after April 1, 2003, and before July 1, 2004, the amounts shall be determined in accordance with the applicable provisions of subsections B, C, D, and E.

3. For contracts issued on or after July 1, 2004, and before July 1, 2005, the amounts shall be determined in accordance with the applicable provisions of subsections B, C, D, and E unless the insurer makes the election authorized by subsection F, in which case the amounts shall be determined in accordance with subdivisions F 1 through F 4.

4. For contracts issued on or after July 1, 2005, the amounts shall be determined in accordance with subdivisions F 1 through F 4.

B. 1. For contracts providing for flexible considerations, the minimum nonforfeiture amount at or any time before the beginning of any annuity payments shall equal any accumulation up to that time at an annual rate of interest of three percent of percentages of the net considerations as defined in this subsection, paid prior to that time, increased by an existing additional amount credited by the insurer to the contract and decreased by the sum of:

a. Any prior withdrawals from or partial surrenders of the contract accumulated at a rate of interest of three percent per year; and

b. The amount of any indebtedness to the insurer on the contract, including interest due and accrued.

2. The net considerations for a given contract year used to define the minimum nonforfeiture amount shall be not less than zero and shall equal the corresponding gross considerations credited to the contract during that contract year less an annual contract charge of $30 and less a collection charge of $1.25 per consideration credited to the contract during that contract year. The percentages of net considerations shall be 65 percent of the net consideration for the first contract year and 87 ½ percent of the net considerations for the second and later contract years. Notwithstanding the provisions of the preceding sentence, the percentage shall be 65 percent of the portion of the total net consideration for

any renewal contract year that exceeds by not more than two times the sum of those portions of the net considerations in all prior contract years for which the percentage was 65 percent.

C. For contracts providing for fixed scheduled considerations, minimum nonforfeiture amounts shall be calculated on the assumption that considerations are paid annually in advance and shall be the same as for contracts with flexible considerations that are paid annually with two exceptions:

1. The portion of the net consideration for the first contract year to be accumulated shall be the sum of 65 percent of the net consideration for the first contract year plus 22 ½ percent of the excess of the net consideration for the first contract year over the lesser of the net considerations for the second and third contract years.

2. The annual contract charge shall be the lesser of (i) $30 or (ii) 10 percent of the gross annual consideration.

D. For contracts providing for a single consideration, minimum nonforfeiture amounts shall be the same as for contracts with flexible considerations except that the percentage of net consideration used to determine the minimum nonforfeiture amount shall equal 90 percent, and the net consideration shall be the gross consideration less a contract charge of $75.

E. Notwithstanding any other provision of this section, for any contract issued on or after April 1, 2003, and before July 1, 2005, the interest rate at which net considerations, partial withdrawals, and partial surrenders may be accumulated, for the purposes of determining minimum nonforfeiture amounts, may be one and one-half percent per year.

F. The following provisions shall apply for contracts issued on or after July 1, 2005, and at the election of the insurer may apply also to specified contracts issued on or after July 1, 2004. An insurer may make this election on a contract-form-by-contract-form basis by filing written notice with the Commission and specifying a date for the provisions to apply prior to July 1, 2005.

1. The minimum nonforfeiture amount at or any time before the beginning of any annuity payments shall equal an accumulation up to that time at rates of interest, as indicated in subdivision 3, of the net considerations as defined in this subsection, paid prior to that time, and decreased by the sum of:

a. Any prior withdrawals from or partial surrenders of the contract accumulated at rates of interest as indicated in subdivision 3;

b. An annual contract charge of $50, accumulated at rates of interest as indicated in subdivision 3;

c. Any premium tax paid by the insurer for the contract, accumulated at rates of interest as indicated in subdivision 3, adjusted for any tax that is not actually paid or which has been credited back to the insurer, such as upon early termination of the contract; and

d. The amount of any indebtedness to the insurer on the contract, including interest due and accrued.

2. The net considerations for a given contract year used to define the minimum nonforfeiture amount shall be equal to 87.5 percent of the gross considerations credited to the contract during that contract year.

3. The interest rate used in determining minimum nonforfeiture amounts shall be an annual rate of interest determined as the lesser of three percent per annum and the following, which shall be specified in the contract if the interest rate will be reset:

a. The five-year Constant Maturity Treasury Rate reported by the Federal Reserve as of a date, or average over a period, rounded to the nearest one-twentieth of one percent, specified in the contract no longer than 15 months prior to the contract issue date or redetermination date under this subdivision;

b. Reduced by 125 basis points;

c. Where the resulting interest rate is not less than 15 basis points (0.15 percent); and

d. The interest rate shall apply for an initial period and may be redetermined for additional periods. The redetermination date, basis and period, if any, shall be stated in the contract. The basis is the date or average over a specified period that produces the value of the five-year Constant Maturity Treasury Rate to be used at each redetermination date.

4. During the period or term that a contract provides substantive participation in an equity indexed benefit, it may increase the reduction described in subdivision 3 b by up to an additional 100 basis points to reflect the value of the equity index benefit. The present value at the contract issue date, and at each redetermination date thereafter, of the additional reduction shall not exceed the market value of the benefit. The Commission may require a demonstration that the present value of the additional reduction does not exceed the market value of the benefit. Where administration is lacking or unacceptable, the Commission may, at its discretion, disallow or limit the additional reduction.

G. The Commission may adopt rules and regulations to implement the provisions of subdivision F 4 and to provide for further adjustments to the calculation of minimum nonforfeiture amounts for contracts that provide substantive participation in an equity index benefit and for other contracts for which the Commission determines adjustments are justified.

1979, c. 437, § 38.1-470.1; 1986, c. 562; 2003, c. 440; 2004, c. 313; 2022, c. 176.

§ 38.2-3222. Computation of present value.

Any paid-up annuity benefit available under a contract shall be such that its present value on the date annuity payments are to commence at least equals the minimum nonforfeiture amount on that date. The present value shall be computed using the mortality table, if any, and the interest rate or rates specified in the contract for determining the minimum paid-up annuity benefits guaranteed in the contract.

1979, c. 437, § 38.1-470.1; 1986, c. 562; 2004, c. 313.

§ 38.2-3223. Calculation of cash surrender values.

For contracts that provide cash surrender benefits, the cash surrender benefits available before maturity shall not be less than the present value as of the date of surrender of that portion of the maturity

value of the paid-up annuity benefit that would be provided under the contract at maturity arising from considerations paid before the time of cash surrender, reduced by the amount appropriate to reflect any prior withdrawals from or partial surrenders of the contract. The present value shall be calculated on the basis of an interest rate not more than one percent higher than the interest rate specified in the contract for accumulating the net considerations to determine the maturity value, decreased by the amount of any indebtedness to the insurer on the contract, including interest due and accrued, and increased by any existing additional amounts credited by the insurer to the contract. In no event shall any cash surrender benefit be less than the minimum nonforfeiture amount at that time. The death benefit under such contracts shall at least equal the cash surrender benefit.

1979, c. 437, § 38.1-470.1; 1986, c. 562.

§ 38.2-3224. Calculation of paid-up annuity benefits.

For contracts that do not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time prior to maturity shall not be less than the present value of that portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid before the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity. The present value shall be calculated for the period before the maturity date on the basis of the interest rate specified in the contract for accumulating the net considerations to determine the maturity value, and increased by any existing additional amounts credited by the insurer to the contract. For contracts that do not provide any death benefits before the beginning of any annuity payments, the present values shall be calculated on the basis of the interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit. In no event shall the present value of a paid-up annuity benefit be less than the minimum nonforfeiture amount at that time.

1979, c. 437, § 38.1-470.1; 1986, c. 562.

§ 38.2-3225. Maturity date.

For the purpose of determining the benefits calculated under §§ 38.2-3223 and 38.2-3224 for annuity contracts under which an election may be made to have annuity payments commence at optional maturity dates, the maturity date shall be deemed to be the latest date for which election is permitted by the contract, but shall not be deemed to be later than the anniversary of the contract next following the annuitant's seventieth birthday or the tenth anniversary of the contract, whichever is later.

1979, c. 437, § 38.1-470.1; 1986, c. 562.

§ 38.2-3226. Disclosure of limited death benefits.

Any contract that does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount before the beginning of any annuity payments shall include a statement in a prominent place in the contract that those benefits are not provided.

1979, c. 437, § 38.1-470.1; 1986, c. 562.

§ 38.2-3227. Inclusion of lapse of time considerations.

Any paid-up annuity, cash surrender or death benefits available at any time, other than on the contract anniversary under any contract with fixed scheduled considerations, shall be calculated with allowance for a lapse of time and the payment of any scheduled considerations beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs.

1979, c. 437, § 38.1-470.1; 1986, c. 562.

§ 38.2-3228. Proration of values; additional benefits.

For any contract that provides, within the same contract by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall equal the sum of the minimum nonforfeiture benefits for the annuity portion and any minimum nonforfeiture benefits for the life insurance portion computed as if each portion were a separate contract. Notwithstanding the provisions of §§ 38.2-3222 through 38.2-3225 and 38.2-3227, additional benefits payable (i) in the event of total and permanent disability, (ii) as reversionary annuity or deferred reversionary annuity benefits, or (iii) as other policy benefits additional to life insurance, endowment and annuity benefits, and considerations for all the additional benefits, shall be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits that may be required by this article. The inclusion of these additional benefits shall not be required in any paid-up benefits, unless the additional benefits separately would require minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits.

1979, c. 437, § 38.1-470.1; 1986, c. 562.

§ 38.2-3229. Effective date.

After July 1, 1979, for contracts subject to subsection B, C, or D of § 38.2-3221, the operative date for application of § 38.2-3219 shall be the earlier of July 1, 1981, or the date on which the insurer filed with the Commission a written notice of its election to comply with the provisions of §§ 38.2-3219 through 38.2-3229 after a specified date before July 1, 1981. For contracts subject to subsection F of § 38.2-3221, the operative date shall be July 1, 2005, unless the insurer specifies an earlier date by filing with the Commission written notice of its election to apply subdivisions F 1 through F 4 of § 38.2-3221 on a contract-form-by-contract-form basis after a specified date, which shall be on or after July 1, 2004, and before July 1, 2005.

1979, c. 437, § 38.1-470.1; 1986, c. 562; 2004, c. 313.

Chapter 33 - LIFE INSURANCE POLICIES

Article 1 - LIFE INSURANCE POLICIES; ANNUITIES

§ 38.2-3300. Requirements; exceptions.

A. No individual life insurance policy shall be delivered or issued for delivery in this Commonwealth unless it contains in substance all of the requirements prescribed in §§ 38.2-3301 through 38.2-3315 of this article.

B. As used in this article, "individual life insurance" means any life insurance other than group life insurance, industrial life insurance, annuities, credit life insurance, and pure endowments, with or without return of premiums or of premiums and interest. However, for the purposes of § 38.2-3308, "policy" includes annuity contracts that provide for policy loans and certificates issued by a fraternal benefit society.

C. The requirements of §§ 38.2-3300 through 38.2-3315 shall not apply to policies of reinsurance or to policies issued or granted in exchange for lapsed or surrendered policies.

Code 1950, §§ 38-371, 38-373; 1952, c. 317, §§ 38.1-390, 38.1-405; 1977, c. 174; 1986, c. 562.

§ 38.2-3301. Ten-day right to examine policy.

No individual life insurance policy shall be delivered or issued for delivery in this Commonwealth unless it has printed on it a notice stating in substance that if, during a ten-day period from the date the policy is delivered to the policyowner, the policy is surrendered to the insurer or its agent with a written request for cancellation, the policy shall be void from the beginning and the insurer shall refund any premium paid for the policy. Nothing in this section shall prohibit an insurer from extending the right to examine period to more than ten days if the period is specified in the policy.

1977, c. 174, § 38.1-390.1; 1986, c. 562.

§ 38.2-3301.1. Delivery of individual life insurance policies.

A. For purposes of determining the commencement of the period during which the owner of an individual life insurance policy may exercise any statutory right to examine, surrender, or return the policy for cancellation, the date of delivery of the policy shall be:

1. The date of the signed receipt of delivery if the life insurance policy is (i) delivered by United States mail or other postal delivery system, or (ii) physically delivered to the owner by a representative of the insurer; or

2. The date of electronic transmission of the policy, provided the electronic transmission has been effected in accordance with this title and any other state or federal laws governing the electronic transmission of documents and information. The insurer shall retain evidence of electronic transmittal for the entire period of the life insurance policy.

B. If an insurer does not deliver a policy by the means set forth in subsection A, the burden of proof shall be on the insurer to establish that the policy was delivered, in the event of a dispute with the owner of the policy.

C. Notwithstanding subsections A and B, a policy shall be deemed to have been received by the owner of the policy as of the date of its issuance if six months have passed since its issuance and the owner of the policy has paid the premiums pursuant to the contract for those six months.

2009, c. 299.

§ 38.2-3302. How premiums payable.

Each individual life insurance policy shall have a provision that all premiums after the first premium shall be payable in advance.

Code 1950, § 38-371(1); 1950, p. 179; 1952, c. 317, § 38.1-391; 1986, c. 562.

§ 38.2-3303. Grace period.

A. Each individual life insurance policy shall contain a provision that the insured is entitled to a grace period of not less than thirty-one days within which the payment of any premium after the first premium may be made, subject at the insurer's option to an interest charge that is not to exceed six percent per year for the number of days of grace elapsing before the payment of the premium.

B. The provision shall also state that during the grace period the policy shall continue in full force, but if a claim arises under the policy during the grace period before the overdue premium or any overdue premium installment is paid, the amount of any earned overdue premium or installment through the policy month of death with interest may be deducted from any amount payable under the policy in settlement. The grace period shall start on the premium payment due date.

Code 1950, § 38-371(2); 1950, p. 179; 1952, c. 317, § 38.1-392; 1986, c. 562.

§ 38.2-3304. Policy constitutes entire contract; statements deemed representations.

A. Each individual life insurance policy shall contain a provision that the policy, or the policy and the application for the policy if a copy of the application is endorsed upon or attached to the policy when issued or delivered, shall constitute the entire contract between the parties.

B. The provision shall also state that:

1. All statements made by the insured shall, in the absence of fraud, be deemed representations and not warranties; and

2. No statement shall be used in defense of a claim under the policy unless it is contained in a written application that is endorsed upon or attached to the policy when issued or delivered.

C. As used in this section, "policy" shall include any riders, endorsements or amendments.

Code 1950, § 38-371(3); 1950, p. 179; 1952, c. 317, § 38.1-393; 1986, c. 562; 1990, c. 223.

§ 38.2-3305. Incontestability.

A. Each individual life insurance policy shall contain a provision that the policy shall be incontestable after it has been in force during the lifetime of the insured for two years from its date of issue except for nonpayment of premiums.

B. Provisions relating to benefits in event of disability, and provisions granting additional insurance specifically against death by accident or accidental means, may be excepted in the incontestability provision.

Code 1950, § 38-371(3); 1950, p. 179; 1952, c. 317, § 38.1-394; 1986, c. 562.

§ 38.2-3306. Misstatement of age.

Each individual life insurance policy shall contain a provision that if, at any time before final settlement under the policy, the age of the insured, or the age of any other person if considered in determining the premium, is found to have been misstated, the amount payable under the policy shall equal the amount that the premium would have purchased at the insured's or other person's correct age at the time the policy was issued.

Code 1950, § 38-371(4); 1950, p. 179; 1952, c. 317, § 38.1-395; 1986, c. 562.

§ 38.2-3307. Participation in surplus.

A. Each participating individual life insurance policy shall contain a provision that the policy shall participate in the surplus of the insurer. Any policy containing a provision for participation at the end of the first policy year, and annually thereafter, may also provide that each dividend shall be paid subject to the payment of the premiums for the next ensuing year. The policyowner under any annual dividend policy shall have the right each year to have the dividend arising from the participation paid in cash. If the policy provides other dividend options, it shall also state which of the options shall be effective if the insured does not elect any option on or before the expiration of the grace period allowed for the payment of the premium.

B. This section shall not apply to any form of paid-up insurance, temporary insurance, or pure endowment insurance, issued or granted in exchange for lapsed or surrendered policies.

Code 1950, § 38-371 (5); 1950, p. 180; 1952, c. 317, § 38.1-396; 1986, c. 562.

§ 38.2-3308. Policy loans.

A. Each individual life insurance policy shall contain a provision that after the policy has been in force three policy years the insurer shall at any time, while the policy is in force other than as extended term insurance, advance, on proper assignment or pledge of the policy and on the sole security of the policy, a sum equal to or, at the option of the policyowner, less than the amount required by § 38.2-3218, under the conditions specified by that section.

B. Each individual life insurance policy issued after July 1, 1975, and prior to July 1, 1981, shall contain only one of the following policy loan interest rate provisions:

1. A provision that a policy loan shall bear interest at a specified rate not exceeding eight percent per year; or

2. A provision that all loans under the policy, including outstanding loans, shall bear interest at a variable rate not exceeding eight percent per year, specified from time to time by the insurer. The effective date of any increase in the variable rate shall be not less than one year after the effective date of the establishment of the previous rate. If the interest rate is increased, the amount of the increase shall not exceed one percent per year. The variable rate may be decreased without restriction as to amount or frequency. With respect to policies providing for a variable rate, the insurer shall give notice of:

a. The variable rate currently effective when a loan is made and when notification of interest due is furnished;

b. Any increase in the variable rate at least thirty days before the effective date for any loans outstanding forty days before that date; and

c. The increase at the time a loan is made for any loans made during the forty days before the effective date of the increase. The notice shall be given as directed by the policyowner and any assignee as shown on the records of the insurer at its home office.

C. 1. Each individual life insurance policy issued after July 1, 1981, shall contain a policy loan interest rate provision permitting either:

a. A maximum fixed interest rate of not more than eight percent per year; or

b. An adjustable maximum interest rate established from time to time by the insurer as permitted by law.

2. The interest rate charged on a policy loan made under subdivision 1 b of this subsection shall not exceed the greater of:

a. The Published Monthly Average for the calendar month ending two months before the date on which the rate is determined; or

b. The rate used to compute the cash surrender values under the policy during the applicable period plus one percent per year.

3. For the purposes of this subsection, the "Published Monthly Average" means:

a. Moody's Corporate Bond Yield Average -- Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto; or

b. If the Moody's Corporate Bond Yield Average -- Monthly Average Corporates is no longer published, a substantially similar average, established by regulation issued by the Commission.

4. If the maximum interest rate is determined pursuant to subdivision 1 b of this subsection, the policy shall contain a provision setting forth the frequency at which the rate is to be determined for that policy.

5. The maximum interest rate for each policy shall be determined at regular intervals at least once every twelve months, but not more frequently than once every three months. At the intervals specified in the policy:

a. The rate being charged may be increased whenever the increase as determined under subdivision 2 of this subsection would increase that rate by one-half percent or more per year;

b. The rate being charged shall be reduced whenever the reduction as determined under subdivision 2 of this subsection would decrease that rate by one-half percent or more per year.

6. The insurer shall:

a. Notify the policyowner at the time a cash loan is made of the initial interest rate;

b. Notify the policyowner of the initial interest rates on a premium loan as soon as it is reasonably practical to do so after making the loan. Notice need not be given to the policyowner when a further premium loan is added, except as provided in subdivision 6 c below;

c. Send reasonable advance notice of any increase in the rates to policyowners with loans; and

d. Include the substance of the pertinent provisions of subdivisions 1 and 4 of this subsection in the notices required above.

7. No policy shall terminate in a policy year as the sole result of a change in the interest rate during that policy year, and the insurer shall maintain coverage during that policy year until the time at which it would otherwise have terminated if there had been no change during that policy year.

8. The substance of the pertinent provisions of subdivisions 1 and 4 of this subsection shall be set forth in the policies to which they apply.

9. For the purposes of this section:

a. The interest rate on policy loans permitted under this section includes the interest rate charged on reinstatement of policy loans for the period during and after any lapse of a policy.

b. The term "policy loan" includes any premium loan made under a policy to pay one or more premiums that were not paid to the insurer as they fell due.

c. The term "policy" includes certificates issued by a fraternal benefit society and annuity contracts that provide for policy loans.

10. No other provision of law, including Chapter 3 (§ 6.2-300 et seq.) of Title 6.2, shall apply to policy loan interest rates unless made specifically applicable to the rates.

D. The insurer may deduct from the loan value any indebtedness not already deducted in determining the value of any unpaid balance of the premium for the current policy year and any interest that may be allowable on the loan to the end of the current policy year. The policy may further provide that if the interest on the loan is not paid when due, it shall be added to the existing loan and shall bear interest at the same rate.

E. A policy loan provision shall not be required in term insurance policies.

1981, c. 46, § 38.1-397.1; 1986, c. 562.

§ 38.2-3309. Nonforfeiture benefits and cash surrender values.

A. Each individual life insurance policy shall contain a provision for nonforfeiture benefits. The provision shall specify the options to which the policyowner is entitled, in accordance with the requirements of § 38.2-3202.

B. Each individual life insurance policy shall have a provision for cash surrender values in accordance with the requirements of § 38.2-3203.

Code 1950, § 38-371(7), (8); 1950, p. 180; 1952, c. 317, § 38.1-398; 1986, c. 562.

§ 38.2-3310. Table of values and options.

Each individual life insurance policy shall contain a table showing the loan values in figures, line by line. The table shall also show any options available under the policy each year upon default in premium payments, during at least the first twenty years of the policy or during the premium-paying period if it is less than twenty years.

Code 1950, § 38-371(9); 1950, p. 180; 1952, c. 317, § 38.1-399; 1986, c. 562.

§ 38.2-3311. Reinstatement.

Each individual life insurance policy shall have a provision that in the event of default in premium payments, if (i) the value of the policy has been applied automatically to the purchase of other insurance as provided for in this article, (ii) the insurance is in force, and (iii) the original policy has not been surrendered to the insurer and cancelled, the policy may be reinstated within three years from default, upon:

1. Evidence of insurability satisfactory to the insurer;

2. Payment of premiums in arrears with interest at a rate not exceeding six percent per year payable annually; and

3. The payment or reinstatement of any other indebtedness to the insurer upon the policy, with interest at the rate set forth in the policy for the indebtedness.

Code 1950, § 38-371(10); 1950, p. 180; 1952, c. 317, § 38.1-400; 1986, c. 562.

§ 38.2-3312. Settlement.

Each individual life insurance policy shall contain a provision that when a death claim arises under the policy, settlement shall be made upon receipt of due proof of death.

Code 1950, § 38-371(11); 1950, p. 181; 1952, c. 317, § 38.1-401; 1986, c. 562.

§ 38.2-3313. Table of installments.

If an individual life insurance policy provides that the proceeds may be payable in installments that are determinable prior to the maturity of the policy, the policy shall have a table showing the guaranteed installments.

Code 1950, § 38-371(12); 1950, p. 181; 1952, c. 317, § 38.1-402; 1986, c. 562.

§ 38.2-3314. Title.

Each individual life insurance policy shall have a title on its face that shall briefly and accurately describe the nature and form of the policy.

Code 1950, § 38-371(13); 1950, p. 181; 1952, c. 317, § 38.1-403; 1986, c. 562.

§ 38.2-3315. Variations for certain forms of policies; providing more favorable terms.

A. Any of the requirements of §§ 38.2-3300 through 38.2-3314 not applicable to single premium, nonparticipating, term, variable, or flexible premium life insurance policies shall to that extent, as approved by the Commission, be appropriately modified or not be incorporated in these policies.

B. Any individual life insurance policy that, in the opinion of the Commission, contains provisions more favorable to the policyholder than those required by §§ 38.2-3300 through 38.2-3314, may be delivered or issued for delivery in this Commonwealth after approval by the Commission.

Code 1950, § 38-372; 1952, c. 317, § 38.1-404; 1976, c. 562; 1986, c. 562.

§ 38.2-3316. Provisions prohibited.

No individual life insurance policy shall be delivered or issued for delivery in this Commonwealth if it contains any provision:

1. Limiting the time within which any action at law or in equity may be commenced to less than one year after the cause of action accrues;

2. For any mode of settlement at maturity, of less value than the amount insured on the face of the policy plus any dividend additions, less any indebtedness to the insurer on or secured by the policy, and less any premium or portion of any premium, that may by the terms of the policy be deducted. This paragraph shall not apply to any nonforfeiture provision that employs the cash value less any indebtedness to purchase paid-up or extended insurance, and shall not prohibit the issuance of policies providing for a limitation in the amount payable under certain specified conditions;

3. For forfeiture of the policy for failure to repay any loan on the policy, or to pay interest on any policy loan, while the total indebtedness on the policy, including interest, is less than the loan value of the policy; or

4. To the effect that the agent soliciting the insurance is the agent of the person insured under the policy, or making the acts or representations of the agent binding upon the person insured under the policy.

Code 1950, § 38-386; 1952, c. 317, § 38.1-406; 1956, c. 417; 1986, c. 562.

§ 38.2-3317. Provisions required by other jurisdictions.

Individual life insurance policies issued by any foreign or alien insurer for delivery in this Commonwealth may contain any provision that is prescribed by the laws of its domiciliary jurisdiction and that is not in conflict with the laws of this Commonwealth. Policies issued by any domestic insurer for delivery in any other jurisdiction may contain any provision required by the laws of that jurisdiction.

Code 1950, § 38-387; 1952, c. 317, § 38.1-407; 1986, c. 562.

Article 2 - GROUP LIFE INSURANCE POLICIES

§ 38.2-3318. Repealed.

Repealed by Acts 1998, c. 154.

§ 38.2-3318.1. Group life insurance requirements.

Except as provided in § 38.2-3319.1, no policy of group life insurance shall be delivered in this Commonwealth unless it conforms to one of the following descriptions:

A. A policy issued to an employer, or to the trustees of a fund established by an employer, which employer or trustees shall be deemed the policyholder, to insure employees of the employer for the benefit of persons other than the employer, subject to the following requirements:

1. The employees eligible for insurance under the policy shall be all of the employees of the employer, or all of any class or classes thereof. The policy may provide that the term "employees" include:

a. The employees of one or more subsidiary corporations, and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the employer and of such affiliated corporations, proprietorships, or partnerships is under common control;

b. The individual proprietor or partners if the employer is an individual proprietorship or partnership;

c. Retired employees, former employees and directors of a corporate employer; or

d. If the policy is issued to insure the employees of a public body, elected or appointed officials.

2. The premium for the policy shall be paid either from the employer's funds or from funds contributed by the insured employees, or from both. Except as provided in subdivision 3 of this subsection, a policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, except those who reject such coverage in writing.

3. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

B. A policy which is:

1. Not subject to Chapter 37.1 (§ 38.2-3727 et seq.) of this title, and

2. Issued to a creditor or its parent holding company or to a trustee or trustees or agent designated by two or more creditors, which creditor, holding company, affiliate, trustee, trustees or agent shall be deemed the policyholder, to insure debtors of the creditor, or creditors, subject to the following requirements:

a. The debtors eligible for insurance under the policy shall be all of the debtors of the creditor or creditors, or all of any class or classes thereof. The policy may provide that the term "debtors" includes:

(1) Borrowers of money or purchasers or lessees of goods, services, or property for which payment is arranged through a credit transaction;

(2) The debtors of one or more subsidiary corporations; and

(3) The debtors of one or more affiliated corporations, proprietorships, or partnerships if the business of the policyholder and of such affiliated corporations, proprietorships, or partnerships is under common control.

b. The premium for the policy shall be paid either from the creditor's funds, or from charges collected from the insured debtors, or from both. Except as provided in subdivision 3 of this subsection, a policy

on which no part of the premium is to be derived from the funds contributed by insured debtors specifically for their insurance must insure all eligible debtors.

3. An insurer may exclude any debtors as to whom evidence of individual insurability is not satisfactory to the insurer.

4. The amount of the insurance on the life of any debtor shall at no time exceed the greater of the scheduled or actual amount of unpaid indebtedness to the creditor.

5. The insurance may be payable to the creditor or any successor to the right, title, and interest of the creditor. Such payment shall reduce or extinguish the unpaid indebtedness of the debtor to the extent of such payment and any excess of the insurance shall be payable to the estate of the insured.

6. Notwithstanding the provisions of the above subsections, insurance on agricultural credit transaction commitments may be written up to the amount of the loan commitment on a nondecreasing or level term plan. Insurance on educational credit transaction commitments may be written up to the amount of the loan commitment less the amount of any repayments made on the loan.

C. A policy issued to a labor union, or similar employee organization, which shall be deemed to be the policyholder, to insure members of such union or organization for the benefit of persons other than the union or organization or any of its officials, representatives, or agents, subject to the following requirements:

1. The members eligible for insurance under the policy shall be all of the members of the union or organization, or all of any class or classes thereof.

2. The premium for the policy shall be paid either from funds of the union or organization, or from funds contributed by the insured members specifically for their insurance, or from both. Except as provided in subdivision 3 of this subsection, a policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members, except those who reject such coverage in writing.

3. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

D. A policy issued to or for (i) a multiple employer welfare arrangement, a rural electric cooperative, or a rural electric telephone cooperative as these terms are defined in 29 U.S.C. § 1002, or (ii) a trust or to the trustees of a fund established or adopted by two or more employers, or by one or more labor unions or similar employee organizations, or by one or more employers and one or more labor unions or similar employee organizations, which trust or trustees shall be deemed the policyholder, to insure employees of the employers or members of the unions or organizations for the benefit of persons other than the employees or the unions or organizations, subject to the following requirements:

1. The persons eligible for insurance shall be all of the employees of the employers or all of the members of the unions or organizations, or all of any class or classes thereof. The policy may provide that the term employees includes:

a. The employees of one or more subsidiary corporations, and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the employer and of such affiliated corporations, proprietorships or partnerships is under common control;

b. The individual proprietor or partners if the employer is an individual proprietorship or partnership;

c. Retired employees, former employees and directors of a corporate employer; or

d. The trustees or their employees, or both, if their duties are principally connected with such trusteeship.

2. The premium for the policy shall be paid from funds contributed by the employer or employers of the insured persons, or by the union or unions or similar employee organizations, or by both, or from funds contributed by the insured persons or from both the insured persons and the employers or unions or similar employee organizations. Except as provided in subdivision 3 of this subsection, a policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance must insure all eligible persons, except those who reject such coverage in writing.

3. 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. 1. 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:

a. Have at the outset a minimum of 100 persons;

b. Have been organized and maintained in good faith for purposes other than that of obtaining insurance;

c. Have been in active existence for at least five years; and

d. Have a constitution and bylaws which provide that: (i) the association or associations hold regular meetings not less than annually to further purposes of the members, (ii) except for credit unions, the association or associations collect dues or solicit contributions from members, and (iii) the members have voting privileges and representation on the governing board and committees.

2. The policy shall be subject to the following requirements:

a. The policy may insure members of such association or associations, employees thereof or employees of members, or one or more of the preceding or all of any class or classes thereof for the benefit of persons other than the employee's employer.

b. The premium for the policy shall be paid from funds contributed by the association or associations, or by employer members, or by both, or from funds contributed by the covered persons or from both the covered persons and the association, associations, or employer members.

c. Except as provided in clause 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 the insurance must insure all eligible persons, except those who reject such 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.

F. A policy issued to a credit union or to a trustee or trustees or agent designated by two or more credit unions, which credit union, trustee, trustees, or agent shall be deemed policyholder, to insure members of such credit union or credit unions for the benefit of persons other than the credit union or credit unions, trustee or trustees, or agent or any of their officials, subject to the following requirements:

1. The members eligible for insurance shall be all of the members of the credit union or credit unions, or all of any class or classes thereof.

2. The premium for the policy shall be paid by the policyholder from the credit union's funds and, except as provided in subdivision 3 of this subsection, must insure all eligible members.

3. An insurer may exclude or limit the coverage on any member as to whom evidence of individual insurability is not satisfactory to the insurer.

G. A policy issued to an incorporated association as described in § 38.2-4000, whose principal purpose is to assist its members in (i) financial planning for their funerals and burials and (ii) obtaining insurance for the payment, in whole or in part, for funeral, burial and other expenses. The association shall be deemed the policyholder, to insure the members of the association for the benefit of persons other than the association. The policy shall be subject to the following requirements:

1. A policy may not be issued to an association in which membership is conditioned upon the member's designation at any time of a specific funeral director or cemetery as the beneficiary under the insurance, so as to deprive the representatives or family of the deceased member from, or in any way control them in, obtaining funeral supplies and services in an open competitive market.

2. The policy shall insure members of such association.

3. The premium for the policy shall be paid from funds contributed by the association, or from funds contributed by the covered persons, or both.

4. Except as provided in subdivision 5 of this subsection, a policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for the insurance must insure all eligible persons except those who reject the coverage in writing.

5. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

1998, c. 154.

§ 38.2-3319. Repealed.

Repealed by Acts 1998, c. 154.

§ 38.2-3319.1. Limits of group life insurance.

Group life insurance offered to a resident of this Commonwealth under a group life insurance policy issued to a group other than one described in § 38.2-3318.1 shall be subject to the following requirements:

A. No such group life insurance policy shall be delivered in this Commonwealth unless the Commission finds that:

1. The issuance of such group policy is not contrary to Virginia's public policy and is in the best interest of the citizens of this Commonwealth;

2. The issuance of the group policy would result in economies of acquisition or administration; and

3. The benefits are reasonable in relation to the premiums charged.

Insurers filing policy forms seeking approval under the provisions of this subsection shall accompany the forms with a certification, signed by the officer of the company with the responsibility for forms compliance, in which the company certifies that each such policy form will be issued only where the requirements set forth in subdivisions 1 through 3 of this subsection have been met.

B. No such group life insurance coverage may be offered in this Commonwealth by an insurer under a policy issued in another state unless this Commonwealth or another state having requirements substantially similar to those contained in subdivisions 1, 2 and 3 of subsection A has made a determination that such requirements have been met.

An insurer offering group life insurance coverage in this Commonwealth under this subsection shall file a certification, signed by the officer of the company having responsibility for forms compliance in which the company certifies that all group insurance coverage marketed to residents of this Commonwealth under policies which have not been approved by this Commonwealth will comply with the provisions of § 38.2-3318.1 or have met the requirements set forth in subdivisions A 1 through A 3 of this section, and which clearly demonstrates that the substantially similar requirements of the state in which the contract will be issued have been met. The certification shall be accompanied by documentation from such state evidencing the determination that such requirements have been met.

C. The premium for the policy shall be paid either from the policyholder's funds or from funds contributed by the covered persons, or from both.

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.

1998, c. 154.

§ 38.2-3319.2. Review of records.

The Commission may review the records of any insurer to determine that the insurer's policies have been issued in compliance with the requirements set forth in this article. Insurers issuing coverage not complying with the provisions of § 38.2-3318.1 and not complying with the requirements of § 38.2-

3319.1 shall be deemed to have committed a knowing and willful violation of this article, and shall be punished as set forth in subsection A of § 38.2-218.

1998, c. 154.

§ 38.2-3320. Repealed.

Repealed by Acts 1998, c. 154.

§ 38.2-3320.1. Policies issued outside of the Commonwealth of Virginia.

A group life insurance policy issued outside of this Commonwealth, providing coverage to residents of this Commonwealth, that does not qualify under § 38.2-3318.1 or does not comply with § 38.2-3319.1 shall be subject to the statutory requirements of this title and may subject the insurer issuing such policy to the penalties available under this title for violation of such requirements.

1998, c. 154.

§ 38.2-3321. Repealed.

Repealed by Acts 1998, c. 154.

§ 38.2-3321.1. Requirements for those marketing group life insurance.

Insurance marketed to certificate holders of a group that does not qualify pursuant to § 38.2-3318.1 must be marketed by a person holding a valid life and health insurance agent license as required by Chapter 18 (§ 38.2-1800 et seq.) of this title.

1998, c. 154.

§ 38.2-3322. Repealed.

Repealed by Acts 1998, c. 154.

§ 38.2-3322.1. Regulations.

The Commission may issue regulations to establish standards for group life insurance pursuant to the authority provided in § 38.2-223.

1998, c. 154.

§ 38.2-3322.2. Lives covered.

A group life insurance policy shall cover at least two persons, other than spouses or minor children, at the issue date and at each policy anniversary date.

1998, c. 154.

§ 38.2-3323. Group life insurance coverages of spouses, dependent children, and other persons.

A. Coverage under a group life insurance policy, except a policy issued pursuant to § 38.2-3318.1 B, may be extended to insure:

1. The spouse and any child who is under the age of 19 years or who is a dependent and a full-time student under 25 years of age, or any class of spouses and dependent children, of each insured group member who so elects; and

2. Any other person in whom the insured group member has an insurable interest as defined in §§ 38.2-301 and 38.2-302 as may mutually be agreed upon by the insurer and the group policyholder.

The amount of insurance on the life of a spouse, child, or other person shall not exceed the amount of insurance for which the insured group member is eligible.

B. A spouse insured under this section shall have the same conversion right to the insurance on his or her life as the insured group member.

C. Notwithstanding the provisions of § 38.2-3331, one certificate may be issued for each insured group member if a statement concerning any spouse's, dependent child's, or other person's coverage is included in the certificate.

D. In addition to the coverages afforded by the provisions of this section, any such plan for group life insurance which includes coverage for children shall afford coverage to any child who is both (i) incapable of self-sustaining employment by reason of intellectual or physical disability and (ii) chiefly dependent upon the employee for support and maintenance. Upon request of the insurer, proof of incapacity and dependency shall be furnished to the insurer by the insured group member within 31 days of the child's attainment of the specified age. Subsequent proof may be required by the insurer but not more frequently than annually after the two-year period following the child's attainment of the specified age. The insurer shall be allowed to charge a premium at the insurer's then customary rate applicable to such group policy for such extended coverage.

E. 1. Upon termination of such group coverage of a child, the child shall be entitled to have issued to him by the insurer, without evidence of insurability, an individual life insurance policy without disability or other supplementary benefits, if:

a. An application for the individual policy is made, and the first premium paid to the insurer, within 31 days after such termination; and

b. The individual policy, at the option of such person, is on any one of the forms then customarily issued by the insurer at the age and for the amount applied for, except that the group policy may exclude the option to elect term insurance;

c. The individual policy is in an amount not in excess of the amount of life insurance which ceases because of such termination, less the amount of any life insurance for which such person becomes eligible under the same or any other group policy within 31 days after such termination, provided that any amount of insurance which has matured on or before the date of such termination as an endowment payable to the person insured, whether in one sum or in installments or in the form of an annuity, shall not, for the purposes of this provision, be included in the amount which is considered to cease because of such termination; and

d. The premium on the individual policy is at the insurer's then customary rate applicable to the form and amount of the individual policy, to the class of risk to which such person then belongs, and to the individual age attained on the effective date of the individual policy.

2. Subject to the same conditions set forth above, the conversion privilege shall be available (i) to a surviving dependent, if any, at the death of the group member, with respect to the coverage under the group policy which terminates by reason of such death, and (ii) to the dependent of the group member upon termination of coverage of the dependent, while the group member remains insured under the group policy, by reason of the dependent ceasing to be a qualified family member under the group policy.

1960, c. 272, § 38.1-472.1; 1976, c. 111; 1980, c. 110; 1984, c. 364; 1985, c. 28; 1986, c. 562; 1995, c. 259; 1998, c. 154; 2010, cc. 227, 374; 2012, cc. 476, 507; 2023, cc. 148, 149.

§ 38.2-3324. Standard provisions required; exceptions.

A. No group life insurance policy shall be delivered or issued for delivery in this Commonwealth unless it contains in substance the standard provisions prescribed in this article. The standard provisions required for individual life insurance policies shall not apply to group life insurance policies.

B. If a group life insurance policy is not term insurance, it shall contain a nonforfeiture provision that in the opinion of the Commission is equitable to the insured persons and to the policyholder. This subsection shall not be construed to require that group life insurance policies contain the same nonforfeiture provisions as are required for individual life insurance policies.

C. The provisions of § 38.2-3330, subsection A of § 38.2-3331, and §§ 38.2-3332 through 38.2-3334 shall not apply to policies issued pursuant to § 38.2-3318.1 B or group life insurance contracts in which the insurable interest is as described in subdivision 3 of subsection B of § 38.2-301.

Code 1950, §§ 38-429, 38-431; 1952, c. 317, § 38.1-424; 1960, c. 273; 1968, c. 282; 1970, c. 145; 1986, c. 562; 1993, c. 105; 1998, c. 154.

§ 38.2-3325. Grace period.

Each group life insurance policy shall contain a provision that the policyowner is entitled to a grace period of not less than thirty-one days for the payment of any premium due except the first. The provision shall also state that during the grace period the death benefit coverage shall continue in force, unless the policyowner has given the insurer written notice of discontinuance in accordance with the terms of the policy and in advance of the date of discontinuance. The policy may provide that the policyowner shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during the grace period.

1960, c. 273, § 38.1-424.1; 1986, c. 562.

§ 38.2-3326. Incontestability.

A. Each group life insurance policy shall contain a provision that the validity of the policy shall not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue.

B. The provision shall also state that no statement made by any person insured under the policy relating to his insurability or the insurability of his insured dependents shall be used in contesting the validity of the insurance with respect to which such statement was made:

1. After the insurance has been in force prior to the contest for a period of two years during the lifetime of the person about whom the statement was made; and

2. Unless the statement is contained in a written instrument signed by him.

Code 1950, § 38-429(1); 1952, c. 317, § 38.1-425; 1986, c. 562.

§ 38.2-3327. Entire contract; statements deemed representations.

A. Each group life insurance policy shall contain a provision that the policy and any application of the policyowner, and any individual applications of the persons insured shall constitute the entire contract between the parties.

B. The provision shall also state that:

1. A copy of any application of the policyowner shall be attached to the policy when issued;

2. All statements made by the policyowner or by the persons insured shall be deemed representations and not warranties; and

3. No written statement made by any person insured shall be used in any contest unless a copy of the statement has been furnished to the person, his beneficiary or his personal representative.

Code 1950, § 38-429(2); 1952, c. 317, § 38.1-426; 1960, c. 273; 1986, c. 562.

§ 38.2-3328. Evidence of individual insurability.

Each group life insurance policy shall contain a provision setting forth any conditions under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of his coverage.

1960, c. 273, § 38.1-426.1; 1986, c. 562.

§ 38.2-3329. Misstatement of age.

Each group life insurance policy shall contain a provision that an equitable adjustment of premiums, benefits, or both shall be made if the age of a person insured has been misstated. The provision shall contain a clear statement of the method of adjustment to be used.

Code 1950, § 38-429(3); 1952, c. 317, § 38.1-427; 1960, c. 273; 1986, c. 562.

§ 38.2-3330. Payment of benefits.

Each group life insurance policy shall contain a provision that any sum payable because of the death of the person insured shall be payable to the beneficiary or beneficiaries designated by the person insured, subject to:

1. The provisions of the policy as to all or any part of such sum if there is no designated beneficiary living at the time of death of the person insured; and

2. Any right reserved by the insurer in the policy and set forth in the certificate to pay a part of the sum, not exceeding $2,000, to any person appearing to the insurer to be equitably entitled thereto because of having incurred funeral or other expenses incident to the death or last illness of the person insured.

1960, c. 273, § 38.1-427.1; 1986, c. 562.

§ 38.2-3331. Individual certificates.

A. Each group life insurance policy shall contain a provision that the insurer will issue to the policyholder, for delivery to each person insured, an individual certificate setting forth:

1. The insured person's insurance protection, including any limitations, reductions and exclusions applicable to the coverage provided;

2. To whom the insurance benefits are payable; and

3. The rights and conditions set forth in §§ 38.2-3332, 38.2-3333 and 38.2-3334.

B. Each policy issued pursuant to § 38.2-3318.1 B, where any part of the premium is paid by the debtors or by the creditor from identifiable charges collected from the insured debtors not required of an uninsured debtor, shall contain a provision that the insurer will furnish to the policyholder for delivery to each debtor insured under the policy a form that will contain a statement that the life of the debtor is insured under the policy and that any death benefit paid under the policy by reason of his death shall be applied to reduce or extinguish the indebtedness.

Code 1950, § 38-429(4); 1952, c. 317, § 38.1-428; 1960, c. 273, § 38.1-428.4; 1986, c. 562; 1998, c. 154.

§ 38.2-3332. Right to individual policy upon termination of employment or membership.

Each group life insurance policy shall contain a provision that if the insurance, or any portion of it, on a person covered under the policy, other than a minor child insured pursuant to § 38.2-3323, ceases because of termination of employment or of membership in the class or classes eligible for coverage under the policy, the person shall be entitled to have the insurer issue him without evidence of insurability an individual policy of life insurance, without disability or other supplementary benefits, subject to the following:

1. Application for the individual policy shall be made, and the first monthly or other mutually agreeable modal premium paid to the insurer, within thirty-one days after the termination;

2. The individual policy shall at the option of the person be on any one of the forms, except term insurance, then customarily issued by the insurer, subject to the insurer's customary age and amount requirements for the forms;

3. The amount of the individual policy shall not exceed the amount of terminated group life insurance less the amount of any group life insurance that the person is or becomes eligible for within thirty-one days after the termination. Any amount of insurance maturing on or before the date of the termination as an endowment payable to the person insured, whether in one sum, installments or in the form of an annuity, shall not be included in the amount of terminated group life insurance; and

4. The premium on the individual policy shall be at the insurer's then current rate applicable to the form and amount of the individual policy, to the class of risk to which the person then belongs, and to the person's age on the effective date of the individual policy.

1960, c. 273, § 38.1-428.1; 1986, c. 562.

§ 38.2-3333. Right to individual policy upon termination of group policy or elimination of class of insured persons.

Each group life insurance policy shall contain a provision that if the group policy terminates or is amended so as to terminate the insurance of any class of insured persons, every person, other than a minor child insured pursuant to § 38.2-3323, whose insurance terminates and who has been insured for at least five years prior to the termination date shall be entitled to have the insurer issue him an individual life insurance policy. The individual life policy shall be subject to the conditions and limitations set forth in § 38.2-3332. However, the group policy may contain a provision that the amount of the individual policy shall not exceed the smaller of (i) the amount of the person's life insurance protection ceasing because of the termination or amendment of the group policy, less the amount of any life insurance for which he is or becomes eligible under any group policy issued or reinstated by the same or another insurer within 31 days after the termination, or (ii) $10,000.

1960, c. 273, § 38.1-428.2; 1986, c. 562.

§ 38.2-3334. Death after termination of group insurance and before issuance of individual policy.

Each group life insurance policy shall contain a provision that if a person insured under the group policy dies during the period within which he is entitled to have an individual policy issued to him in accordance with § 38.2-3332 or § 38.2-3333 and before the individual policy has become effective, the amount of life insurance that he would have been entitled to have issued to him under an individual policy shall be payable as a claim under the group policy, whether or not application for the individual policy or the payment of the first premium was made.

1960, c. 273, § 38.1-428.3; 1986, c. 562.

§ 38.2-3335. Additional persons becoming eligible.

Each group life insurance policy shall contain a provision that any person who subsequently becomes a member of a group or class that is covered under the policy shall be eligible for group life insurance in accordance with the same requirements as any other member of the group or class.

Code 1950, § 38-429(5); 1952, c. 317, § 38.1-429; 1986, c. 562.

§ 38.2-3336. Provisions required by other jurisdictions.

Group life insurance policies issued by any foreign or alien insurer for delivery in this Commonwealth may contain any provision that is prescribed by the laws of its domiciliary jurisdiction and that is not in conflict with the laws of this Commonwealth. Policies issued by any domestic insurer for delivery in any other jurisdiction may contain any provision required by the laws of that jurisdiction.

Code 1950, § 38-430; 1952, c. 317, § 38.1-430; 1986, c. 562.

§ 38.2-3337. Assignment.

With mutual agreement among the insured, the policyholder, and the insurer, any person insured under a group life insurance policy may make an irrevocable assignment of the rights and benefits conferred on him by any provision of the policy or by this article. The assignment may be made to any person other than the insured's employer.

Code 1950, §§ 38-429, 38-431; 1952, c. 317, § 38.1-424; 1960, c. 273; 1968, c. 282; 1970, c. 145; 1986, c. 562.

§ 38.2-3338. Provisions prohibited.

No group life insurance policy shall be delivered or issued for delivery in this Commonwealth if it contains any provision:

1. Limiting the time within which any action at law or in equity may be commenced to less than one year after the cause of action accrues; or

2. To the effect that the agent soliciting the insurance is the agent of the person insured under the policy, or making the acts or representations of the agent binding upon the person insured under the policy.

Code 1950, § 38-386; 1952, c. 317, § 38.1-406; 1956, c. 417; 1986, c. 562.

§ 38.2-3339. Exemption of group life insurance policies from legal process.

No group life insurance policy, nor its proceeds, shall be liable to attachment, garnishment, or other process, or to be seized, taken, appropriated, or applied by any legal or equitable process or operation of law, to pay any debt or liability of any person insured under the policy, or his beneficiary, or any other person who has a right under the policy, either before or after payment. If the proceeds of a group life insurance policy are not made payable to a named beneficiary, the proceeds shall not constitute a part of the insured person's estate for the payment of his debts.

Code 1950, § 38-432; 1952, c. 317, § 38.1-482; 1986, c. 562.

Article 3 - INDUSTRIAL LIFE INSURANCE POLICIES

§ 38.2-3340. Definition of industrial life insurance.

"Industrial life insurance" means life insurance provided by an individual insurance contract (i) under which premiums are payable monthly or more frequently, and (ii) with the words "industrial policy" printed upon the policy as a part of the descriptive matter.

Code 1950, § 38-433; 1952, c. 317, § 38.1-482; 1986, c. 562.

§ 38.2-3341. Standard provisions required.

No industrial life insurance policy shall be delivered or issued for delivery in this Commonwealth, unless it contains in substance the provisions prescribed in this article or provisions that are, in the Commission's opinion, more favorable to policyowners.

Code 1950, §§ 38-434, 38-435; 1952, c. 317, § 38.1-410; 1986, c. 562.

§ 38.2-3342. Ten-day right to examine policy.

No industrial life insurance policy shall be delivered or issued for delivery in this Commonwealth unless it has printed on it a notice stating in substance that if during a ten-day period from the date the policy is delivered to the policyowner, the policy is surrendered to the insurer or its agent with a written request for cancellation, the policy shall be void from the beginning and the insurer shall refund any premium paid for the policy. Nothing in this section shall prohibit an insurer from extending the right to examine period to more than ten days if the period is specified in the policy.

1977, c. 174, § 38.1-410.1; 1986, c. 562.

§ 38.2-3343. Grace period.

A. Each industrial life insurance policy shall contain a provision that the insured is entitled to a grace period of twenty-eight days within which the payment of any premium after the first may be made. This grace period shall terminate at noon on the twenty-eighth day after the due date of the defaulted premium. However, for monthly payment policies the insured shall be entitled to a grace period of not less than thirty-one days.

B. Each policy shall also contain a provision that during the grace period the policy shall continue in full force, but if a claim arises under the policy during the grace period and before the overdue premiums are paid, the amount of overdue premiums may be deducted in any settlement under the policy.

Code 1950, § 38-434(1); 1952, c. 317, § 38.1-411; 1986, c. 562.

§ 38.2-3344. Policy and application to constitute entire contract; statements deemed representations.

A. Each industrial life insurance policy shall contain a provision that the policy, or the policy and the application for the policy, if a copy of the application is endorsed upon or attached to the policy when issued, shall constitute the entire contract between the parties.

B. The provision shall also state that:

1. All statements made by the insured shall, in the absence of fraud, be deemed representations and not warranties; and

2. No such statement shall be used in defense of a claim under the policy unless it is contained in a written application that is endorsed upon or attached to the policy when issued.

Code 1950, § 38-434(2); 1952, c. 317, § 38.1-412; 1986, c. 562.

§ 38.2-3345. Incontestability.

Each industrial life insurance policy shall contain a provision that the policy shall be incontestable after it has been in force for two years from the date of issue during the lifetime of the insured, except for nonpayment of premiums, and except as to provisions and conditions (i) relating to benefits in the event of certain specific types of disability and (ii) granting additional insurance specifically against death by accident or accidental means.

Code 1950, § 38-434(3); 1952, c. 317, § 38.1-413; 1986, c. 562.

§ 38.2-3346. Misstatement of age.

Each industrial life insurance policy shall contain a provision that if, before final settlement of the policy, the age of the insured or the age of any other person if considered in determining the premium is found to have been misstated, the amount payable under the policy shall equal the amount that the premium would have purchased at the insured's or other person's correct age, at the time the policy was issued.

Code 1950, § 38-434(4); 1952, c. 317, § 38.1-414; 1986, c. 562.

§ 38.2-3347. Nonforfeiture benefits and cash surrender values.

Each industrial life insurance policy shall contain a provision for nonforfeiture benefits in accordance with the requirements of §§ 38.2-3202 and 38.2-3208, and a provision for cash surrender values in accordance with the requirements of §§ 38.2-3203 and 38.2-3209.

Code 1950, § 38-434(5), (6); 1952, c. 317, § 38.1-415; 1986, c. 562.

§ 38.2-3348. Reinstatement.

Each industrial life insurance policy shall contain a provision that the policy, if not surrendered for its cash value or if the period of extended term insurance has not expired, may be reinstated within one year from the date of default in payment of premiums upon:

1. Payment of all overdue premiums and, at the insurer's option, interest on the overdue premiums at an annual rate not exceeding six percent; and

2. Presentation of evidence satisfactory to the insurer of the insurability of the insured.

Code 1950, § 38-434(7); 1952, c. 317, § 38.1-416; 1986, c. 562.

§ 38.2-3349. Table of nonforfeiture options.

Each industrial life insurance policy shall contain a table showing the nonforfeiture options available under the policy each year upon default in the payment of premiums during at least the first twenty years of the policy, or during the premium-paying period if less than twenty years. There shall also be a provision that the insurer will furnish, upon request, an extension of the table beyond the years shown in the policy.

Code 1950, § 38-434(8); 1952, c. 317, § 38.1-417; 1986, c. 562.

§ 38.2-3350. Settlement.

Each industrial life insurance policy shall contain a provision that when a death claim arises under the policy, settlement shall be made within two months after receipt of due proof of death.

Code 1950, § 38-434(9); 1952, c. 317, § 38.1-418; 1986, c. 562.

§ 38.2-3351. Title.

Each industrial life insurance policy shall have a title on its face that briefly and accurately describes the nature and form of the policy.

Code 1950, § 38-434(10); 1952, c. 317, § 38.1-419; 1986, c. 562.

§ 38.2-3352. Provisions not required in certain policies.

The provisions of this article do not apply to policies issued or granted in exercise of the nonforfeiture provisions of § 38.2-3347.

Code 1950, § 38-438; 1952, c. 317, § 38.1-420; 1986, c. 562.

§ 38.2-3353. Provisions required by other jurisdictions.

Industrial life insurance policies issued by any foreign or alien insurer for delivery in this Commonwealth may contain any provision that is prescribed by the laws of its domiciliary jurisdiction and is not in conflict with the laws of this Commonwealth. Policies issued by any domestic insurer for delivery in any other jurisdiction may contain any provision required by the laws of that jurisdiction.

Code 1950, § 38-436; 1952, c. 317, § 38.1-421; 1986, c. 562.

§ 38.2-3354. Prohibited provisions.

No industrial life insurance policy shall be delivered or issued for delivery in this Commonwealth if it contains any of the following provisions:

1. Limiting the time within which any action at law or in equity may be commenced to less than one year after the cause of action accrues;

2. For any mode of settlement at maturity of less value than the amount insured by the policy plus any dividend additions to the policy, less (i) any indebtedness to the insurer on or secured by the policy and (ii) any premium that may by the terms of the policy be deducted. This subdivision shall not apply to any nonforfeiture provision that employs the cash value less any indebtedness, to purchase paid up or extended insurance, and shall not prohibit the issuance of policies providing for a limitation in the amount payable under certain specified conditions; or

3. To the effect that the agent soliciting the insurance is the agent of the person insured under the policy, or making the acts or representations of the agent binding upon the person insured under the policy.

Code 1950, § 38-437; 1952, c. 317, § 38.1-422; 1986, c. 562.

Chapter 34 - Provisions Relating to Accident and Sickness Insurance

Article 1 - General Provisions

§ 38.2-3400. Application of chapter.

A. This chapter and Chapter 35 (§ 38.2-3500 et seq.) of this title apply to insurance policies or contracts of the class described in § 38.2-109 delivered or issued for delivery in this Commonwealth except as provided in subsection B of this section.

B. Nothing in this chapter shall apply to or affect:

1. Any workers' compensation insurance policy;

2. Any liability insurance policy with or without supplementary expense coverage, including any motor vehicle liability insurance policy, providing weekly indemnity or other specific benefits to persons who are injured and specific death benefits to dependents, beneficiaries or personal representatives of persons who are killed, irrespective of the legal liability of the insured or any other person;

3. Any policy or contract of reinsurance;

4. Life insurance or annuities;

5. Any industrial sick benefit insurance; or

6. Any credit accident and sickness insurance policy.

Code 1950, § 38-225; 1950, p. 1016; 1952, c. 317, §§ 38.1-347, 38.1-360; 1956, c. 678; 1974, c. 95; 1975, c. 281; 1976, c. 355; 1977, c. 606; 1978, c. 496; 1979, cc. 13, 97; 1980, c. 719; 1986, c. 562.

§ 38.2-3401. Forms of insurance authorized.

A. Accident and sickness insurance shall be issued only in the following forms:

1. Individual accident and sickness policies; or

2. Group accident and sickness policies.

B. Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such regulations as may be necessary or appropriate to govern insurers' practices with regard to Acquired Immunodeficiency Syndrome (AIDS) or the presence of the Human Immunodeficiency Virus (HIV), including advertising practices, underwriting practices, policy provisions, claim practices, or other practices with regard to individual or group accident and sickness insurance policies delivered or issued for delivery in the Commonwealth of Virginia and certificates or evidences of coverage, issued under any contract delivered or issued for delivery in the Commonwealth of Virginia.

1986, c. 562; 1989, c. 653.

§ 38.2-3402. Certification to accompany application.

A. Each application for an individual accident and sickness insurance policy shall contain a certification, signed by both the applicant and the agent soliciting the insurance, to the effect that: "The undersigned applicant and agent certify that the applicant has read, or had read to him, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy." If the application is to be used in a solicitation where no agent is involved, the certification may delete the reference to and signature of the agent soliciting the insurance.

B. Subsection A of this section shall also apply to an application by an individual for coverage under a group policy where individual underwriting is done.

C. If the certification is wholly or partially inapplicable to a particular form of policy, the insurer may modify or omit the certification with the approval of the Commission.

1966, c. 342, § 38.1-348.2; 1986, c. 562.

§ 38.2-3403. Fraudulent procurement of policy.

A. No person shall knowingly secure, attempt to secure or cause to be secured an individual accident and sickness insurance policy on any person not in an insurable condition by means of misrepresentations or false or fraudulent statements.

B. An insurance agent who violates this section shall be subject to the penalties under § 38.2-1831 in addition to the penalties of § 38.2-218.

1966, c. 342, § 38.1-348.3; 1986, c. 562.

§ 38.2-3404. Commission may establish rules and regulations for simplified and readable accident and sickness insurance policies.

A. Pursuant to the authority granted in § 38.2-223, the Commission may issue rules and regulations establishing standards for simplified and readable accident and sickness insurance policy forms. Any such rules and regulations shall apply to any policy forms of accident and sickness insurance as defined in § 38.2-109, except credit accident and sickness insurance, issued on a nongroup basis or to groups with ten or fewer members.

B. The rules and regulations issued hereunder may permit an insurer to issue policies containing policy provisions that deviate in language from the policy provisions required by §§ 38.2-3500 through 38.2-3506 where applicable, provided the provisions in each instance are not less favorable to the insured or the beneficiary.

C. No insurer shall deliver or issue for delivery an accident and sickness insurance policy in this Commonwealth unless the Commission has determined that the policy form satisfies the readability standards established by the rules and regulations and is in compliance with other statutory requirements.

1979, c. 47, § 38.1-354.1; 1986, c. 562.

§ 38.2-3405. Certain subrogation provisions and limitations upon recovery in hospital, medical, etc., policies forbidden; limitations on disclosure of medical treatment options prohibited.

A. No insurance contract providing hospital, medical, surgical and similar or related benefits, and no subscription contract or health services plan delivered or issued for delivery or providing for payment of benefits to or on behalf of persons residing in or employed in this Commonwealth shall contain any provision providing for subrogation of any person's right to recovery for personal injuries from a third person.

B. No such contract, subscription contract or health services plan shall contain any provision requiring the beneficiary of any such contract or plan to sign any agreement to pay back to any company issuing such a contract or creating a health services plan any benefits paid pursuant to the terms of such contract or plan from the proceeds of a recovery by such a beneficiary from any other source; provided, that this provision shall not prohibit an exclusion of benefits paid or payable under workers' compensation laws or federal or state programs, nor shall this provision prohibit coordination of benefits provisions when there are two or more such accident and sickness insurance contracts or plans providing for the payment of the same benefits. Coordination of benefits provisions may not operate to

reduce benefits because of any benefits paid, payable, or provided by any liability insurance contract or any benefits paid, payable, or provided by any medical expense or medical payments insurance provided in conjunction with liability coverage.

C. No insurance contract providing hospital, medical, surgical and similar or related benefits, and no subscription contract or health services plan delivered or issued for delivery or providing for payment of benefits to or on behalf of persons residing in or employed in this Commonwealth shall contain any provision limiting, restricting, or prohibiting a physician from disclosing fully all medical treatment options to patients whether or not such treatment options are (i) experimental or covered services, (ii) services that the health insurer will not authorize, or (iii) the costs of the treatment will be borne by the health insurer or the patient to facilitate an informed decision by the patient, if the physician determines that such an option is in the best interest of the patient. For the purposes of this subsection, "medical treatment options" means any alternative or experimental therapeutic, psychiatric, medical treatment or procedure, health care service, drug, or remedy.

D. Whenever benefits paid or payable under workers' compensation are excluded from coverage under the terms of any such contract, subscription contract or health services plan, the issuer thereof shall not exclude coverage for any medical condition pursuant to such exclusion if (i) an award of the Workers' Compensation Commission pursuant to § 65.2-704 denies compensation benefits relating to such medical condition and no request for review of such award is made pursuant to and within the time prescribed by § 65.2-705 or (ii) an award of the Workers' Compensation Commission, after review by the full Commission pursuant to § 65.2-705, denies compensation benefits relating to such medical condition. Following the entry of a workers' compensation award pursuant to clause (i) or (ii) having the effect of prohibiting the application of any such exclusion, the issuer shall immediately provide coverage for such medical condition to the extent otherwise covered under the contract, subscription contract or health services plan. If, upon appeal to the Court of Appeals or the Supreme Court, such medical condition is held to be compensable under the Virginia Workers' Compensation Act (Title 65.2), the issuer may recover from the applicable employer or workers' compensation insurance carrier the costs of coverage for medical conditions found to be compensable under the Act.

1973, c. 28, § 38.1-342.2; 1979, c. 341; 1986, c. 562; 1988, c. 840; 1989, c. 487; 1994, c. 609; 1995, c. 68; 2004, c. 675.

§ 38.2-3405.1. Commonwealth's right to certain accident and sickness benefits.

A. The Department of Medical Assistance Services shall be entitled to direct reimbursement under any accident and sickness insurance policy, health services plan, or health maintenance organization contract for covered services or items to the extent that payment has been made by the Department of Medical Assistance Services on behalf of an individual covered under such policy, plan, or contract for such services or items.

B. No insurer, health services plan, or health maintenance organization shall impose upon the Department of Medical Assistance Services or any state agency, which has been assigned or has otherwise

acquired the rights of an individual eligible for medical assistance ("Medicaid") and covered for health benefits by the insurance policy, health services plan, or health maintenance organization contract, any requirements that are different from requirements applicable to an agent or assignee of any other individual so covered.

1994, c. 213.

§ 38.2-3406. Accident and sickness benefits not subject to legal process.

The installment payments to the holder of any accident and sickness insurance policy or certificate shall not be subject to the lien of any attachment, garnishment proceeding, writ of fieri facias, or to levy or distress in any manner for any debt due by the holder of the policy or certificate.

Code 1950, § 38-227; 1952, c. 317, § 38.1-346; 1986, c. 562.

§ 38.2-3406.1. Application of requirements that policies offered by small employers include state-mandated health benefits.

A. As used in this section:

"Eligible individual" means an individual who is employed by a small employer and has satisfied applicable waiting period requirements.

"Health insurance coverage" means benefits consisting of coverage for costs of medical care, whether directly, through insurance or reimbursement, or otherwise, and including items and services paid for as medical care under a group policy of accident and sickness insurance, hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract, which coverage is subject to this title or is provided under a plan regulated under the Employee Retirement Income Security Act of 1974.

"Health insurer" means any insurance company that issues accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis, a corporation that provides accident and sickness subscription contracts, or any health maintenance organization that provides a health care plan that provides, arranges for, pays for, or reimburses any part of the cost of any health care services, that is licensed to engage in such business in the Commonwealth, and that is subject to the laws of the Commonwealth that regulate insurance within the meaning of § 514(b)(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1144(b)(2)).

"Small employer" has the same meaning ascribed to the term in § 38.2-3431.

"State-mandated health benefit" means coverage required under this title or other laws of the Commonwealth to be provided in a policy of accident and sickness insurance or a contract for a health-related condition that (i) includes coverage for specific health care services or benefits; (ii) places limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts; or (iii) includes a specific category of licensed health care practitioners from whom an insured is entitled to receive care. "State-mandated health benefit" includes, without limitation, any

coverage, or the offering of coverage, of a benefit or provider pursuant to §§ 38.2-3407.5 through 38.2-3407.6:1, 38.2-3407.9:01, 38.2-3407.9:02, 38.2-3407.11 through 38.2-3407.11:3, 38.2-3407.16, 38.2-3408, 38.2-3411 through 38.2-3414.1, 38.2-3418 through 38.2-3418.14, or § 38.2-4221. For purposes of this article, "state-mandated health benefit" does not include a benefit that is mandated by federal law.

B. Notwithstanding any statute, rule, or regulation to the contrary, and for the purposes of this section, a group accident and sickness insurance policy providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; a group accident and sickness subscription contract providing health insurance coverage for eligible individuals; and a health care plan that provides, arranges for, pays for, or reimburses any part of the cost of any health care services that is offered, sold, or issued by a health insurer to a small employer:

1. Shall not be required to include coverage, or the offer of coverage, for any state-mandated health benefit, except for:

a. Coverage for mammograms pursuant to § 38.2-3418.1;

b. Coverage for pap smears pursuant to § 38.2-3418.1:2;

c. Coverage for PSA testing pursuant to § 38.2-3418.7; and

d. Coverage for colorectal cancer screening pursuant to § 38.2-3418.7:1.

2. May include any, or none, of the state-mandated health benefits not otherwise noted in subdivision B 1 as the health insurer and the small employer shall agree.

Notwithstanding any provision of this section to the contrary, if any plan authorized by this section includes and offers health care services covered by the plan that may be legally rendered by a health care provider listed in § 38.2-3408, that plan shall allow for the reimbursement of such covered services when rendered by such provider. Unless otherwise provided in this section, this provision shall not require any benefit be provided as a covered service.

C. Any application and any enrollment form used in connection with coverage under this section shall prominently disclose that the policy, contract, or evidence of coverage is not required to provide state-mandated health benefits, shall prominently disclose any and all state-mandated health benefits that the policy, subscription contract, or evidence of coverage does not provide, and shall clearly describe all eligibility requirements.

D. A policy form, subscription contract, or evidence of coverage issued under this section to a small employer shall prominently disclose any and all state-mandated health benefits that the policy, subscription contract, or evidence of coverage does not provide. Such disclosure shall also be included in certificate forms or other evidences of coverage furnished to each participant. Health insurers proposing to issue forms providing coverage under this section shall clearly disclose the intended purposes for such policies, contracts, or evidences of coverage when submitting the forms to the Commission for approval in accordance with § 38.2-316.

E. The Commission shall adopt any regulations necessary to implement this section.

F. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

2009, cc. 796, 877; 2010, cc. 155, 515, 687; 2011, c. 882; 2013, c. 751; 2016, c. 1; 2018, c. 782.

§ 38.2-3406.2. Capped benefits under insurance policies and contracts.

A. Nothing in this chapter or Chapters 35 (§ 38.2-3500 et seq.) or 42 (§ 38.2-4200 et seq.) shall prohibit the offering, sale, or issuance of accident and sickness insurance policies or subscription contracts that cap or limit the total annual or lifetime benefits provided under an accident and sickness insurance policy or subscription contracts at specified dollar amounts.

B. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

2009, cc. 796, 877; 2011, c. 882.

§ 38.2-3407. Health benefit programs.

A. One or more insurers may offer or administer a health benefit program under which the insurer or insurers may offer preferred provider policies or contracts that limit the numbers and types of providers of health care services eligible for payment as preferred providers.

B. Any such insurer shall establish terms and conditions that shall be met by a hospital, physician or type of provider listed in § 38.2-3408 in order to qualify for payment as a preferred provider under the policies or contracts. These terms and conditions shall not discriminate unreasonably against or among such health care providers. No hospital, physician or type of provider listed in § 38.2-3408 willing to meet the terms and conditions offered to it or him shall be excluded. Neither differences in prices among hospitals or other institutional providers produced by a process of individual negotiations with providers or based on market conditions, or price differences among providers in different geographical areas, shall be deemed unreasonable discrimination. The Commission shall have no jurisdiction to adjudicate controversies growing out of this subsection.

C. Mandated types of providers set forth in § 38.2-3408, and types of providers whose services are required to be made available and that have been specifically contracted for by the holder of any such policy or contract shall, to the extent required by § 38.2-3408, have the same opportunity to qualify for payment as a preferred provider as do doctors of medicine.

D. Preferred provider policies or contracts shall provide for payment for services rendered by nonpreferred providers, but the payments need not be the same as for preferred providers.

E. An insurer may offer individual or group exclusive provider policies or contracts if:

1. The insurer provides or includes a benefit for preferred and nonpreferred providers in accordance with the provisions of subsection D to a group contract holder to be provided or offered as a benefit for the enrollee, at the enrollee's option, individually to accept or reject. In connection with its group enrollment application, every insurer shall, at no additional cost to the group contract holder, make available

or arrange with a carrier to make available to the prospective group contract holder and to all prospective enrollees, in advance of initial enrollment and in advance of each reenrollment, a notice in form and substance approved by the Commission as required under § 38.2-316, that accurately and completely explains to the group contract holder and prospective enrollee the benefit for preferred and nonpreferred providers and permits each enrollee to make his election. The form of notice provided in connection with any reenrollment may be the same as the approved form of notice filed under § 38.2-316 used in connection with initial enrollment and may be made available to the group contract holder and prospective enrollee by the carrier in any reasonable manner; and

2. The insurer provides out-of-network emergency services at the minimum level required by the preferred provider policy or contract.

F. For the purposes of this section, "exclusive provider policies or contracts" are insurance policies or contracts that condition the payment of benefits on the use of preferred providers, and "preferred provider policies or contracts" are insurance policies or contracts that specify how services are to be covered when rendered by preferred and nonpreferred classifications of providers.

1983, c. 464, § 38.1-347.2; 1986, c. 562; 2008, c. 215.

§ 38.2-3407.1. Interest on accident and sickness claim proceeds.

A. If an action to recover the claim proceeds due under an individual or group accident and sickness policy results in a judgment against an insurer, interest on the judgment at the legal rate of interest shall be paid from the date of presentation to the insurer of proof of loss to the date judgment is entered.

B. If no action is brought, interest upon the claim proceeds paid to the policyholder, insured, claimant, or assignee entitled thereto shall be computed daily at the legal rate of interest from the date of fifteen working days from the insurer's receipt of proof of loss to the date of claim payment.

C. This section shall not apply to individual policies issued prior to July 1, 1990, but shall apply to any renewals or reissues of group accident and sickness policies occurring after that date.

D. This section shall not apply to claims for which payment has been or will be made directly to health care providers pursuant to a negotiated reimbursement arrangement requiring uniform or periodic interim payments to be applied against the insurer's obligation on such claims.

E. For purposes of this section, "proof of loss" means all necessary documentation reasonably required by the insurer to make a determination of benefit coverage.

F. This section shall not apply to claims proceeds payable to an out-of-state provider of pharmacy services for pharmacy services rendered outside of the Commonwealth. Notwithstanding the foregoing sentence, this section shall apply to claims proceeds payable to such an out-of-state provider if the state where such services are rendered fails to provide for the payment of interest on the claims proceeds. If this section is applicable to claims proceeds payable to such an out-of-state provider as a result of the failure of such other state to provide for the payment of interest on the claims proceeds, then,

notwithstanding the provisions of subsection B, interest upon the claim proceeds paid to the policyholder, insured, claimant, or assignee entitled thereto shall be computed daily at the legal rate of interest from the thirtieth day following the insurer's receipt of proof of loss to the date of claim payment.

1990, c. 531; 1992, c. 23; 1996, c. 75; 2009, c. 226.

§ 38.2-3407.2. Coverage for medical child support.

A. No insurer, health services plan, or health maintenance organization shall refuse to enroll a child under a parent's coverage because (i) the child was born out of wedlock; (ii) the child is not claimed as a dependent on the parent's federal income tax return; or (iii) the child does not reside with the parent or in the insurer's, health services plan's, or health maintenance organization's service area.

B. Upon receipt of proof that a parent eligible for family coverage under an accident and sickness policy, health services plan, or health maintenance organization contract has been required by a court or administrative order to provide health coverage for a child, the insurer, health services plan, or health maintenance organization shall:

1. Permit such parent to enroll under such family coverage any such child who is otherwise eligible for such coverage, without regard to any enrollment season restrictions;

2. If such parent is enrolled but fails to make application to obtain coverage for such child, enroll such child upon application by the child's other parent or by the Department of Social Services; and

3. Not disenroll or otherwise eliminate coverage of such child unless the insurer, health services plan, or health maintenance organization is provided satisfactory written evidence that:

a. Such court or administrative order is no longer in effect;

b. Such child is or will be enrolled in comparable health coverage through another insurer, health services plan, or health maintenance organization which will take effect not later than the effective date of termination of the child's coverage under the policy or contract issued by the insurer, health services plan, or health maintenance organization; or

c. Family health coverage has been eliminated under the insurance policy, health services plan, or health maintenance organization contract.

C. Any insurer, health services plan, or health maintenance organization providing coverage to the child of a noncustodial parent shall (i) provide to the custodial parent, upon request, any information that is necessary to obtain benefits for such child under such coverage; (ii) permit the custodial parent, or the provider of health services if approved by the custodial parent, to submit claims for services without the approval of the noncustodial parent; and (iii) make payment on claims submitted pursuant to clause (ii) directly to such custodial parent, provider, or the Department of Medical Assistance Services.

1994, c. 213.

§ 38.2-3407.3. Calculation of cost-sharing provisions.

A. An insurer, health services plan, or health maintenance organization that issues an accident and sickness insurance policy or contract pursuant to which the insured, subscriber or enrollee is required to pay a specified percentage of the cost of covered services, shall calculate such amount payable based upon an amount not to exceed the total amount actually paid or payable to the provider of such services for the services provided to the insured, subscriber, or enrollee. When there is no amount actually paid or payable to the provider by the insurer, health services plan, or health maintenance organization for the services provided, the insurer, health services plan, or health maintenance organization shall use such insurer's, health services plan's, or health maintenance organization's pre-established allowed amount to calculate the amount payable by the insured for such services. When an insured, subscriber, or enrollee receives covered services outside the insurer's, health services plan's, or health maintenance organization's provider network, and such entity utilizes another insurer's, health services plan's, or health maintenance organization's provider network located outside the Commonwealth, such entity may satisfy the obligation of this section by using the cost of services as reported by the out-of-state insurer, health services plan, or health maintenance organization when calculating the insured's, subscriber's, or enrollee's percentage of the cost of covered services.

B. Any insurer, health services plan, or health maintenance organization failing to administer its contracts as set forth herein shall be deemed to have committed a knowing and willful violation of this section, and shall be punished as set forth in subsection A of § 38.2-218. Each claim payment found to have been calculated in noncompliance with this section shall be deemed a separate and distinct violation, and shall further be deemed a violation subject to subdivision D 1 c of § 38.2-218, permitting the Commission to require restitution in addition to any other penalties.

1994, c. 320; 1997, c. 56; 1998, c. 49; 2017, c. 588.

§ 38.2-3407.3:1. Premium payment arrearages; order of crediting payments.

Each (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, (ii) corporation providing individual or group accident and sickness subscription contracts, and (iii) health maintenance organization providing a health care plan for health care services, shall when accepting premium payments in arrears, credit any such payments first to the longest-outstanding arrearage, and then in succession to the most recent arrearage or payment due.

1999, c. 321.

§ 38.2-3407.4. Explanation of benefits.

A. Each insurer issuing an accident and sickness insurance policy, a corporation issuing subscription contracts, and each health maintenance organization shall file for approval explanation of benefits forms. These explanation of benefit forms shall be subject to the requirements of § 38.2-316 or § 38.2-4306 as applicable.

B. The explanation of benefits shall accurately and clearly set forth the benefits payable under the contract.

C. The Commission may issue regulations to establish (i) standards for the accuracy and clarity of the information presented in an explanation of benefits and (ii) alternative methods of delivery of the explanation of benefits that permit (a) a subscriber who is legally authorized to consent to care for a covered person or recipient, (b) a covered person or recipient who is legally authorized to consent to that covered person's or recipient's own care, or (c) another party who has the exclusive legal authorization to consent to care for the covered person or recipient to receive the explanation of benefits by an alternative method, provided that each such alternative method is in compliance with the provisions of 45 C.F.R. § 164.522 regarding the right to request privacy protection for protected health information.

D. The term "explanation of benefits" as used in this section shall include any form provided by an insurer, health services plan, or health maintenance organization which explains the amounts covered under a policy or plan or shows the amounts payable by a covered person to a health care provider.

1994, c. 320; 2020, cc. 715, 716.

§ 38.2-3407.4:1. Repealed.

Repealed by Acts 2001, c. 208, cl. 1.

§ 38.2-3407.4:2. Requirements for prescription benefit cards.

A. Each (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis, (ii) corporation providing individual or group accident and sickness subscription contracts, and (iii) health maintenance organization providing a health care plan for health care services, whose policy, contract or plan, including any certificate or evidence of coverage issued in connection with such policy, contract or plan, includes coverage for prescription drugs on an outpatient basis, shall provide its insureds, subscribers or enrollees a prescription benefit card, health insurance benefit card or other technology that complies with the National Council for Prescription Drug Programs Pharmacy ID Card Implementation Guide in effect at the time of card issuance or includes, at a minimum, the following data elements:

1. The name or identifying trademark of the insurer, corporation, or health maintenance organization or, if another entity administers the prescription benefit, the name or identifying trademark of the benefit administrator;

2. The insured's, subscriber's, or enrollee's name and identification number;

3. The telephone number that providers may call for pharmacy benefit assistance; and

4. The electronic transaction routing information and other numbers required by the insurer, corporation, health maintenance organization or benefit administrator to electronically process a prescription claim.

B. The prescription benefit card, health insurance benefit card, or other technology shall be issued to each insured, subscriber or enrollee, and shall upon any changes in the required data elements set

forth in subsection A, either reissue the card or provide the insured, subscriber or enrollee such corrective information as may be required to electronically process a prescription claim. Notwithstanding the requirements of § 38.2-4300 and subdivision A 2 of § 38.2-4306, a prescription benefit card, health benefit card or other technology issued pursuant to this section shall not be considered part of the evidence of coverage and shall not be required to be filed with or approved by the Commission.

C. An insurer, corporation, or health maintenance organization may comply with this section by issuing to each insured, subscriber or enrollee a health insurance benefit card that contains data elements related to both prescription and non-prescription health insurance benefits.

D. Compliance with any federal law or regulation that requires the prescription benefit data elements on a prescription benefit card or health insurance benefit card pursuant to subsection A shall be deemed to be compliance with this section.

E. The provisions of this section shall not apply to (i) short-term travel, or accident-only, policies, (ii) short-term nonrenewable policies of not more than six months' duration, (iii) such an insurer, corporation, or health maintenance organization that does not include coverage for prescription drugs; or (iv) any health maintenance organization that operates or maintains its own pharmacies and dispenses, on an annual basis, over ninety-five percent of prescription drugs or devices to its enrollees at its own pharmacies.

F. The provisions of this section shall apply to contracts, policies or plans delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 2002.

2001, c. 334.

§ 38.2-3407.5. Denial of benefits for certain prescription drugs prohibited.

A. Each (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis, (ii) corporation providing individual or group accident and sickness subscription contracts, and (iii) health maintenance organization providing a health care plan for health care services, whose policy, contract or plan, including any certificate or evidence of coverage issued in connection with such policy, contract or plan, includes coverage for prescription drugs, whether on an inpatient basis, outpatient basis, or both, shall provide in each such policy, contract, plan, certificate, and evidence of coverage that such benefits will not be denied for any drug approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of the specific type of cancer for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendia.

B. Each (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, (ii) corporation providing individual or group accident and sickness subscription contracts, and (iii) health maintenance organization providing a health care plan for health care services, whose policy, contract

or plan, including any certificate or evidence of coverage issued in connection with such policy, contract or plan, includes coverage for prescription drugs, whether on an inpatient basis, outpatient basis, or both, shall provide in each such policy, contract, plan, certificate, and evidence of coverage that such benefits will not be denied for any drug prescribed to treat a covered indication so long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

C. For the purposes of subsections A and B:

"Peer-reviewed medical literature" means a scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier.

"Standard reference compendia" means:

1. American Hospital Formulary Service Drug Information;

2. National Comprehensive Cancer Network's Drugs & Biologics Compendium; or

3. Elsevier Gold Standard's Clinical Pharmacology.

D. Coverage, as described in subsections A and B, includes medically necessary services associated with the administration of the drug.

E. Subsections A and B shall not be construed to do any of the following:

1. Require coverage for any drug if the United States Food and Drug Administration has determined its use to be contraindicated for the treatment of the specific type of cancer or indication for which the drug has been prescribed;

2. Require coverage for experimental drugs not otherwise approved for any indication by the United States Food and Drug Administration;

3. Alter any law with regard to provisions limiting the coverage of drugs that have not been approved by the United States Food and Drug Administration;

4. Create, impair, alter, limit, modify, enlarge, abrogate, or prohibit reimbursement for drugs used in the treatment of any other disease or condition; or

5. Require coverage for prescription drugs in any contract, policy or plan that does not otherwise provide such coverage.

F. The provisions of this section shall not apply to short-term travel, or accident-only policies, or to short-term nonrenewable policies of not more than six months' duration.

G. The provisions of subsection A are applicable to contracts, policies or plans delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 1994, and the provisions of subsection B are applicable to contracts, policies or plans delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 1997.

1994, c. 374; 1997, c. 656; 2010, c. 443.

§ 38.2-3407.5:1. Coverage for prescription contraceptives.

A. Each (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis; (ii) corporation providing individual or group accident and sickness subscription contracts; and (iii) health maintenance organization providing a health care plan for health care services, whose policy, contract or plan, including any certificate or evidence of coverage issued in connection with such policy, contract or plan, includes coverage for prescription drugs on an outpatient basis, shall offer and make available coverage thereunder for any prescribed drug or device approved by the United States Food and Drug Administration for use as a contraceptive.

B. No insurer, corporation or health maintenance organization shall impose upon any person receiving prescription contraceptive benefits pursuant to this section any (i) copayment, coinsurance payment or fee that is not equally imposed upon all individuals in the same benefit category, class, coinsurance level or copayment level receiving benefits for prescription drugs, or (ii) reduction in allowable reimbursement for prescription drug benefits.

C. The provisions of subsection A shall not be construed to:

1. Require coverage for prescription coverage benefits in any contract, policy or plan that does not otherwise provide coverage for prescription drugs;

2. Preclude the use of closed formularies, provided, however, that such formularies shall include oral, implant and injectable contraceptive drugs, intrauterine devices and prescription barrier methods; or

3. Require coverage for experimental contraceptive drugs not approved by the United States Food and Drug Administration.

D. The provisions of this section shall not apply to short-term travel, accident-only, limited or specified disease policies, or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans, or to short-term nonrenewable policies of not more than six months' duration.

E. The provisions of this section shall be applicable to contracts, policies or plans delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 1997.

1997, c. 748.

§ 38.2-3407.5:2. Reimbursements for dispensing hormonal contraceptives.

A. As used in this section:

"Covered person" means a policyholder, subscriber, enrollee, participant, or other individual covered by a health benefit plan.

"Health benefit plan" means any accident and health insurance policy or certificate, health services plan contract, health maintenance organization subscriber contract, plan provided by a multiple employer welfare arrangement (MEWA), or plan provided by another benefit arrangement. "Health benefit plan" does not mean accident only, credit, or disability insurance; coverage of Medicare services or federal employee health plans, pursuant to contracts with the United States government; Medicare supplement or long-term care insurance; Medicaid coverage; dental only or vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; short-term limited duration coverage; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; medical expense and loss of income benefits; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

"Health carrier" means an entity subject to the insurance laws and regulations of the Commonwealth and subject to the jurisdiction of the Commission that contracts or offers to contract to provide a health benefit plan.

"Hormonal contraceptive" means a medication taken to prevent pregnancy by means of ingestion of hormones, including medications containing estrogen or progesterone, that is self-administered, requires a prescription, and is approved by the U.S. Food and Drug Administration for such purpose.

"Provider" means a facility, physician or other type of health care practitioner licensed, accredited, certified or authorized by statute to deliver or furnish health care items or services.

B. Any health benefit plan that is amended, renewed, or delivered on or after January 1, 2018, that provides coverage for hormonal contraceptives shall cover up to a 12-month supply of hormonal contraceptives when dispensed or furnished at one time for a covered person by a provider or pharmacy or at a location licensed or otherwise authorized to dispense drugs or supplies.

C. Nothing in this section shall be construed to require a provider to prescribe, furnish, or dispense 12 months of self-administered hormonal contraceptives at one time.

D. A health benefit plan that provides coverage for hormonal contraceptives, in the absence of clinical contraindications, shall not impose utilization controls or other forms of medical management limiting the supply of hormonal contraceptives that may be dispensed or furnished by a provider or pharmacy, or at a location licensed or otherwise authorized to dispense drugs or supplies, to an amount that is less than a 12-month supply.

E. This section shall not be construed to exclude coverage for hormonal contraceptives as prescribed by a provider, acting within his scope of practice, for reasons other than contraceptive purposes, such

as decreasing the risk of ovarian cancer or eliminating symptoms of menopause, or for contraception that is necessary to preserve the life or health of an enrollee.

F. Nothing in this section shall be construed to require a health carrier to cover hormonal contraceptives provided by a provider or pharmacy or at a location licensed or otherwise authorized to dispense drugs or supplies, that does not participate in the health carrier's provider network, except as may be otherwise authorized or required by state law or by the plan's policies governing out-of-network coverage.

2017, c. 716.

§ 38.2-3407.6. Exclusion of podiatrist not permitted under certain circumstances.

No podiatrist shall be excluded from participating in any preferred provider plan pursuant to this chapter or Chapter 42 (§ 38.2-4200 et seq.) of this title or health maintenance organization pursuant to Chapter 43 (§ 38.2-4300 et seq.) of this title solely because such preferred provider plan or health maintenance organization requires that participating health care providers have active medical staff privileges or admitting medical staff privileges at specified hospitals, provided that the podiatrist has a delineation of privileges that enables such podiatrist to perform the type of services that are covered by the preferred provider plan or health maintenance organization at the designated hospital or hospitals. The Commission shall have no jurisdiction to adjudicate controversies arising out of this section.

1994, c. 522.

§ 38.2-3407.6:1. Denial of benefits for certain prescription drugs prohibited.

A. Each (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, (ii) corporation providing individual or group accident and sickness subscription contracts, and (iii) health maintenance organization providing a health care plan for health care services, whose policy, contract or plan, including any certificate or evidence of coverage issued in connection with such policy, contract or plan, includes coverage for prescription drugs, whether on an inpatient basis, an outpatient basis, or both, shall provide in each such policy, contract, plan, certificate, and evidence of coverage that such benefits shall not be denied for any drug approved by the United States Food and Drug Administration for use in the treatment of cancer pain on the basis that the dosage is in excess of the recommended dosage of the pain-relieving agent, if the prescription in excess of the recommended dosage has been prescribed in compliance with §§ 54.1-2971.01, 54.1-3303 and 54.1-3408.1 for a patient with intractable cancer pain.

B. The provisions of this section shall not apply to short-term travel, or accident-only policies, or to short-term nonrenewable policies of not more than six months' duration.

C. The provisions of this section are applicable to contracts, policies or plans delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 1999.

1999, c. 857.

§ 38.2-3407.7. Pharmacies; freedom of choice.

A. Notwithstanding any provision of § 38.2-3407 to the contrary, no insurer or its pharmacy benefits manager, as defined in § 38.2-3465, proposing to issue either preferred provider policies or contracts or exclusive provider policies or contracts shall prohibit any person receiving pharmacy benefits, including specialty pharmacy benefits, furnished thereunder from selecting, without limitation, the pharmacy of his choice to furnish such benefits. This right of selection extends to and includes any pharmacy that is a nonpreferred or nonparticipating provider and that has previously notified the insurer on its own behalf or through an intermediary, by facsimile or otherwise, of its agreement to accept reimbursement for its services at rates applicable to pharmacies that are preferred or participating providers, including any copayment consistently imposed by the insurer, as payment in full. Each insurer or its pharmacy benefits manager shall permit prompt electronic or telephonic transmittal of the reimbursement agreement by the pharmacy and ensure prompt verification to the pharmacy of the terms of reimbursement. In no event shall any person receiving a covered pharmacy benefit from a nonpreferred or nonparticipating provider that has submitted a reimbursement agreement be responsible for amounts that may be charged by the nonpreferred or nonparticipating provider in excess of the copayment and the insurer's reimbursement applicable to all of its preferred or participating pharmacy providers. If a pharmacy has provided notice pursuant to this subsection through an intermediary, the insurer or its intermediary may elect to respond directly to the pharmacy instead of the intermediary. Nothing in this subsection shall (i) require an insurer or its intermediary to contract with or to disclose confidential information to a pharmacy's intermediary or (ii) prohibit an insurer or its intermediary from contracting with or disclosing confidential information to a pharmacy's intermediary.

B. No such insurer or its pharmacy benefits manager shall impose upon any person receiving pharmaceutical benefits furnished under any such policy or contract:

1. Any copayment, fee or condition that is not equally imposed upon all individuals in the same benefit category, class or copayment level, whether or not such benefits are furnished by pharmacists who are nonpreferred or nonparticipating providers;

2. Any monetary penalty that would affect or influence any such person's choice of pharmacy; or

3. Any reduction in allowable reimbursement for pharmacy services related to utilization of pharmacists who are nonpreferred or nonparticipating providers.

C. For purposes of this section, a prohibited condition or penalty shall include, without limitation: (i) denying immediate access to electronic claims filing to a pharmacy that is a nonpreferred or nonparticipating provider and that has complied with subsection D or (ii) requiring a person receiving pharmacy benefits to make payment at point of service, except to the extent such conditions and penalties are similarly imposed on preferred or participating providers.

D. Any pharmacy that wishes to be covered by this section shall, if requested to do so in writing by an insurer or its pharmacy benefits manager, within 30 days of the pharmacy's receipt of the request, execute and deliver to the insurer or its pharmacy benefits manager the direct service agreement or

preferred or participating provider agreement that the insurer requires all of its preferred or participating providers of pharmacy benefits to execute. Any pharmacy that fails to timely execute and deliver such agreement shall not be covered by this section with respect to that insurer or its pharmacy benefits manager unless and until the pharmacy executes and delivers the agreement. No pharmacy shall be precluded from obtaining a direct service agreement or participating provider agreement for retail and specialty pharmacy if the pharmacy meets the terms and conditions of participation. Any request by a pharmacy for a direct service agreement or a participating provider agreement shall be acted upon by an insurer or its pharmacy benefits manager within 60 days of receipt of the pharmacy's request or any subsequent submission of supplemental information if requested by the insurer or its pharmacy benefits manager.

E. The Commission shall have no jurisdiction to adjudicate controversies arising out of this section.

F. Nothing in this section shall limit the authority of an insurer proposing to issue preferred provider policies or contracts or exclusive provider policies or contracts to select a single mail order pharmacy provider as the exclusive provider of pharmacy services that are delivered to the covered person's address by mail, common carrier, or delivery service. The provisions of this section shall not apply to such contracts. As used in this subsection, "mail order pharmacy provider" means a pharmacy permitted to conduct business in the Commonwealth whose primary business is to dispense a prescription drug or device under a prescriptive drug order and to deliver the drug or device to a patient primarily by mail, common carrier, or delivery service.

1994, c. 963; 1995, c. 467; 2010, cc. 157, 357; 2017, c. 615; 2019, c. 674; 2021, Sp. Sess. I, c. 229.

§ 38.2-3407.8. Repealed.

Repealed by Acts 1995, c. 467.

§ 38.2-3407.9. Reimbursement for emergency medical services vehicle transportation services.

A. If an accident and sickness insurance policy provides coverage for services provided by an emergency medical services vehicle, any person providing such services to a person covered under such policy shall receive reimbursement for such services directly from the issuer of such policy, when the issuer of such policy is presented with an assignment of benefits by the person providing such services.

B. No (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, (ii) corporation providing individual or group accident and sickness subscription contracts, or (iii) health maintenance organization providing a health care plan for health care services shall establish or promote an emergency medical response and transportation system that encourages or directs access by a person covered under such policy, contract or plan in competition with or in substitution of an emergency 911 system or other state, county or municipal emergency medical system for services provided by an emergency medical services vehicle. An entity subject to this subsection may use transportation

outside an emergency 911 system or other state, county or municipal emergency medical system for services that are not services provided by an emergency medical services vehicle.

C. For the purposes of this section, "services provided by an emergency medical services vehicle" means the transportation of any person requiring resuscitation or emergency relief or where human life is endangered, by means of any emergency medical services vehicle designed or used principally for such purposes. No (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, (ii) corporation providing individual or group accident and sickness subscription contracts, or (iii) health maintenance organization providing a health care plan for health care services shall require a person covered under such policy, contract or plan to obtain prior authorization before accessing an emergency 911 system or other state, county or municipal emergency medical system for services provided by an emergency medical services vehicle.

1995, c. 420; 2000, c. 630; 2015, cc. 502, 503.

§ 38.2-3407.9:01. Prescription drug formularies.

A. Each (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, (ii) corporation providing individual or group accident and sickness subscription contracts, and (iii) health maintenance organization providing a health care plan for health care services, whose policy, contract or plan, including any certificate or evidence of coverage issued in connection with such policy, contract or plan, includes coverage for prescription drugs on an outpatient basis may apply a formulary to the prescription drug benefits provided by the insurer, corporation, or health maintenance organization if the formulary is developed, reviewed at least annually, and updated as necessary in consultation with and with the approval of a pharmacy and therapeutics committee, a majority of whose members are actively practicing licensed pharmacists, physicians and other licensed health care providers.

B. If an insurer, corporation, or health maintenance organization maintains one or more closed drug formularies, each insurer, corporation, or health maintenance organization shall:

1. Make available to participating providers and pharmacists and to any nonpreferred or nonparticipating pharmacists as described in §§ 38.2-3407.7 and 38.2-4312.1, the complete, current drug formulary or formularies, or any updates thereto, maintained by the insurer, corporation, or health maintenance organization, including a list of the prescription drugs on the formulary by major therapeutic category that specifies whether a particular prescription drug is preferred over other drugs;

2. Establish a process to allow an enrollee to obtain, without additional cost-sharing beyond that provided for formulary prescription drugs in the enrollee's covered benefits, a specific, medically necessary nonformulary prescription drug if the formulary drug is determined by the insurer, corporation, or health maintenance organization, after reasonable investigation and consultation with the prescribing physician, to be an inappropriate therapy for the medical condition of the enrollee. The

insurer, corporation or health maintenance organization shall act on such requests within one business day of receipt of the request; and

3. Establish a process to allow an enrollee to obtain, without additional cost-sharing beyond that provided for formulary prescription drugs in the enrollee's covered benefits, a specific, medically necessary nonformulary prescription drug when the enrollee has been receiving the specific nonformulary prescription drug for at least six months previous to the development or revision of the formulary and the prescribing physician has determined that the formulary drug is an inappropriate therapy for the specific patient or that changing drug therapy presents a significant health risk to the specific patient. After reasonable investigation and consultation with the prescribing physician, the insurer, corporation or health maintenance organization shall act on such requests within one business day of receipt of the request. For purposes of this subsection, substituting the generic equivalent drug, which has been approved by the U.S. Food and Drug Administration, for a branded version of such drug shall not constitute a change in drug therapy.

C. Each insurer, corporation, or health maintenance organization that applies a formulary to the prescription drug benefits provided as set forth in subsection A shall provide to each affected group health benefit plan policyholder or contract holder or each affected individual health benefit plan policyholder or contract holder not less than 30 days' prior written notice of a modification to a formulary that results in the movement of a prescription drug to a tier with higher cost-sharing requirements. This section does not apply to modifications that occur at the time of coverage renewal.

1999, cc. 643, 649; 2000, c. 873; 2014, cc. 272, 297.

§ 38.2-3407.9:02. Requirement for prescription drug coverage.

No (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, (ii) corporation providing individual or group accident and sickness subscription contracts, or (iii) health maintenance organization providing a health care plan for health care services, whose policy, contract or plan, including any certificate or evidence of coverage issued in connection with such policy, contract or plan, includes coverage for prescription drugs shall exclude coverage for any prescription drug solely on the basis of the length of time since the drug obtained FDA approval.

2000, c. 508.

§ 38.2-3407.9:03. Payment of clean claims to administrators of pharmacy benefits.

A. As used in this section, "clean claim," "carrier," and "provider contract," shall have the meanings set forth in subsection A of § 38.2-3407.15.

B. Any contract between a carrier and its pharmacy benefits administrator or a carrier and a participating pharmacy, or its contracting agent, that requires claims be submitted electronically shall require that payment be made electronically to the participating provider or its designee for clean claims, as defined in subsection A of § 38.2-3407.15, submitted electronically. An electronic claim must be submitted in the form required by the carrier and in compliance with 45 CFR Part 142, as

amended, provided that the participating provider or designee agrees to accept claims details for such payments electronically, in compliance with 45 CFR Part 142, as amended, and provides accurate electronic funds transfer information to the carrier.

C. This section shall apply with respect to contracts between a carrier and its pharmacy benefits administrator or a carrier and a pharmacy, or its contracting agent, that are entered into, amended, extended, or renewed on or after January 1, 2009.

2008, c. 104.

§ 38.2-3407.9:04. Medication synchronization.

A. As used in this section:

"Carrier," "health plan," and "provider contract" have the meanings ascribed thereto in subsection A of § 38.2-3407.15.

"Enrollee" and "provider" have the meanings ascribed thereto in subsection A of § 38.2-3407.10.

"Network pharmacy" means a pharmacy that has agreed to provide pharmacy services to enrollees with an expectation of receiving payments, other than coinsurance, copayments, or deductibles, directly or indirectly from the carrier under the terms of a provider contract.

B. Any health plan providing prescription drug coverage in the Commonwealth shall permit and apply a prorated daily cost-sharing rate to prescriptions that are dispensed by a network pharmacy for a partial supply if the prescribing provider or the pharmacist determines the fill or refill to be in the best interest of the enrollee and the enrollee requests or agrees to a partial supply for the purpose of synchronizing the enrollee's medications, provided that such a proration for any prescription shall not occur more frequently than annually.

C. No health plan providing prescription drug coverage shall deny coverage for the dispensing of a medication that is dispensed by a network pharmacy on the basis that the dispensing is for a partial supply if the prescribing provider or the pharmacist determines the fill or refill to be in the best interest of the enrollee and the enrollee requests or agrees to a partial supply for the purpose of synchronizing the enrollee's medications. The health plan shall allow a pharmacy to override any denial codes indicating that a prescription is being refilled too soon for the purposes of synchronizing the enrollee's medications.

D. No health plan providing prescription drug coverage shall use payment structures incorporating prorated dispensing fees. Dispensing fees for partially filled or refilled prescriptions shall be paid in full for each prescription dispensed, regardless of any prorated copay or fee paid for synchronization services.

E. This section shall apply with respect to health plans that are entered into, amended, extended, or renewed on or after January 1, 2019.

F. Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such rules and regulations as it may deem necessary to implement this section.

G. The Commission shall have no jurisdiction to adjudicate individual controversies arising out of this section.

2018, c. 561.

§ 38.2-3407.9:05. Step therapy protocols.

A. As used in this section:

"Carrier" means any (i) insurer issuing individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; (ii) corporation providing individual or group accident and sickness subscription contracts; or (iii) health maintenance organization providing a health care plan for health care services. "Carrier" includes any entity administering a policy or plan providing health insurance coverage to state employees pursuant to § 2.2-2818 but does not include any entity administering a policy or plan providing coverage pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare); Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid); or Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq. (CHIP).

"Clinical practice guideline" means a systematically developed statement to assist decision making by providers about appropriate health care for a specific clinical circumstance or condition.

"Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by a carrier, utilization review organization, or independent review organization to determine the medical necessity and appropriateness of a health care service.

"Health benefit plan" means a policy, contract, certificate, or agreement offered by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease and that provides coverage for prescription drugs. "Health benefit plan" includes any policy or plan providing health insurance coverage to state employees pursuant to § 2.2-2818.

"Patient" means a policyholder, subscriber, participant, or other individual covered by a health benefit plan.

"Provider" means a hospital, physician, or any type of provider licensed, certified, or authorized by statute to provide a covered service under the health benefit plan.

"Step therapy exception" means overriding a step therapy protocol in favor of immediate coverage of the provider's selected prescription drug provided that such drug is covered under the health benefit plan, which determination is based on a review of the patient's or prescribing provider's request for an override, along with supporting rationale and documentation.

"Step therapy protocol" means a protocol setting the sequence in which prescription drugs for a specified medical condition and medically appropriate for a particular patient are covered under a health benefit plan.

"Utilization review organization" means an entity that conducts utilization review, other than a carrier performing utilization review for its own health benefit plans.

B. Carriers or utilization review organizations that develop step therapy protocols for a health benefit plan shall ensure that those step therapy protocols:

1. Are developed and endorsed by a multidisciplinary panel of experts that manages conflicts of interest among the members of the writing and review groups by requiring members to disclose to the carrier any potential conflict of interest, including carriers and pharmaceutical manufacturers, and recuse themselves of voting if they have a conflict of interest;

2. Are based on peer-reviewed research and medical practice, and may also consider published clinical practice guidelines established for relevant patient subgroups in addition to or in the absence of peer-reviewed research; and

3. Are continually updated based on a review of new evidence, research, and newly developed treatments.

C. When establishing a step therapy protocol, a utilization review agent may also take into account the needs of atypical patient populations and diagnoses when establishing clinical review criteria.

D. This section shall not be construed to require carriers to set up a new entity to develop clinical review criteria used for step therapy protocols.

E. When coverage of a prescription drug for the treatment of any medical condition is restricted for use by a carrier or utilization review organization through the use of a step therapy protocol, the patient and prescribing provider shall have access to a clear, readily accessible, and convenient process to request a step therapy exception. A carrier or utilization review organization may use its existing medical exceptions process to satisfy this requirement. The process shall be made easily accessible on the carrier's or utilization review organization's website.

F. A step therapy exception request shall be granted if the prescribing provider's submitted justification and supporting clinical documentation, if needed, are determined to support the prescribing provider's statement that:

1. The required prescription drug is contraindicated;

2. The required drug would be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen;

3. The patient has tried the step therapy-required prescription drug while under their current or a previous health benefit plan, and such prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event; or

4. The patient is currently receiving a positive therapeutic outcome on a prescription drug recommended by his provider for the medical condition under consideration while on a current or the immediately preceding health benefit plan.

G. Upon the granting of a step therapy exception, the carrier or utilization review organization shall authorize coverage for the prescription drug prescribed by the patient's treating provider, provided that the prescription drug is covered under the current health benefit plan.

H. The carrier or utilization review organization shall respond to a step therapy exception request within 72 hours of receipt, including hours on weekends, that the request is approved, denied, or requires supplementation. In cases where exigent circumstances exist, a carrier or utilization review organization shall respond within 24 hours of receipt, including hours on weekends, that the request is approved, denied, or requires supplementation.

I. A patient may appeal any step therapy exception request denial made pursuant to this section under the health benefit plan's existing appeal procedures.

J. Drug samples shall not be considered trial and failure of a preferred drug.

K. This section shall not be construed to prevent a carrier or utilization review organization from requiring an enrollee to try an AB-rated generic equivalent or interchangeable biological product prior to providing coverage, or substitute a generic for a branded drug.

L. Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such rules and regulations as it may deem necessary to implement this section.

M. This section shall apply to any health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2020.

2019, c. 337.

§ 38.2-3407.10. (Effective until January 1, 2024) Health care provider panels.

A. As used in this section:

"Carrier" means:

Any insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis;

Any corporation providing individual or group accident and sickness subscription contracts;

Any health maintenance organization providing health care plans for health care services;

Any corporation offering prepaid dental or optometric services plans; or

Any other person or organization that provides health benefit plans subject to state regulation, and includes an entity that arranges a provider panel for compensation.

"Enrollee" means any person entitled to health care services from a carrier.

"Provider" means a hospital, physician or any type of provider licensed, certified or authorized by statute to provide a covered service under the health benefit plan.

"Provider panel" means those providers with which a carrier contracts to provide health care services to the carrier's enrollees under the carrier's health benefit plan. However, such term does not include an arrangement between a carrier and providers in which any provider may participate solely on the basis of the provider's contracting with the carrier to provide services at a discounted fee-for-service rate.

B. Any such carrier that offers a provider panel shall establish and use it in accordance with the following requirements:

1. Notice of the development of a provider panel in the Commonwealth or local service area shall be filed with the Department of Health Professions.

2. Carriers shall provide a provider application and the relevant terms and conditions to a provider upon request.

C. A carrier that uses a provider panel shall establish procedures for:

1. Notifying an enrollee of:

a. The termination from the carrier's provider panel of the enrollee's primary care provider who was furnishing health care services to the enrollee; and

b. The right of an enrollee upon request to continue to receive health care services for a period of up to 90 days from the date of the primary care provider's notice of termination from a carrier's provider panel, except when a provider is terminated for cause.

2. Notifying a provider at least 90 days prior to the date of the termination of the provider, except when a provider is terminated for cause.

3. Providing reasonable notice to primary care providers in the carrier's provider panel of the termination of a specialty referral services provider.

4. Notifying the purchaser of the health benefit plan, whether such purchaser is an individual or an employer providing a health benefit plan, in whole or in part, to its employees and enrollees of the health benefit plan of:

a. A description of all types of payment arrangements that the carrier uses to compensate providers for health care services rendered to enrollees, including, but not limited to, withholds, bonus payments, capitation and fee-for-service discounts; and

b. The terms of the plan in clear and understandable language that reasonably informs the purchaser of the practical application of such terms in the operation of the plan.

D. Whenever a provider voluntarily terminates his contract with a carrier to provide health care services to the carrier's enrollees under a health benefit plan, he shall furnish reasonable notice of such termination to his patients who are enrollees under such plan.

E. A carrier may not deny an application for participation or terminate participation on its provider panel on the basis of gender, race, age, sexual orientation, gender identity, religion or national origin.

F. 1. For a period of at least 90 days from the date of the notice of a provider's termination from the carrier's provider panel, except when a provider is terminated for cause, the provider shall be permitted by the carrier to render health care services to any of the carrier's enrollees who:

a. Were in an active course of treatment from the provider prior to the notice of termination; and

b. Request to continue receiving health care services from the provider.

2. Notwithstanding the provisions of subdivision 1, any provider shall be permitted by the carrier to continue rendering health services to any enrollee who has entered the second trimester of pregnancy at the time of a provider's termination of participation, except when a provider is terminated for cause. Such treatment shall, at the enrollee's option, continue through the provision of postpartum care directly related to the delivery.

3. Notwithstanding the provisions of subdivision 1, any provider shall be permitted by the carrier to continue rendering health services to any enrollee who is determined to be terminally ill (as defined under § 1861 (dd)(3)(A) of the Social Security Act) at the time of a provider's termination of participation, except when a provider is terminated for cause. Such treatment shall, at the enrollee's option, continue for the remainder of the enrollee's life for care directly related to the treatment of the terminal illness.

4. A carrier shall reimburse a provider under this subsection in accordance with the carrier's agreement with such provider existing immediately before the provider's termination of participation.

G. 1. A carrier shall provide to a purchaser upon enrollment and make available to existing enrollees at least once a year a list of members in its provider panel, which list shall also indicate those providers who are not currently accepting new patients. Such list may be made available in a form other than a printed document, provided the purchaser or existing enrollee is given the means to request and receive a printed copy of such list.

2. The information provided under subdivision 1 shall be updated at least once a year if in paper form, and monthly if in electronic form.

H. No contract between a carrier and a provider may require that the provider indemnify the carrier for the carrier's negligence, willful misconduct, or breach of contract, if any.

I. No contract between a carrier and a provider shall require a provider, as a condition of participation on the panel, to waive any right to seek legal redress against the carrier.

J. No contract between a carrier and a provider shall prohibit, impede or interfere in the discussion of medical treatment options between a patient and a provider.

K. A contract between a carrier and a provider shall permit and require the provider to discuss medical treatment options with the patient.

L. Any carrier requiring preauthorization for medical treatment shall have personnel available to provide such preauthorization at all times when such preauthorization is required.

M. Carriers shall provide to their group policyholders written notice of any benefit reductions during the contract period at least 60 days before such benefit reductions become effective. Group policyholders shall, in turn, provide to their enrollees written notice of any benefit reductions during the contract period at least 30 days before such benefit reductions become effective. Such notice shall be provided to the group policyholder as a separate and distinct notification, and may not be combined with any other notification or marketing materials.

N. No contract between a provider and a carrier shall include provisions that require a health care provider or health care provider group to deny covered services that such provider or group knows to be medically necessary and appropriate that are provided with respect to a specific enrollee or group of enrollees with similar medical conditions.

O. If a provider panel contract between a provider and a carrier, or other entity that provides hospital, physician or other health care services to a carrier, includes provisions that require a provider, as a condition of participating in one of the carrier's or other entity's provider panels, to participate in any other provider panel owned or operated by that carrier or other entity, the contract shall contain a provision permitting the provider to refuse participation in one or more such other provider panels at the time the contract is executed. If a provider contracts with a carrier or other entity that subsequently contracts with one or more unaffiliated carriers to include such provider in the provider panels of such unaffiliated carriers, and which permits an unaffiliated carrier to impose participation terms with respect to such provider that differ materially in reimbursement rates or in managed care procedures, such as conducting economic profiling or requiring a patient to obtain primary care physician referral to a specialist, from the terms agreed to by the provider in the original contract, the provider panel contract shall contain a provision permitting the provider to refuse participation with any such unaffiliated carrier. Utilization review pursuant to Article 1.2 (§ 32.1-137.7 et seq.) of Chapter 5 of Title 32.1 shall not constitute a materially different managed care procedure. This subsection shall apply to provider panels utilized by health maintenance organizations and preferred provider organizations. For purposes of this subsection, "preferred provider organization" means a carrier that offers preferred provider contracts or policies as defined in § 38.2-3407 or preferred provider subscription contracts as defined in § 38.2-4209. The status of a physician as a member of or as being eligible for other existing or new provider panels shall not be adversely affected by the exercise of such right to refuse participation. This subsection shall not apply to the Medallion II and children's health insurance plan administered by or pursuant to contract with the Department of Medical Assistance Services.

P. A carrier that rents or leases its provider panel to unaffiliated carriers shall make available, upon request, to its providers a list of unaffiliated carriers that rent or lease its provider panel. Such list if

available in electronic format shall be updated monthly. The provider shall be given the means to request and receive a printed copy of such list.

Q. The Commission shall have no jurisdiction to adjudicate controversies arising out of this section.

R. The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, or extended on or after July 1, 1996. However, the 90-day period referred to in subdivisions C 1 b and C 2 of this section, the requirements set forth in subdivisions F 2 and F 3, and the requirements set forth in subsections L, M, and N shall apply to contracts between carriers and providers that are entered into or renewed on or after July 1, 1999, the requirements set forth in subsection O shall apply to contracts between carriers and providers that are entered into, reissued, extended or renewed on or after July 1, 2001, and the requirements set forth in subsection P shall be effective on and after January 1, 2007.

1996, c. 776; 1999, cc. 643, 649; 2000, cc. 862, 922, 934; 2001, c. 239; 2004, c. 715; 2006, c. 398; 2020, c. 1137.

§ 38.2-3407.10:1. Processing of new provider applications and reimbursement for services rendered during pendency of a participating provider's credentialing application.

A. As used in this section:

"Carrier" means an entity subject to the insurance laws and regulations of the Commonwealth and subject to the jurisdiction of the Commission that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services or mental health services, including an insurer licensed to sell accident and sickness insurance, a health maintenance organization, a health services plan, or any other entity providing a plan of health insurance, health benefits, health care services, or mental health services.

"Covered person" means a policyholder, subscriber, enrollee, participant, or other individual covered by a health benefit plan.

"Health benefit plan" means a policy, contract, certificate, or agreement offered by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

"Mental health professional" has the meaning ascribed thereto in § 54.1-2400.1.

"Mental health services" means benefits with respect to items or services provided by mental health professionals for mental health conditions as defined under the terms of a health benefit plan.

"Network" means a group of participating providers who provide health care services under the carrier's health benefit plan that requires or creates incentives for a covered person to use the participating providers.

"New provider applicant" means a physician, mental health professional, or other provider who has submitted a completed credentialing application to a carrier.

"Other provider" means a person, corporation, facility, or institution licensed by the Commonwealth under Title 32.1 or 54.1 to provide health care or professional health-related services on a fee basis.

"Participating mental health professional" means a mental health professional who is managed, under contract with, or employed by a carrier and who has agreed to provide health care services to covered persons with an expectation of receiving payments, other than coinsurance, copayments, or deductibles, directly or indirectly from the carrier.

"Participating other provider" means an other provider who is managed, under contract with, or employed by a carrier and who has agreed to provide such health care or professional services to covered persons with an expectation of receiving payments, other than coinsurance, copayments, or deductibles, directly or indirectly from the carrier.

"Participating physician" means a physician who is managed, under contract with, or employed by a carrier and who has agreed to provide health care services or mental health services to covered persons with an expectation of receiving payments, other than coinsurance, copayments, or deductibles, directly or indirectly from the carrier.

"Participating provider" means a participating physician, participating mental health professional, or participating other provider.

"Physician" means a doctor of medicine or osteopathic medicine holding an active license from the Board of Medicine.

B. A carrier that credentials the physicians, mental health professionals, or other providers in its network shall establish reasonable protocols and procedures for processing new provider credentialing applications and reimbursing new provider applicants for health care services or mental health services provided to covered persons during the period in which an approved applicant's completed credentialing application was pending. At a minimum, the protocols and procedures shall require the following:

1. If the carrier accepts applications through an online credentialing system, the carrier shall notify a new provider applicant through the online credentialing system that the provider has submitted and attested to the application as notice by the carrier that the application is received. If the carrier does not accept applications through an online credentialing system, the carrier shall within 10 days of receiving an application provide notification to the new provider applicant either by mail or electronic mail, as selected by the applicant, that the application was received;

2. Beginning January 1, 2024, a new provider applicant's application is deemed complete within 30 days of the carrier receiving the application, unless the carrier has provided notice that the application is not complete. Notice shall be provided by electronic mail unless the provider applicant has selected notification by mail;

3. The carrier shall approve or deny new provider applicant credentialing applications within 60 days of receiving a completed application;

4. Claims submitted according to carrier claims submittal policies for services rendered during the period of a pending application shall be adjudicated and paid no later than 40 days after the new provider applicant is credentialed and contracted;

5. The protocols and procedures shall apply only if a contractual relationship exists between the carrier and the new provider applicant or entity for whom the new provider applicant is employed or engaged; and

6. Any reimbursement shall be paid at the in-network rate that the new provider applicant would have received had he been, at the time the covered health care services were provided, a credentialed participating provider in the network for the applicable health benefit plan.

C. Nothing in this section shall require reimbursement of the new provider applicant-rendered services that are not benefits or services covered by the carrier's health benefit plan.

D. Nothing in this section requires a carrier to pay reimbursement at the contracted in-network rate for any covered health care services or mental health services provided by the new provider applicant if the new provider applicant's credentialing application is not approved or the carrier is otherwise not willing to contract with the new provider applicant.

E. Payments made or retroactive denials of payments made under this section shall be governed by § 38.2-3407.15.

F. If a payment is made by the carrier to a new provider applicant or any entity that employs or engages such new provider applicant under this section for a covered service, the patient shall only be responsible for any coinsurance, copayments, or deductibles permitted under the insurance contract with the carrier or participating provider agreement with the physician, mental health professional, or other provider. If the new provider applicant is not credentialed by the carrier, the new provider applicant or any entity that employs or engages such physician, mental health professional, or other provider shall not collect any amount from the patient for health care services or mental health services provided from the date the completed credentialing application was submitted to the carrier until the applicant received notification from the carrier that credentialing was denied.

G. New provider applicants, in order to submit claims to the carrier pursuant to this section, shall provide written or electronic notice to covered persons in advance of treatment that they have submitted a credentialing application to the carrier of the covered person, stating that the carrier is in the process of obtaining and verifying the following pursuant to credentialing regulations:

"Notice of Provider credentialing and re-credentialing.

Your health insurance carrier is required to establish and maintain a comprehensive credentialing verification program to ensure that its physicians, mental health professionals, and other providers meet the minimum standards of professional licensure or certification. Written supporting documentation for (i) physicians, (ii) mental health professionals who have completed their residency or fellowship

requirements for their specialty area more than 12 months prior to the credentialing decision, or (iii) other providers shall include:

1. Current valid license and history of licensure or certification;

2. Status of hospital privileges, if applicable;

3. Valid U.S. Drug Enforcement Administration certificate, if applicable;

4. Information from the National Practitioner Data Bank, as available;

5. Education and training, including postgraduate training, if applicable;

6. Specialty board certification status, if applicable;

7. Practice or work history covering at least the past five years; and

8. Current, adequate malpractice insurance and malpractice history covering at least the past five years.

Your health insurance carrier is in the process of obtaining and verifying the above information in order to determine if your physician, mental health professional, or other provider will be credentialed or not."

H. The provisions of this section shall not apply to coverages issued by a Medicare Advantage plan, but shall apply to health maintenance organizations that issue coverage pursuant to Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid).

I. The Commission shall have no jurisdiction to adjudicate individual controversies arising out of this section.

2018, c. 703; 2019, c. 689; 2020, c. 840; 2022, cc. 471, 472; 2023, cc. 376, 377.

§ 38.2-3407.10:2. Credentialing of private mental health agencies.

A. As used in this section, "carrier," "covered person," and "health benefit plan," have the same meaning ascribed thereto in § 38.2-3407.10:1.

"Mental health professional" means a person who by education and experience is professionally qualified to provide counseling interventions designed to facilitate an individual's achievement of human development goals and remediate mental, emotional, or behavioral disorders and associated distresses that interfere with mental health and development.

"Network" means a group of participating mental health professionals who provide mental health services under the carrier's health benefit plan that requires or creates incentives for a covered person to use the participating mental health professionals.

"Private mental health agency" means a practice group of mental health professionals at least one of whom is licensed under Chapter 24 (§ 54.1-2400 et seq.) of Title 54.1.

B. A carrier that credentials the mental health professionals in its network may establish reasonable protocols and procedures for credentialing private mental health agencies. Upon approval by a carrier of a credentialing application made by a private mental health agency, any mental health professional employed or engaged by such agency shall be deemed credentialed pursuant to the approved credentialing application of the private mental health agency. If a carrier opts to credential a private mental health agency, at a minimum the protocols and procedures established by the carrier shall:

1. Apply only if the private mental health agency's credentialing application is approved by the carrier; and

2. Require a private mental health agency to maintain minimum audit report requirements, as determined by the Department of Behavioral Health and Developmental Services.

C. The Commission shall have no jurisdiction to adjudicate individual controversies arising out of this section.

2019, c. 689.

§ 38.2-3407.10. (Effective January 1, 2024) Health care provider panels.

A. As used in this section:

"Carrier" means:

1. Any insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis;

2. Any corporation providing individual or group accident and sickness subscription contracts;

3. Any health maintenance organization providing health care plans for health care services;

4. Any corporation offering prepaid dental or optometric services plans; or

5. Any other person or organization that provides health benefit plans subject to state regulation, and includes an entity that arranges a provider panel for compensation.

"Enrollee" means any person entitled to health care services from a carrier.

"Provider" means a hospital, physician or any type of provider licensed, certified or authorized by statute to provide a covered service under the health benefit plan.

"Provider panel" means those providers with which a carrier contracts to provide health care services to the carrier's enrollees under the carrier's health benefit plan. However, such term does not include an arrangement between a carrier and providers in which any provider may participate solely on the basis of the provider's contracting with the carrier to provide services at a discounted fee-for-service rate.

B. Any such carrier that offers a provider panel shall establish and use it in accordance with the following requirements:

1. Notice of the development of a provider panel in the Commonwealth or local service area shall be filed with the Department of Health Professions.

2. Carriers shall provide a provider application and the relevant terms and conditions to a provider upon request.

C. A carrier that uses a provider panel shall establish procedures for:

1. Notifying an enrollee of:

a. The termination from the carrier's provider panel of a provider who was furnishing health care services to the enrollee or furnished health care services to the enrollee in the six months prior to the notice; and

b. The right of an enrollee to continue to receive health care services as provided in subsection E following the provider's termination from a carrier's provider panel, except when a provider is terminated for cause.

The carrier shall provide notice required by this subdivision 1 prior to the date of the termination of the provider, except when a provider is terminated for cause.

2. Notifying a provider at least 90 days prior to the date of the termination of the provider, except when a provider is terminated for cause.

Notifying the purchaser of the health benefit plan, whether such purchaser is an individual or an employer providing a health benefit plan, in whole or in part, to its employees and enrollees of the health benefit plan of:

a. A description of all types of payment arrangements that the carrier uses to compensate providers for health care services rendered to enrollees, including withholds, bonus payments, capitation, and fee-for-service discounts; and

b. The terms of the plan in clear and understandable language that reasonably informs the purchaser of the practical application of such terms in the operation of the plan.

For the purposes of subdivisions 1 and 2, "provider" includes a provider group.

A carrier may not deny an application for participation or terminate participation on its provider panel on the basis of gender, race, age, sexual orientation, gender identity, religion or national origin.

E. 1. A provider shall be permitted by the carrier to render health care services to any of the carrier's enrollees for a period of at least 90 days from the date of such provider's termination from the carrier's provider panel, except when a provider is terminated for cause

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2. Notwithstanding the provisions of subdivision 1, any provider shall be permitted by the carrier to continue rendering health services to any enrollee who has been medically confirmed to be pregnant at the time of a provider's termination of participation, except when a provider is terminated for cause.

Such treatment shall, at the enrollee's option, continue through the provision of postpartum care directly related to the delivery.

3. Notwithstanding the provisions of subdivision 1, any provider shall be permitted by the carrier to continue rendering health services to any enrollee who is determined to be terminally ill (as defined under § 1861 (dd)(3)(A) of the Social Security Act) at the time of a provider's termination of participation, except when a provider is terminated for cause. Such treatment shall, at the enrollee's option, continue for the remainder of the enrollee's life for care directly related to the treatment of the terminal illness.

4. Notwithstanding the provisions of subdivision 1, any provider shall be permitted by the carrier to continue rendering health services to any enrollee who has been determined by a medical professional to have a life-threatening condition at the time of a provider's termination of participation. Such treatment shall, at the enrollee's option, continue for up to 180 days for care directly related to the life-threatening condition.

5. Notwithstanding the provisions of subdivision 1, any provider shall be permitted by the carrier to continue rendering health services to any enrollee who is admitted to and receiving treatment in any inpatient facility at the time of a provider's termination of participation. Such admission and treatment shall continue until the enrollee is discharged from the inpatient facility.

For any health care services received by an enrollee from a provider after the date the provider has been terminated from the carrier's provider panel:

a. A carrier shall reimburse a provider under this subsection in accordance with the carrier's agreement with such provider existing immediately before the provider's termination of participation;

b. The provider shall accept such reimbursement from the carrier and any cost-sharing payment from the enrollee for items and services as payment in full; and

c. The provider shall continue to adhere to all policies and procedures and quality standards imposed by the carrier for an enrollee that were required of the provider immediately before the provider's termination of participation.

For the purposes of this subsection, "provider" includes a provider group.

F. 1. A carrier shall provide to a purchaser upon enrollment and make available to existing enrollees at least once a year a list of members in its provider panel, which list shall also indicate those providers who are not currently accepting new patients. Such list may be made available in a form other than a printed document, provided the purchaser or existing enrollee is given the means to request and receive a printed copy of such list.

2. The information provided under subdivision 1 shall be updated at least once a year if in paper form, and monthly if in electronic form.

G. No contract between a carrier and a provider may require that the provider indemnify the carrier for the carrier's negligence, willful misconduct, or breach of contract, if any.

H. No contract between a carrier and a provider shall require a provider, as a condition of participation on the panel, to waive any right to seek legal redress against the carrier.

I. No contract between a carrier and a provider shall prohibit, impede or interfere in the discussion of medical treatment options between a patient and a provider.

J. A contract between a carrier and a provider shall permit and require the provider to discuss medical treatment options with the patient.

K. Any carrier requiring preauthorization for medical treatment shall have personnel available to provide such preauthorization at all times when such preauthorization is required.

L. Carriers shall provide to their group policyholders written notice of any benefit reductions during the contract period at least 60 days before such benefit reductions become effective. Group policyholders shall, in turn, provide to their enrollees written notice of any benefit reductions during the contract period at least 30 days before such benefit reductions become effective. Such notice shall be provided to the group policyholder as a separate and distinct notification, and may not be combined with any other notification or marketing materials.

M. No contract between a provider and a carrier shall include provisions that require a health care provider or health care provider group to deny covered services that such provider or group knows to be medically necessary and appropriate that are provided with respect to a specific enrollee or group of enrollees with similar medical conditions.

N. If a provider panel contract between a provider and a carrier, or other entity that provides hospital, physician or other health care services to a carrier, includes provisions that require a provider, as a condition of participating in one of the carrier's or other entity's provider panels, to participate in any other provider panel owned or operated by that carrier or other entity, the contract shall contain a provision permitting the provider to refuse participation in one or more such other provider panels at the time the contract is executed. If a provider contracts with a carrier or other entity that subsequently contracts with one or more unaffiliated carriers to include such provider in the provider panels of such unaffiliated carriers, and which permits an unaffiliated carrier to impose participation terms with respect to such provider that differ materially in reimbursement rates or in managed care procedures, such as conducting economic profiling or requiring a patient to obtain primary care physician referral to a specialist, from the terms agreed to by the provider in the original contract, the provider panel contract shall contain a provision permitting the provider to refuse participation with any such unaffiliated carrier. Utilization review pursuant to Article 1.2 (§ 32.1-137.7 et seq.) of Chapter 5 of Title 32.1 shall not constitute a materially different managed care procedure. This subsection shall apply to provider panels utilized by health maintenance organizations and preferred provider organizations. For purposes of this subsection, "preferred provider organization" means a carrier that offers preferred provider contracts or policies as defined in § 38.2-3407 or preferred provider subscription contracts as defined in § 38.2-4209. The status of a physician as a member of or as being eligible for other existing or new provider panels shall not be adversely affected by the exercise of such right to refuse participation. This

subsection shall not apply to the Medallion II and children's health insurance plan administered by or pursuant to contract with the Department of Medical Assistance Services.

O. A carrier that rents or leases its provider panel to unaffiliated carriers shall make available, upon request, to its providers a list of unaffiliated carriers that rent or lease its provider panel. Such list if available in electronic format shall be updated monthly. The provider shall be given the means to request and receive a printed copy of such list.

P. The Commission shall have no jurisdiction to adjudicate controversies arising out of this section.

1996, c. 776; 1999, cc. 643, 649; 2000, cc. 862, 922, 934; 2001, c. 239; 2004, c. 715; 2006, c. 398; 2020, c. 1137; 2023, c. 490.

§ 38.2-3407.11. Access to obstetrician-gynecologists.

A. Each (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis, (ii) corporation providing individual or group accident and sickness subscription contracts, and (iii) health maintenance organization providing a health care plan for health care services, whose policies, contracts or plans, including any certificate or evidence of coverage issued in connection with such policies, contracts or plans, include coverage for obstetrical or gynecological services, shall permit any female of age 13 or older covered thereunder direct access, as provided in subsection B, to the health care services of a participating obstetrician-gynecologist (a) authorized to provide services under such policy, contract or plan and (b) selected by such female.

B. An annual examination, and routine health care services incident to and rendered during an annual visit, may be performed without prior authorization from the primary care physician. However, additional health care services may be provided subject to the following:

1. Consultation, which may be by telephone or electronically, with the primary care physician for follow-up care or subsequent visits;

2. Prior consultation and authorization by the primary care physician before the patient may be directed to another specialty provider; and

3. Prior authorization by the insurer, corporation, or health maintenance organization for proposed inpatient hospitalization or outpatient surgical procedures.

C. For the purpose of this section, "health care services" means the full scope of medically necessary services provided by the obstetrician-gynecologist in the care of or related to the female reproductive system and breasts and in performing annual screening and immunization for disorders and diseases in accordance with the most current published recommendations of the American College of Obstetricians and Gynecologists. The term includes services provided by advanced practice registered nurses and physician assistants in collaboration with the obstetrician-gynecologists providing care to individuals covered under any such policies, contracts or plans.

D. Nothing contained herein shall prohibit an insurer, corporation, or health maintenance organization from requiring a participating obstetrician-gynecologist to provide written notification to the covered female's primary care physician of any visit to such obstetrician-gynecologist. Such notification may include a description of the health care services rendered at the time of the visit.

E. Each insurer, corporation or health maintenance organization subject to the provisions of this section shall inform subscribers of the provisions of this section. Such notice shall be provided in writing.

F. The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, renewed, or extended or at any time when any term of any such policy, contract, or plan is changed or any premium adjustment is made. The provisions of this section shall not apply to short-term travel or accident-only policies, or to short-term nonrenewable policies of not more than six months' duration.

G. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

1996, c. 967; 1997, c. 806; 2001, c. 99; 2011, c. 882; 2023, c. 183.

§ 38.2-3407.11:1. Access to specialists; standing referrals.

A. Each (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, (ii) corporation providing individual or group accident and sickness subscription contracts, and (iii) health maintenance organization providing a health care plan for health care services shall permit any individual covered thereunder a standing referral, as provided in subsection B, to the health care services of a participating specialist (i) authorized to provide services under such policy, contract or plan and (ii) selected by such individual.

B. If the care of a covered individual who has an ongoing special condition would, as determined by the primary care physician, most appropriately be coordinated by a specialist for such condition, each insurer, corporation, or health maintenance organization, in connection with the provision of health insurance coverage, shall have a procedure by which such individual shall, after consultation with the primary care physician, receive a referral to a specialist for such condition. Within the treatment period authorized by the referral, such specialist shall be permitted to treat the individual for the special condition without a further referral from the individual's primary care provider and may authorize such referrals, procedures, tests, and other medical services related to the special condition as the individual's primary care provider would otherwise be permitted to provide or authorize. For the purposes of this section, "special condition" means a condition or disease that is (i) life-threatening, degenerative, or disabling and (ii) requires specialized medical care over a prolonged period of time.

C. An insurer, corporation, or health maintenance organization, in connection with the provision of health insurance coverage, shall have a procedure by which an individual who is a participant, beneficiary, or enrollee and who has an ongoing special condition that requires ongoing care from a specialist may receive a standing referral to a participating specialist for the treatment of the special

condition. If the plan or issuer, or if the primary care provider in consultation with the plan or issuer and the participating specialist, if any, determines that such a standing referral is appropriate, the plan or issuer shall make such a referral to a specialist.

D. Nothing contained herein shall prohibit an insurer, corporation, or health maintenance organization from requiring a participating specialist to provide written notification to the covered individual's primary care physician of any visit to such specialist. Such notification may include a description of the health care services rendered at the time of the visit.

E. Each insurer, corporation or health maintenance organization subject to the provisions of this section shall inform subscribers of the provisions of this section. Such notice shall be provided in writing, and included in the policy or evidence of coverage.

F. The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, renewed, or extended or at any time when any term of any such policy, contract, or plan is changed or any premium adjustment is made. The provisions of this section shall not apply to short-term travel or accident-only policies, to short-term nonrenewable policies of not more than six months' duration, or policies or contracts issued to persons eligible under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

1999, cc. 643, 649; 2000, c. 922.

§ 38.2-3407.11:2. Standing referral for cancer patients.

A. Each (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis, (ii) corporation providing individual or group accident and sickness subscription contracts, and (iii) health maintenance organization providing a health care plan for health care services, whose policies, contracts or plans, including any certificate or evidence of coverage issued in connection with such policies, contracts or plans, shall have a procedure in place to permit any individual covered thereunder who has been diagnosed with cancer to have a standing referral to a board-certified physician in pain management or oncologist who is authorized to provide services under such policy, contract or plan and has been selected by the cancer patient.

B. The board-certified physician in pain management or oncologist shall consult on a regular basis, as required under the terms of the policy, contract or plan, by telephone or through written communication, with the primary care physician and any oncologist providing care to the patient concerning the plan of pain management for the patient. Further, this section shall not be construed to authorize the board-certified physician in pain management or oncologist to direct the patient to other health care services.

C. Nothing contained herein shall prohibit an insurer, corporation, or health maintenance organization from requiring a participating board-certified physician in pain management or oncologist to provide

written notification to the cancer patient's primary care physician of any visit to him. Such notification may include a description of the health care services rendered at the time of the visit.

D. Each insurer, corporation or health maintenance organization subject to the provisions of this section shall inform subscribers, in writing, within the policy or evidence of coverage of the provisions of this section.

E. The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, renewed, or extended or at any time when any term of any such policy, contract, or plan is changed or any premium adjustment is made. The provisions of this section shall not apply to short-term travel or accident-only policies, to short-term nonrenewable policies of not more than six months' duration, or policies or contracts issued to persons eligible under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

1999, c. 856.

§ 38.2-3407.11:3. Breast cancer underwriting and preexisting condition restrictions.

A. No (i) insurer proposing to issue group accident and sickness insurance policies or individual health insurance coverage providing hospital, medical and surgical, major medical or cancer-only coverage on an expense-incurred basis, and policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans; (ii) corporation providing individual or group accident and sickness subscription contracts; or (iii) health maintenance organization providing a health care plan for health care services shall deny the issuance or renewal of, or cancel, a policy, subscription contract or plan or include any exception or exclusion of benefits in such policy, subscription contract or plan for the following:

1. Solely because the insured has been diagnosed as having a fibrocystic condition or a nonmalignant lesion, or solely due to the family history of the insured related to breast cancer, or solely due to any combination of these factors; or

2. Solely due to breast cancer, if the insured has been free from breast cancer for a period of five years or more prior to the date of application for coverage. In the case of coverage subject to §§ 38.2-3432.3, 38.2-3514.1 or § 38.2-3605, the provisions of those sections shall be controlling as to the extent of any preexisting conditions period under such coverage.

Benefits provided under a policy, subscription contract or plan for such insureds shall be provided with durational limits, deductibles, coinsurance factors, and copayments that are no less favorable than for physical illness generally.

B. No (i) insurer proposing to issue group accident and sickness insurance policies or individual health insurance coverage providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, and policies or contracts designed for issuance to persons eligible for

coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans; (ii) corporation providing individual or group accident and sickness subscription contracts; or (iii) health maintenance organization providing a health care plan for health care services shall consider routine follow-up care, used to determine whether a breast cancer has recurred in a person who has been previously determined to be free of breast cancer as evidenced by negative follow-up care for a period of at least five years following completion of local and adjuvant therapies, to constitute medical advice, diagnosis, care or treatment for purposes of determining a preexisting condition unless evidence of breast cancer is found during, or as a result of, the follow-up care.

C. The requirements of this section shall apply to all insurance policies, contracts and plans delivered, issued for delivery, reissued, renewed or extended or at any time when any term of any such policy, contract or plan is changed or any premium adjustment is made. The provisions of this section shall not apply to short-term travel, accident-only, limited or specified disease policies except those providing coverage for cancer on an expense-incurred basis, nor to short-term nonrenewable policies of not more than six months' duration.

2001, c. 242.

§ 38.2-3407.11:4. Disability arising out of childbirth; minimum benefit.

A. Each insurer proposing to issue individual or group accident and sickness insurance policies providing short-term disability income protection coverage whose policies provide coverage for short-term disability arising out of childbirth shall provide coverage for a payable benefit of at least 12 weeks immediately following childbirth for such a disability.

B. The provisions of this section shall apply to any policy delivered or issued for delivery in the Commonwealth on and after July 1, 2021.

2020, c. 935.

§ 38.2-3407.11:5. Interhospital transfer for newborn or mother; prior authorization prohibited.

A. Notwithstanding any provision of § 38.2-3407.11 or 38.2-3419 or any other section of this title to the contrary, no insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis, corporation providing individual or group accident and sickness subscription contracts, or health maintenance organization providing a health care plan for health care services shall require prior authorization for the interhospital transfer of (i) a newborn infant experiencing a life-threatening emergency condition or (ii) the hospitalized mother of such newborn infant to accompany the infant.

B. The requirements of this section shall apply to all policies, contracts, and plans delivered, issued for delivery, reissued, or extended in the Commonwealth on and after January 1, 2021, or at any time thereafter when any term of the policy, contract, or plan is changed or any premium adjustment is made thereto.

C. The provisions of this section shall not apply to short-term travel, accident-only, or limited or specified disease policies, contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans, or short-term nonrenewable policies of not more than six months' duration.

2020, c. 940, § 38.2-3407.11:4.

§ 38.2-3407.12. Patient optional point-of-service benefit.

A. As used in this section:

"Affiliate" shall have the meaning set forth in § 38.2-1322.

"Allowable charge" means the amount from which the carrier's payment to a provider for any covered item or service is determined before taking into account any cost-sharing arrangement.

"Carrier" means:

1. Any insurer licensed under this title proposing to offer or issue accident and sickness insurance policies which are subject to Chapter 34 (§ 38.2-3400 et seq.) or 39 (§ 38.2-3900 et seq.) of this title;

2. Any nonstock corporation licensed under this title proposing to issue or deliver subscription contracts for one or more health services plans, medical or surgical services plans or hospital services plans which are subject to Chapter 42 (§ 38.2-4200 et seq.) of this title;

3. Any health maintenance organization licensed under this title which provides or arranges for the provision of one or more health care plans which are subject to Chapter 43 (§ 38.2-4300 et seq.) of this title;

4. Any nonstock corporation licensed under this title proposing to issue or deliver subscription contracts for one or more dental or optometric services plans which are subject to Chapter 45 (§ 38.2-4500 et seq.) of this title; and

5. Any other person licensed under this title which provides or arranges for the provision of health care coverage or benefits or health care plans or provider panels which are subject to regulation as the business of insurance under this title.

"Co-insurance" means the portion of the carrier's allowable charge for the covered item or service which is not paid by the carrier and for which the enrollee is responsible.

"Co-payment" means the out-of-pocket charge other than co-insurance or a deductible for an item or service to be paid by the enrollee to the provider towards the allowable charge as a condition of the receipt of specific health care items and services.

"Cost sharing arrangement" means any co-insurance, co-payment, deductible or similar arrangement imposed by the carrier on the enrollee as a condition to or consequence of the receipt of covered items or services.

"Deductible" means the dollar amount of a covered item or service which the enrollee is obligated to pay before benefits are payable under the carrier's policy or contract with the group contract holder.

"Enrollee" or "member" means any individual who is enrolled in a group health benefit plan provided or arranged by a health maintenance organization or other carrier. If a health maintenance organization arranges or contracts for the point-of-service benefit required under this section through another carrier, any enrollee selecting the point-of-service benefit shall be treated as an enrollee of that other carrier when receiving covered items or services under the point-of-service benefit.

"Group contract holder" means any contract holder of a group health benefit plan offered or arranged by a health maintenance organization or other carrier. For purposes of this section, the group contract holder shall be the person to which the group agreement or contract for the group health benefit plan is issued.

"Group health benefit plan" shall mean any health care plan, subscription contract, evidence of coverage, certificate, health services plan, medical or hospital services plan, accident and sickness insurance policy or certificate, or other similar certificate, policy, contract or arrangement, and any endorsement or rider thereto, offered, arranged or issued by a carrier to a group contract holder to cover all or a portion of the cost of enrollees (or their eligible dependents) receiving covered health care items or services. Group health benefit plan does not mean (i) health care plans, contracts or policies issued in the individual market; (ii) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid) or Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq. (CHIP), 5 U.S.C. § 8901 et seq. (federal employees), 10 U.S.C. § 1071 et seq. (TRICARE) or Chapter 28 (§ 2.2-2800 et seq.) of Title 2.2 (state employees); (iii) accident only, credit or disability insurance, or long-term care insurance, plans providing only limited health care services under § 38.2-4300 (unless offered by endorsement or rider to a group health benefit plan), TRICARE supplement, Medicare supplement, or workers' compensation coverages; or (iv) an employee welfare benefit plan (as defined in section 3 (1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002 (1)), which is self-insured or self-funded.

"Group specific administrative cost" means the direct administrative cost incurred by a carrier related to the offer of the point-of-service benefit to a particular group contract holder.

"Health care plan" shall have the meaning set forth in § 38.2-4300.

"Person" means any individual, corporation, trust, association, partnership, limited liability company, organization or other entity.

"Point-of-service benefit" means a health maintenance organization's delivery system or covered benefits, or the delivery system or covered benefits of another carrier under contract or arrangement with the health maintenance organization, which permit an enrollee (and eligible dependents) to receive covered items and services outside of the provider panel, including optometrists and clinical psychologists, of the health maintenance organization under the terms and conditions of the group

contract holder's group health benefit plan with the health maintenance organization or with another carrier arranged by or under contract with the health maintenance organization and which otherwise complies with this section. Without limiting the foregoing, the benefits offered or arranged by a carrier's indemnity group accident and sickness policy under Chapter 34 (§ 38.2-3400 et seq.) of this title, health services plan under Chapter 42 (§ 38.2-4200 et seq.) of this title or preferred provider organization plan under Chapter 34 (§ 38.2-3400 et seq.) or 42 (§ 38.2-4200 et seq.) of this title which permit an enrollee (and eligible dependents) to receive the full range of covered items and services outside of a provider panel, including optometrists and clinical psychologists, and which are otherwise in compliance with applicable law and this section shall constitute a point-of-service benefit.

"Preferred provider organization plan" means a health benefit program offered pursuant to a preferred provider policy or contract under § 38.2-3407 or covered services offered under a preferred provider subscription contract under § 38.2-4209.

"Provider" means any physician, hospital or other person, including optometrists and clinical psychologists, that is licensed or otherwise authorized in the Commonwealth to deliver or furnish health care items or services.

"Provider panel" means the participating providers or referral providers who have a contract, agreement or arrangement with a health maintenance organization or other carrier, either directly or through an intermediary, and who have agreed to provide items or services to enrollees of the health maintenance organization or other carrier.

B. To the maximum extent permitted by applicable law, every health care plan offered or proposed to be offered in the large group market in the Commonwealth by a health maintenance organization licensed under this title to a group contract holder shall provide or include, or the health maintenance organization shall arrange for or contract with another carrier to provide or include, a point-of-service benefit to be provided or offered in conjunction with the health maintenance organization's health care plan as an additional benefit for the enrollee, at the enrollee's option, individually to accept or reject. In connection with its group enrollment application, every health maintenance organization shall, at no additional cost to the group contract holder, make available or arrange with a carrier to make available to the prospective group contract holder and to all prospective enrollees, in advance of initial enrollment and in advance of each reenrollment, a notice in form and substance acceptable to the Commission which accurately and completely explains to the group contract holder and prospective enrollee the point-of-service benefit and permits each enrollee to make his or her election. The form of notice provided in connection with any reenrollment may be the same as the approved form of notice used in connection with initial enrollment and may be made available to the group contract holder and prospective enrollee by the carrier in any reasonable manner.

C. To the extent permitted under applicable law, a health maintenance organization providing or arranging, or contracting with another carrier to provide, the point-of-service benefit under this section and a

carrier providing the point-of-service benefit required under this section under arrangement or contract with a health maintenance organization:

1. May not impose, or permit to be imposed, a minimum enrollee participation level on the point-of-service benefit alone;

2. May not refuse to reimburse a provider of the type listed or referred to in § 38.2-3408 or 38.2-4221 for items or services provided under the point-of-service benefit required under this section solely on the basis of the license or certification of the provider to provide such items or services if the carrier otherwise covers the items or services provided and the provision of the items or services is within the provider's lawful scope of practice or authority; and

3. Shall rate and underwrite all prospective enrollees of the group contract holder as a single group prior to any enrollee electing to accept or reject the point-of-service benefit.

D. The premium imposed by a carrier with respect to enrollees who select the point-of-service benefit may be different from that imposed by the health maintenance organization with respect to enrollees who do not select the point-of-service benefit. Unless a group contract holder determines otherwise, any enrollee who accepts the point-of-service benefit shall be responsible for the payment of any premium over the amount of the premium applicable to an enrollee who selects the coverage offered by the health maintenance organization without the point-of-service benefit and for any identifiable group specific administrative cost incurred directly by the carrier or any administrative cost incurred by the group contract holder in offering the point-of-service benefit to the enrollee. If a carrier offers the point-of-service benefit to a group contract holder where no enrollees of the group contract holder elect to accept the point-of-service benefit and incurs an identifiable group specific administrative cost directly as a consequence of the offering to that group contract holder, the carrier may reflect that group specific administrative cost in the premium charged to other enrollees selecting the point-of-service benefit under this section. Unless the group contract holder otherwise directs or authorizes the carrier in writing, the carrier shall make reasonable efforts to ensure that no portion of the cost of offering or arranging the point-of-service benefit shall be reflected in the premium charged by the carrier to the group contract holder for a group health benefit plan without the point-of-service benefit. Any premium differential and any group specific administrative cost imposed by a carrier relating to the cost of offering or arranging the point-of-service benefit must be actuarially sound and supported by a sworn certification of an officer of each carrier offering or arranging the point-of-service benefit filed with the Commission certifying that the premiums are based on sound actuarial principles and otherwise comply with this section. The certifications shall be in a form, and shall be accompanied by such supporting information in a form acceptable to the Commission.

E. Any carrier may impose different co-insurance, co-payments, deductibles and other cost-sharing arrangements for the point-of-service benefit required under this section based on whether or not the item or service is provided through the provider panel of the health maintenance organization;

provided that, except to the extent otherwise prohibited by applicable law, any such cost-sharing arrangement:

1. Shall not impose on the enrollee (or his or her eligible dependents, as appropriate) any co-insurance percentage obligation which is payable by the enrollee which exceeds the greater of: (i) thirty percent of the carrier's allowable charge for the items or services provided by the provider under the point-of-service benefit or (ii) the co-insurance amount which would have been required had the covered items or services been received through the provider panel;

2. Shall not impose on an enrollee (or his or her eligible dependents, as appropriate) a co-payment or deductible which exceeds the greatest co-payment or deductible, respectively, imposed by the carrier or its affiliate under one or more other group health benefit plans providing a point-of-service benefit which are currently offered and actively marketed by the carrier or its affiliate in the Commonwealth and are subject to regulation under this title; and

3. Shall not result in annual aggregate cost-sharing payments to the enrollee (or his or her eligible dependents, as appropriate) which exceed the greatest annual aggregate cost-sharing payments which would apply had the covered items or services been received under another group health benefit plan providing a point-of-service benefit which is currently offered and actively marketed by the carrier or its affiliate in the Commonwealth and which is subject to regulation under this title.

F. Except to the extent otherwise required under applicable law, any carrier providing the point-of-service benefit required under this section may not utilize an allowable charge or basis for determining the amount to be reimbursed or paid to any provider from which covered items or services are received under the point-of-service benefit which is not at least as favorable to the provider as that used:

1. By the carrier or its affiliate in calculating the reimbursement or payment to be made to similarly situated providers under another group health benefit plan providing a point-of-service benefit which is subject to regulation under this title and which is currently offered or arranged by the carrier or its affiliate and actively marketed in the Commonwealth, if the carrier or its affiliate offers or arranges another such group health benefit plan providing a point-of-service benefit in the Commonwealth; or

2. By the health maintenance organization in calculating the reimbursement or payment to be made to similarly situated providers on its provider panel.

G. Except as expressly permitted in this section or required under applicable law, no carrier shall impose on any person receiving or providing health care items or services under the point-of-service benefit any condition or penalty designed to discourage the enrollee's selection or use of the point-of-service benefit, which is not otherwise similarly imposed either: (i) on enrollees in another group health benefit plan, if any, currently offered or arranged and actively marketed by the carrier or its affiliate in the Commonwealth or (ii) on enrollees who receive the covered items or services from the health maintenance organization's provider panel. Nothing in this section shall preclude a carrier offering or arranging a point-of-service benefit from imposing on enrollees selecting the point-of-service

benefit reasonable utilization review, preadmission certification or precertification requirements or other utilization or cost control measures which are similarly imposed on enrollees participating in one or more other group health benefit plans which are subject to regulation under this title and are currently offered and actively marketed by the carrier or its affiliates in the Commonwealth or which are otherwise required under applicable law.

H. Except as expressly otherwise permitted in this section or as otherwise required under applicable law, the scope of the health care items and services which are covered under the point-of-service benefit required under this section shall at least include the same health care items and services which would be covered if provided under the health maintenance organization's health care plan, including without limitation any items or services covered under a rider or endorsement to the applicable health care plan. Carriers shall be required to disclose prominently in all group health benefit plans and in all marketing materials utilized with respect to such group health benefit plans that the scope of the benefits provided under the point-of-service option are at least as great as those provided through the HMO's health care plan for that group. Filings of point-of-service benefits submitted to the Commission shall be accompanied by a certification signed by an officer of the filing carrier certifying that the scope of the point-of-service benefits includes at a minimum the same health care items and services as are provided under the HMO's group health care plan for that group.

I. Nothing in this section shall prohibit a health maintenance organization from offering or arranging the point-of-service benefit (i) as a separate group health benefit plan or under a different name than the health maintenance organization's group health benefit plan which does not contain the point-of-service benefit or (ii) from managing a group health benefit plan under which the point-of-service benefit is offered in a manner which separates or otherwise differentiates it from the group health benefit plan which does not contain the point-of-service benefit.

J. Notwithstanding anything in this section to the contrary, to the extent permitted under applicable law, no health maintenance organization shall be required to offer or arrange a point-of-service benefit under this section with respect to any group health benefit plan offered to a group contract holder if the health maintenance organization determines in good faith that the group contract holder will be concurrently offering another group health benefit plan or a self-insured or self-funded health benefit plan which allows the enrollees to access care from their provider of choice whether or not the provider is a member of the health maintenance organization's panel.

K. This section shall apply only to group health benefit plans issued in the Commonwealth in the commercial large group market by carriers regulated by this title and shall not apply to (i) health care plans, contracts or policies issued in the individual or small group market; (ii) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid) or Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq. (CHIP), 5 U.S.C. § 8901 et seq. (federal employees), 10 U.S.C. § 1071 et seq. (TRICARE) or Chapter 28 (§ 2.2-2800 et seq.) of Title 2.2 (state employees); (iii) accident only, credit or disability insurance, or long-term care insurance, plans providing only limited health care

services under § 38.2-4300 (unless offered by endorsement or rider to a group health benefit plan), TRICARE supplement, Medicare supplement, or workers' compensation coverages; (iv) an employee welfare benefit plan (as defined in section 3 (1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002 (1)), which is self-insured or self-funded; or (v) a qualified health plan when the plan is offered in the Commonwealth by a health carrier through a health benefit exchange established under § 1311 of the federal Patient Protection and Affordable Care Act (P.L. 111-148).

L. Nothing in this section shall operate to limit any rights or obligations arising under § 38.2-3407, 38.2-3407.7, 38.2-3407.10, 38.2-3407.11, 38.2-4209, 38.2-4209.1, 38.2-4312, or 38.2-4312.1.

1998, c. 908; 2013, c. 751; 2014, cc. 157, 417, 814; 2015, c. 709.

§ 38.2-3407.13. Refusal to accept assignments prohibited; dentists and oral surgeons.

A. No insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, no corporation providing individual or group accident and sickness subscription contracts, and no dental services plan offering or administering prepaid dental services shall refuse to accept or make reimbursement pursuant to an assignment of benefits made to a dentist or oral surgeon by an insured, subscriber or plan enrollee.

B. For the purpose of this section, "assignment of benefits" means the transfer of dental care coverage reimbursement benefits or other rights under an insurance policy, subscription contract or dental services plan by an insured, subscriber or plan enrollee to a dentist or oral surgeon. The assignment of benefits shall not be effective until the insured, subscriber or enrollee notifies the insurer, corporation or plan in writing of the assignment.

1999, cc. 643, 649.

§ 38.2-3407.13:1. Coordination of benefits; notice of priority of coverage.

Each (i) insurer issuing individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, (ii) corporation providing individual or group accident and sickness subscription contracts, and (iii) health maintenance organization providing a health care plan for health care services, whose policy, contract or plan, including any certificate or evidence of coverage issued in connection with any such policy, contract or plan, contains a coordination of benefits provision shall provide written notification to the insured, subscriber or member as a prominent part of its enrollment materials that if such insured, subscriber or member is covered under another group accident and sickness insurance policy, group accident and sickness subscription contract, or group health care plan for health care services, that insurance policy, subscription contract or health care plan may have primary responsibility for the covered expenses of other family members enrolled with the insured, subscriber or member. Such written notification shall describe generally the conditions upon which the other coverage would be primary for dependent children enrolled under the insured's, subscriber's, or member's coverage and the method by which the insured, subscriber or member may verify from the insurer, corporation or

health maintenance organization which coverage would have primary responsibility for the covered expenses of each family member. The provisions of this section shall not be construed to abrogate any coordination of benefits provision authorized pursuant to subsection B of § 38.2-3405.

2000, c. 149.

§ 38.2-3407.13:2. Claims paid to insureds for services from nonparticipating physicians.

When an insurer, health services plan or health maintenance organization follows a policy of sending its payment to the insured, subscriber or enrollee for a claim for services received from a nonparticipating physician or osteopath, the insurer, health services plan or health maintenance organization shall: (i) include language in the certificate or evidence of coverage of the insured, subscriber or enrollee that notifies the insured, subscriber or enrollee of the responsibility to apply the plan payment to the claim from such nonparticipating provider, (ii) include this language with any such payment sent to the insured, subscriber or enrollee, and (iii) include the name and any last known address of the nonparticipating provider on the explanation of benefits statement.

2005, c. 739.

§ 38.2-3407.14. Notice of premium or deductible increases.

A. Each (i) insurer issuing individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, (ii) corporation providing individual or group accident and sickness subscription contracts, and (iii) health maintenance organization providing a health care plan for health care services, shall provide in conjunction with the proposed renewal of coverage under any such policies, contracts, or plans, prior written notice of intent to increase by more than 35 percent the annual premium charged for coverage thereunder.

B. Effective with policy, contract, or plan year renewals beginning on or after January 1, 2015, each health carrier providing individual health insurance coverage shall provide in conjunction with the proposed renewal of individual health insurance coverage prior written notice of intent to increase the annual premium charge for coverage or any deductible required thereunder. As used in this section, "deductible" means the annual dollar amount of covered items or services that the insured, subscriber, or enrollee is obligated to pay before benefits are payable under the health benefit plan.

C. Notice required by this section shall be provided in writing at least 60 days prior to the proposed renewal of coverage under any such policy, contract, or plan described in subsection A and effective with policy, contract, or plan year renewals beginning on or after January 1, 2015, at least 75 days prior to the proposed renewal of individual health insurance coverage described in subsection B. In either case, notice shall be provided to the policyholder, contract holder, or subscriber, or to the designated consultant or other agent of the group policyholder, contract holder, or subscriber if requested in writing by the group policyholder, contract holder, or subscriber, as appropriate.

D. The time frames specified in subsection C for the provision of notices may be adjusted by the Commission's Bureau of Insurance to account for delays in product or rate approval by the Bureau of

Insurance that result from filing requirements established by the United States Department of Health and Human Services.

1999, cc. 643, 649; 2005, c. 399; 2014, c. 511.

§ 38.2-3407.14:1. Standard of clinical evidence for decisions on coverage for proton radiation therapy.

A. As used in this section, unless the context requires a different meaning:

"Carrier" means an insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; a corporation providing individual or group accident and sickness subscription contracts; or a health maintenance organization providing a health care plan for health care services.

"Proton radiation therapy" means the advanced form of radiation therapy treatment that utilizes protons as an alternative radiation delivery method for the treatment of tumors.

"Radiation therapy treatment" means a cancer treatment through which a dose of radiation to induce tumor cell death is delivered by means of proton radiation therapy, intensity modulated radiation therapy, brachytherapy, stereotactic body radiation therapy, three-dimensional conformal radiation therapy, or other forms of therapy using radiation.

B. Notwithstanding the provisions of § 38.2-3419, each policy, contract, or plan issued or provided by a carrier that provides coverage for cancer therapy shall not hold proton radiation therapy to a higher standard of clinical evidence for decisions regarding coverage under the policy, contract, or plan than is applied for decisions regarding coverage of other types of radiation therapy treatment.

C. Nothing in this section shall be construed to mandate the coverage of proton radiation therapy under any policy, contract, or plan issued or provided by a carrier.

D. The requirements of this section shall apply to all insurance policies, subscription contracts, and health care plans delivered, issued for delivery, reissued, or extended in the Commonwealth on and after January 1, 2018, or at any time thereafter when any term of the policy, contract, or plan is changed or any premium adjustment is made.

E. This section shall not apply to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

2017, c. 287.

§ 38.2-3407.15. Ethics and fairness in carrier business practices.

A. As used in this section:

"Carrier," "enrollee," and "provider" shall have the meanings set forth in § 38.2-3407.10; however, a "carrier" shall also include any person required to be licensed under this title which offers or operates a managed care health insurance plan subject to Chapter 58 (§ 38.2-5800 et seq.) or which provides

or arranges for the provision of health care services, health plans, networks or provider panels which are subject to regulation as the business of insurance under this title.

"Claim" means any bill, claim, or proof of loss made by or on behalf of an enrollee or a provider to a carrier (or its intermediary, administrator or representative) with which the provider has a provider contract for payment for health care services under any health plan; however, a "claim" shall not include a request for payment of a capitation or a withhold.

"Clean claim" means a claim (i) that has no material defect or impropriety (including any lack of any reasonably required substantiation documentation) which substantially prevents timely payment from being made on the claim or (ii) with respect to which a carrier has failed timely to notify the person submitting the claim of any such defect or impropriety in accordance with this section.

"Health care services" means items or services furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury or physical disability.

"Health plan" means any individual or group health care plan, subscription contract, evidence of coverage, certificate, health services plan, medical or hospital services plan, accident and sickness insurance policy or certificate, managed care health insurance plan, or other similar certificate, policy, contract or arrangement, and any endorsement or rider thereto, to cover all or a portion of the cost of persons receiving covered health care services, which is subject to state regulation and which is required to be offered, arranged or issued in the Commonwealth by a carrier licensed under this title. Health plan does not mean (i) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid) or Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq. (CHIP), 5 U.S.C. § 8901 et seq. (federal employees), or 10 U.S.C. § 1071 et seq. (TRICARE); or (ii) accident only, credit or disability insurance, long-term care insurance, TRICARE supplement, Medicare supplement, or workers' compensation coverages.

"Provider contract" means any contract between a provider and a carrier (or a carrier's network, provider panel, intermediary or representative) relating to the provision of health care services.

"Retroactive denial of a previously paid claim" or "retroactive denial of payment" means any attempt by a carrier retroactively to collect payments already made to a provider with respect to a claim by reducing other payments currently owed to the provider, by withholding or setting off against future payments, or in any other manner reducing or affecting the future claim payments to the provider.

B. Subject to subsection I, every provider contract entered into by a carrier shall contain specific provisions which shall require the carrier to adhere to and comply with the following minimum fair business standards in the processing and payment of claims for health care services:

1. A carrier shall pay any claim within 40 days of receipt of the claim except where the obligation of the carrier to pay a claim is not reasonably clear due to the existence of a reasonable basis supported by specific information available for review by the person submitting the claim that:

a. The claim is determined by the carrier not to be a clean claim due to a good faith determination or dispute regarding (i) the manner in which the claim form was completed or submitted, (ii) the eligibility of a person for coverage, (iii) the responsibility of another carrier for all or part of the claim, (iv) the amount of the claim or the amount currently due under the claim, (v) the benefits covered, or (vi) the manner in which services were accessed or provided; or

b. The claim was submitted fraudulently.

Each carrier shall maintain a written or electronic record of the date of receipt of a claim. The person submitting the claim shall be entitled to inspect such record on request and to rely on that record or on any other admissible evidence as proof of the fact of receipt of the claim, including without limitation electronic or facsimile confirmation of receipt of a claim.

2. A carrier shall, within 30 days after receipt of a claim, request electronically or in writing from the person submitting the claim the information and documentation that the carrier reasonably believes will be required to process and pay the claim or to determine if the claim is a clean claim. Upon receipt of the additional information requested under this subsection necessary to make the original claim a clean claim, a carrier shall make the payment of the claim in compliance with this section. No carrier may refuse to pay a claim for health care services rendered pursuant to a provider contract which are covered benefits if the carrier fails timely to notify or attempt to notify the person submitting the claim of the matters identified above unless such failure was caused in material part by the person submitting the claims; however, nothing herein shall preclude such a carrier from imposing a retroactive denial of payment of such a claim if permitted by the provider contract unless such retroactive denial of payment of the claim would violate subdivision 7. Nothing in this subsection shall require a carrier to pay a claim which is not a clean claim.

3. Any interest owing or accruing on a claim under § 38.2-3407.1 or 38.2-4306.1, under any provider contract or under any other applicable law, shall, if not sooner paid or required to be paid, be paid, without necessity of demand, at the time the claim is paid or within 60 days thereafter.

4. a. Every carrier shall establish and implement reasonable policies to permit any provider with which there is a provider contract (i) to confirm in advance during normal business hours by free telephone or electronic means if available whether the health care services to be provided are medically necessary and a covered benefit and (ii) to determine the carrier's requirements applicable to the provider (or to the type of health care services which the provider has contracted to deliver under the provider contract) for (a) pre-certification or authorization of coverage decisions, (b) retroactive reconsideration of a certification or authorization of coverage decision or retroactive denial of a previously paid claim, (c) provider-specific payment and reimbursement methodology, coding levels and methodology, downcoding, and bundling of claims, and (d) other provider-specific, applicable claims processing and payment matters necessary to meet the terms and conditions of the provider contract, including determining whether a claim is a clean claim. If a carrier routinely, as a matter of policy, bundles or downcodes claims submitted by a provider, the carrier shall clearly disclose that practice in each

provider contract. Further, such carrier shall either (1) disclose in its provider contracts or on its website the specific bundling and downcoding policies that the carrier reasonably expects to be applied to the provider or provider's services on a routine basis as a matter of policy or (2) disclose in each provider contract a telephone or facsimile number or e-mail address that a provider can use to request the specific bundling and downcoding policies that the carrier reasonably expects to be applied to that provider or provider's services on a routine basis as a matter of policy. If such request is made by or on behalf of a provider, a carrier shall provide the requesting provider with such policies within 10 business days following the date the request is received.

b. Every carrier shall make available to such providers within 10 business days of receipt of a request, copies of or reasonable electronic access to all such policies which are applicable to the particular provider or to particular health care services identified by the provider. In the event the provision of the entire policy would violate any applicable copyright law, the carrier may instead comply with this subsection by timely delivering to the provider a clear explanation of the policy as it applies to the provider and to any health care services identified by the provider.

5. Every carrier shall pay a claim if the carrier has previously authorized the health care service or has advised the provider or enrollee in advance of the provision of health care services that the health care services are medically necessary and a covered benefit, unless:

a. The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized;

b. The carrier's refusal is because (i) another payor is responsible for the payment, (ii) the provider has already been paid for the health care services identified on the claim, (iii) the claim was submitted fraudulently or the authorization was based in whole or material part on erroneous information provided to the carrier by the provider, enrollee, or other person not related to the carrier, or (iv) the person receiving the health care services was not eligible to receive them on the date of service and the carrier did not know, and with the exercise of reasonable care could not have known, of the person's eligibility status; or

c. During the post-service claims process, it is determined that the claim was submitted fraudulently.

6. In the case of an invasive or surgical procedure, if the carrier has previously authorized a health care service as medically necessary and during the procedure the health care provider discovers clinical evidence prompting the provider to perform a less or more extensive or complicated procedure than was previously authorized, then the carrier shall pay the claim, provided that the additional procedures were (i) not investigative in nature, but medically necessary as a covered service under the covered person's benefit plan; (ii) appropriately coded consistent with the procedure actually performed; and (iii) compliant with a carrier's post-service claims process, including required timing for submission to carrier.

7. No carrier shall impose any retroactive denial of a previously paid claim unless the carrier has provided the reason for the retroactive denial and (i) the original claim was submitted fraudulently, (ii)

the original claim payment was incorrect because the provider was already paid for the health care services identified on the claim or the health care services identified on the claim were not delivered by the provider, or (iii) the time which has elapsed since the date of the payment of the original challenged claim does not exceed the lesser of (a) 12 months or (b) the number of days within which the carrier requires under its provider contract that a claim be submitted by the provider following the date on which a health care service is provided. Effective July 1, 2000, a carrier shall notify a provider at least 30 days in advance of any retroactive denial of a claim.

8. Notwithstanding subdivision 7, with respect to provider contracts entered into, amended, extended, or renewed on or after July 1, 2004, no carrier shall impose any retroactive denial of payment or in any other way seek recovery or refund of a previously paid claim unless the carrier specifies in writing the specific claim or claims for which the retroactive denial is to be imposed or the recovery or refund is sought. The written communication shall also contain an explanation of why the claim is being retroactively adjusted.

9. No provider contract shall fail to include or attach at the time it is presented to the provider for execution (i) the fee schedule, reimbursement policy, or statement as to the manner in which claims will be calculated and paid that is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis and (ii) all material addenda, schedules, and exhibits thereto and any policies (including those referred to in subdivision 4) applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider under the provider contract.

10. No amendment to any provider contract or to any addenda, schedule, exhibit or policy thereto (or new addenda, schedule, exhibit, or policy) applicable to the provider (or to the range of health care services reasonably expected to be delivered by that type of provider) shall be effective as to the provider, unless the provider has been provided with the applicable portion of the proposed amendment (or of the proposed new addenda, schedule, exhibit, or policy) at least 60 calendar days before the effective date and the provider has failed to notify the carrier within 30 calendar days of receipt of the documentation of the provider's intention to terminate the provider contract at the earliest date thereafter permitted under the provider contract.

11. In the event that the carrier's provision of a policy required to be provided under subdivision 9 or 10 would violate any applicable copyright law, the carrier may instead comply with this section by providing a clear, written explanation of the policy as it applies to the provider.

12. All carriers shall establish, in writing, their claims payment dispute mechanism and shall make this information available to providers.

13. Every carrier shall include in its provider contracts a provision that prohibits a provider from discriminating against any enrollee solely due to the enrollee's status as a litigant in pending litigation or a potential litigant due to being involved in a motor vehicle accident. Nothing in this subdivision shall require a health care provider to treat an enrollee who has threatened to make or has made a

professional liability claim against the provider or the provider's employer, agents, or employees or has threatened to file or has filed a complaint with a regulatory agency or board against the provider or the provider's employer, agents, or employees.

C. If the Commission has cause to believe that any provider has engaged in a pattern of potential violations of subdivision B 13, with no corrective action, the Commission may submit information to the Board of Medicine or the Commissioner of Health for action. Prior to such submission, the Commission may provide the provider with an opportunity to cure the alleged violations or provide an explanation as to why the actions in questions were not violations. If any provider has engaged in a pattern of potential violations of subdivision B 13, with no corrective action, the Board of Medicine or the Commissioner of Health may levy a fine or cost recovery upon the provider and take other action as permitted under its authority. Upon completion of its review of any potential violation submitted by the Commission or initiated directly by an enrollee, the Board of Medicine or the Commissioner of Health shall notify the Commission of the results of the review, including where the violation was substantiated, and any enforcement action taken as a result of a finding of a substantiated violation.

D. Without limiting the foregoing, in the processing of any payment of claims for health care services rendered by providers under provider contracts and in performing under its provider contracts, every carrier subject to regulation by this title shall adhere to and comply with the minimum fair business standards required under subsection B, and the Commission shall have the jurisdiction to determine if a carrier has violated the standards set forth in subsection B by failing to include the requisite provisions in its provider contracts and shall have jurisdiction to determine if the carrier has failed to implement the minimum fair business standards set out in subdivisions B 1 and 2 in the performance of its provider contracts.

E. No carrier shall be in violation of this section if its failure to comply with this section is caused in material part by the person submitting the claim or if the carrier's compliance is rendered impossible due to matters beyond the carrier's reasonable control (such as an act of God, insurrection, strike, fire, or power outages) which are not caused in material part by the carrier.

F. Any provider who suffers loss as the result of a carrier's violation of this section or a carrier's breach of any provider contract provision required by this section shall be entitled to initiate an action to recover actual damages. If the trier of fact finds that the violation or breach resulted from a carrier's gross negligence and willful conduct, it may increase damages to an amount not exceeding three times the actual damages sustained. Notwithstanding any other provision of law to the contrary, in addition to any damages awarded, such provider also may be awarded reasonable attorney fees and court costs. Each claim for payment which is paid or processed in violation of this section or with respect to which a violation of this section exists shall constitute a separate violation. The Commission shall not be deemed to be a "trier of fact" for purposes of this subsection.

G. No carrier (or its network, provider panel or intermediary) shall terminate or fail to renew the employment or other contractual relationship with a provider, or any provider contract, or otherwise penalize any provider, for invoking any of the provider's rights under this section or under the provider contract.

H. This section shall apply only to carriers subject to regulation under this title.

I. This section shall apply with respect to provider contracts entered into, amended, extended or renewed on or after July 1, 1999.

J. Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such rules and regulations as it may deem necessary to implement this section.

K. The Commission shall have no jurisdiction to adjudicate individual controversies arising out of this section.

1999, cc. 709, 739; 2004, c. 425; 2005, c. 349; 2014, cc. 157, 417; 2015, c. 709; 2019, c. 683; 2021, Sp. Sess. I, c. 72.

§ 38.2-3407.15:1. Carrier contracts with pharmacy providers; required provisions; limit on termination or nonrenewal.

A. As used in this section, unless the context requires a different meaning:

"Audit" includes any audit conducted or authorized by a carrier or its intermediary to determine whether the participating pharmacy provider has complied with the terms and conditions for reimbursement under the provider contract.

"Carrier" has the same meaning ascribed thereto in subsection A of § 38.2-3407.15.

"Clerical error" means any clerical or recordkeeping error or omission, such as typographical errors, scrivener's errors, or computer errors, in the keeping, recording, handling, or transcribing of pharmacy records. "Clerical error" does not include any clerical or recordkeeping error or omission that results in an overpayment by a carrier or its intermediary or the dispensing of a prescription in breach of applicable law or regulation.

"Fraud" means a knowingly or willfully false act of misrepresentation or an act in deliberate ignorance of the truth or falsity of the information as evidenced by a review of claims data, evaluation of provider statements, physical review of pharmacy records, or use of similar investigative methods by the carrier or its intermediary.

"Onsite audit" means an audit conducted at the physical location of the pharmacy, the physical location of its corporate offices, or the physical location of its records.

"Overpayment" means a payment by the carrier or its intermediary to the pharmacy provider that is greater than the rate or amount the provider is entitled to under the provider contract or applicable fee schedule.

"Pharmacy record" means a patient record, signature or delivery log, or prescription, including written, phoned-in, faxed, or electronic prescriptions, whether original or substitute, that complies with applicable law and regulation.

"Provider contract" has the same meaning ascribed thereto in subsection A of § 38.2-3407.15.

B. Any contract between a carrier and its intermediary, pursuant to which the intermediary has the right or obligation to conduct audits of participating pharmacy providers, and any provider contract between a carrier and a participating pharmacy provider or its contracting agent, pursuant to which the carrier has the right or obligation to conduct audits of participating pharmacy providers, shall contain specific provisions that prohibit the carrier or intermediary, in the absence of fraud, from recouping amounts calculated from or arising out of any of the following:

1. Probability sampling, extrapolation, or other mathematical or statistical methods that allegedly project an error;

2. Clerical errors by the participating pharmacy provider;

3. An act or omission of the participating pharmacy provider that was not specifically prohibited or required by the provider contract when the claim was adjudicated unless the act or omission was a violation of applicable law or regulation;

4. The refusal of a carrier or its intermediary to consider during an audit or audit appeal a pharmacy record in electronic form to validate a claim;

5. Dispensing fees or interest on the claim, except in the event of an overpayment, if the prescription was dispensed in accordance with applicable law or regulation;

6. Any claim authorized and dispensed more than 24 months prior to the date of the audit unless the claim is adjusted at the direction of the Commission, except that this time period shall be tolled while the denial of the claim is being appealed;

7. An alleged breach of auditing requirements if they are not the same as the requirements that the carrier or intermediary applies to other participating pharmacy providers in the same setting;

8. The refusal of the carrier or its intermediary to consider during an audit or audit appeal a pharmacy record, a prescriber or patient verification, or a prescriber record to validate a claim; or

9. The alleged failure of the participating pharmacy provider to supply during an audit or audit appeal a pharmacy record not specifically identified in the provider contract.

C. Any (i) contract between a carrier and its intermediary pursuant to which the intermediary has the right or obligation to conduct audits of participating pharmacy providers and (ii) provider contract between a carrier and a participating pharmacy provider or its contracting agent pursuant to which the carrier has the right or obligation to conduct audits of participating pharmacy providers, shall contain the following terms and provisions relating to audits, which shall apply in the absence of fraud:

1. The initial onsite audit shall give the pharmacy written notice at least 14 days before conducting the initial audit for each audit cycle and shall disclose the specific prescription numbers to be included in the audit. The carrier or intermediary may mask the last two digits of such numbers. A pharmacy shall have at least 72 hours after receiving the written notice of an onsite audit to request a five business-day extension of the proposed audit date. A pharmacy making such a request shall be granted at least five additional business days and shall cooperate with the auditor to establish an alternative date.

2. Unless otherwise consented to by the pharmacy, an onsite audit shall not be initiated or scheduled during the first five calendar days of any month, or on a Monday and shall not involve the auditing of more than one location of the pharmacy at any particular time.

3. No onsite audit of a particular pharmacy location on behalf of a particular carrier shall occur more than once in a 12-month period.

4. Each pharmacy shall be audited under the same standards and parameters as every other similarly situated pharmacy. Any documentation and records required by an auditor during an audit shall be of the same type as the documentation and records required for all other similarly situated pharmacies.

5. Any audit issues that involve clinical or professional judgment shall be conducted by a pharmacist who has available for consultation a pharmacist licensed by the Commonwealth.

6. Each audit shall be conducted by a field agent who possesses the requisite knowledge and experience in pharmacy practice.

7. Audits shall be conducted in the Commonwealth in compliance with federal and state laws, rules, and regulations, including regulations adopted by the Board of Pharmacy.

8. Prescriptions shall be considered valid prescriptions if they are compliant with the then-current Board of Pharmacy rules and regulations and have been successfully adjudicated upon a clean claim submission. Carrier restrictions shall be addressed during the claims adjudication process either through the rejection of the clean claim or a rejection of the clean claim with direction to obtain a prior authorization and shall not be the basis for a retrospective recoupment of a paid claim.

9. Electronic records, including electronic beneficiary signature logs, electronic tracking of prescriptions, electronic prescriber prescription transmissions and imagery of hard copy prescriptions, electronically scanned store and patient records maintained at or accessible to the offices of an audited pharmacy's central operations, and any other reasonably clear and accurate electronic documentation shall be acceptable for auditing under the same terms, conditions, and validation and for the same purposes as their paper analogs. Point of sale electronic register data shall qualify as proof of delivery to the patient, provided that the auditor can validate the receipt on the basis of the patient data included.

10. A pharmacy may use the historical records of a hospital, physician, or other authorized practitioner of the healing arts for drugs or medicinal supplies written and transmitted by any documented means

of communication for purposes of validating the pharmacy record with respect to orders or refills of a legend or narcotic drug.

11. Validation and documentation at the time of dispensing of appropriate days' supply and drug dosing shall be based on manufacturer guidelines and definitions or, in the case of topical products or titrated products, based on the professional judgment of the pharmacist in communication with the patient or prescriber.

12. A pharmacy's usual and customary price for compounded medications is considered the reimbursable cost unless the pricing methodology is published in the provider contract and signed by both parties or their agents.

13. A carrier or its intermediary shall not make charge backs or seek recoupment from a pharmacy, or assess or collect penalties from a pharmacy, until the time period for filing an appeal to an initial audit report has passed or until the appeals process has been exhausted, whichever is later. If the identified discrepancy for a single audit exceeds $25,000, future payments in excess of that amount may be withheld pending adjudication of an appeal.

14. The preliminary audit report shall (i) be delivered to the pharmacy or its pharmacy corporate office within 60 calendar days, with reasonable extensions allowed, after conclusion of the audit and (ii) contain claim level information for any discrepancy found and total dollar amount of claims subject to recovery.

15. A pharmacy shall be allowed at least 60 calendar days following receipt of the preliminary audit report in which to produce documentation to address any discrepancy found during an audit or to file an appeal.

16. A final audit report containing claim level information for any discrepancy found and total dollar amount of claims subject to recovery shall be delivered to the pharmacy or its pharmacy corporate office (i) within 90 calendar days after the audited pharmacy's receipt of the preliminary audit report, if the audited pharmacy does not file an appeal or offers no documentation to address a discrepancy found during an audit, or (ii) within 60 calendar days after the auditing entity receives the audited pharmacy's appeal or documentation to address a discrepancy.

17. A carrier or its intermediary shall not recover from the pharmacy payment of claims that is identified through the audit process to be the responsibility of another payer.

18. No recoupment of amounts paid to a pharmacy for any claim shall be made solely on the basis of a prescriber's or patient's lack of response to a request made by a carrier or its intermediary.

19. A carrier or its intermediary shall issue its initial audit findings in conformity with the laws of the Commonwealth.

20. A carrier or its intermediary shall not retroactively deny a claim (i) more than one year after the date of payment of the claim if the reason for denial would be patient ineligibility or (ii) at any time if the car-

rier or its intermediary verified the patient's eligibility at the time of dispensing and provided an authentication number to the pharmacy.

D. Any contract between a carrier and its intermediary, pursuant to which the intermediary has the right or obligation to conduct audits of participating pharmacy providers, and any provider contract between a carrier and a participating pharmacy provider or its contracting agent, pursuant to which the carrier has the right or obligation to conduct audits of participating pharmacy providers, shall contain specific provisions that prohibit the carrier or intermediary, in the absence of fraud by the participating pharmacy provider, from terminating or failing to renew the contractual relationship with a participating pharmacy provider for invoking its rights under any contractual provision required to be contained in the contract pursuant to subsection B or C.

E. The Commission shall have no jurisdiction to adjudicate individual controversies arising out of this section.

F. This section shall apply with respect to contracts described in subsection B or D entered into, amended, extended, or renewed on or after January 1, 2015, except that the provisions of subsection C shall apply with respect to contracts described in subsection B or D entered into, amended, extended, or renewed on or after January 1, 2020.

2014, c. 308; 2019, c. 665.

§ 38.2-3407.15:2. Carrier contracts; required provisions regarding prior authorization.

A. As used in this section, unless the context requires a different meaning:

"Carrier" has the same meaning ascribed thereto in subsection A of § 38.2-3407.15.

"Prior authorization" means the approval process used by a carrier before certain drug benefits may be provided.

"Provider contract" has the same meaning ascribed thereto in subsection A of § 38.2-3407.15.

"Supplementation" means a request communicated by the carrier to the prescriber or his designee, for additional information, limited to items specifically requested on the applicable prior authorization request, necessary to approve or deny a prior authorization request.

B. Any provider contract between a carrier and a participating health care provider with prescriptive authority, or its contracting agent, shall contain specific provisions that:

1. Require the carrier to, in a method of its choosing, accept telephonic, facsimile, or electronic submission of prior authorization requests that are delivered from e-prescribing systems, electronic health record systems, and health information exchange platforms that utilize the National Council for Prescription Drug Programs' SCRIPT standards;

2. Require that the carrier communicate to the prescriber or his designee within 24 hours, including weekend hours, of submission of an urgent prior authorization request to the carrier, if submitted tele-

phonically or in an alternate method directed by the carrier, that the request is approved, denied, or requires supplementation;

3. Require that the carrier communicate electronically, telephonically, or by facsimile to the prescriber or his designee, within two business days of submission of a fully completed prior authorization request, that the request is approved, denied, or requires supplementation;

4. Require that the carrier communicate electronically, telephonically, or by facsimile to the prescriber or his designee, within two business days of submission of a properly completed supplementation from the prescriber or his designee, that the request is approved or denied;

5. Require that if the prior authorization request is denied, the carrier shall communicate electronically, telephonically, or by facsimile to the prescriber or his designee, within the timeframes established by subdivision 3 or 4, as applicable, the reasons for the denial;

6. Require that prior authorization approved by another carrier be honored, upon the carrier's receipt from the prescriber or his designee of a record demonstrating the previous carrier's prior authorization approval or any written or electronic evidence of the previous carrier's coverage of such drug, at least for the initial 30 days of a member's prescription drug benefit coverage under a new health plan, subject to the provisions of the new carrier's evidence of coverage;

7. Require that a tracking system be used by the carrier for all prior authorization requests and that the identification information be provided electronically, telephonically, or by facsimile to the prescriber or his designee, upon the carrier's response to the prior authorization request;

8. Require that the carrier's prescription drug formularies, all drug benefits subject to prior authorization by the carrier, all of the carrier's prior authorization procedures, and all prior authorization request forms accepted by the carrier be made available through one central location on the carrier's website and that such information be updated by the carrier within seven days of approved changes;

9. Require a carrier to honor a prior authorization issued by the carrier for a drug, other than an opioid, regardless of changes in dosages of such drug, provided such drug is prescribed consistent with U.S. Food and Drug Administration-labeled dosages;

10. Require a carrier to honor a prior authorization issued by the carrier for a drug regardless of whether the covered person changes plans with the same carrier and the drug is a covered benefit with the current health plan;

11. Require a carrier, when requiring a prescriber to provide supplemental information that is in the covered individual's health record or electronic health record, to identify the specific information required;

12. Require that no prior authorization be required for at least one drug prescribed for substance abuse medication-assisted treatment, provided that (i) the drug is a covered benefit, (ii) the prescription does not exceed the FDA-labeled dosages, and (iii) the drug is prescribed consistent with the regulations of the Board of Medicine;

13. Require that when any carrier has previously approved prior authorization for any drug prescribed for the treatment of a mental disorder listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, no additional prior authorization shall be required by the carrier, provided that (i) the drug is a covered benefit; (ii) the prescription does not exceed the FDA-labeled dosages; (iii) the prescription has been continuously issued for no fewer than three months; and (iv) the prescriber performs an annual review of the patient to evaluate the drug's continued efficacy, changes in the patient's health status, and potential contraindications. Nothing in this subdivision shall prohibit a carrier from requiring prior authorization for any drug that is not listed on its prescription drug formulary at the time the initial prescription for the drug is issued;

14. Require a carrier to honor a prior authorization issued by the carrier for a drug regardless of whether the drug is removed from the carrier's prescription drug formulary after the initial prescription for that drug is issued, provided that the drug and prescription are consistent with the applicable provisions of subdivision 13;

15. Require a carrier, beginning July 1, 2025, notwithstanding the provisions of subdivision 1 or any other provision of this section, to establish and maintain an online process that (i) links directly to all e-prescribing systems and electronic health record systems that utilize the National Council for Prescription Drug Programs SCRIPT standard and the National Council for Prescription Drug Programs Real Time Benefit Standard; (ii) can accept electronic prior authorization requests from a provider; (iii) can approve electronic prior authorization requests (a) for which no additional information is needed by the carrier to process the prior authorization request, (b) for which no clinical review is required, and (c) that meet the carrier's criteria for approval; and (iv) links directly to real-time patient out-of-pocket costs for the office visit, considering copayment and deductible, and (v) otherwise meets the requirements of this section. No carrier shall (a) impose a fee or charge on any person for accessing the online process as required by this subdivision or (b) access, absent provider consent, provider data via the online process other than for the enrollee. No later than July 1, 2024, a carrier shall provide contact information of any third-party vendor or other entity the carrier will use to meet the requirements of this subdivision or the requirements of § 38.2-3407.15:7 to any provider that requests such information. A carrier that posts such contact information on its website shall be considered to have met this requirement; and

16. Require a participating health care provider, beginning July 1, 2025, to ensure that any e-prescribing system or electronic health record system owned by or contracted for the provider to maintain an enrollee's health record has the ability to access, at the point of prescribing, the electronic prior authorization process established by a carrier as required by subdivision 15 and the real-time patient-specific benefit information, including out-of-pocket costs and more affordable medication alternatives made available by a carrier pursuant to § 38.2-3407.15:7. A provider may request a waiver of compliance under this subdivision for undue hardship for a period specified by the appropriate regulatory authority with the Health and Human Resources Secretariat.

C. The Commission shall have no jurisdiction to adjudicate individual controversies arising out of this section.

D. This section shall apply with respect to any contract between a carrier and a participating health care provider, or its contracting agent, that is entered into, amended, extended, or renewed on or after January 1, 2016.

E. Notwithstanding any law to the contrary, the provisions of this section shall not apply to:

1. Coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid), Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq. (CHIP), 5 U.S.C. § 8901 et seq. (federal employees), or 10 U.S.C. § 1071 et seq. (TRICARE);

2. Accident only, credit or disability insurance, long-term care insurance, TRICARE supplement, Medicare supplement, or workers' compensation coverages;

3. Any dental services plan or optometric services plan as defined in § 38.2-4501; or

4. Any health maintenance organization that (i) contracts with one multispecialty group of physicians who are employed by and are shareholders of the multispecialty group, which multispecialty group of physicians may also contract with health care providers in the community; (ii) provides and arranges for the provision of physician services by such multispecialty group physicians or by such contracted health care providers in the community; and (iii) receives and processes at least 85 percent of prescription drug prior authorization requests in a manner that is interoperable with e-prescribing systems, electronic health records, and health information exchange platforms.

2015, cc. 515, 516; 2019, c. 683; 2021, Sp. Sess. I, cc. 66, 67; 2023, cc. 474, 475.

§ 38.2-3407.15:3. Carrier and intermediary contracts with pharmacy providers; disclosure and updating of maximum allowable cost of drugs; limit on termination or nonrenewal.

A. As used in this section, unless the context requires a different meaning:

"Carrier" has the same meaning ascribed thereto in subsection A of § 38.2-3407.15.

"Maximum allowable cost" means the maximum dollar amount that a carrier or its intermediary will reimburse a pharmacy provider for a group of drugs rated as "A", "AB", "NR", or "NA" in the most recent edition of the Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book, published by the U.S. Food and Drug Administration, or similarly rated by a nationally recognized reference.

"Provider contract" has the same meaning ascribed thereto in subsection A of § 38.2-3407.15.

B. Any contract between a carrier and its intermediary, pursuant to which the intermediary has the right or obligation to establish a maximum allowable cost, and any provider contract between a carrier and a participating pharmacy provider or its contracting agent, pursuant to which the carrier has the right or

obligation to establish a maximum allowable cost, shall contain specific provisions that require the intermediary or carrier to:

1. Update, not less frequently than once every seven days, the maximum allowable cost list, unless there has been no change to the maximum allowable cost of any drug on the list since the last update;

2. Verify, not less frequently than once every seven days, that the drugs on the maximum allowable cost list are available to participating pharmacy providers from at least one regional or national pharmacy wholesaler and that the amount for each drug is not obsolete and promptly revise the maximum allowable cost if necessary to comply with this subsection;

3. Provide a process for each participating pharmacy provider to readily access the maximum allowable cost list specific to that provider; and

4. Prohibit the intermediary or carrier from terminating or failing to renew its contractual relationship with a participating pharmacy provider for invoking its rights under any contractual provision required by this section.

C. Any contract between a carrier and its intermediary, pursuant to which the intermediary has the right or obligation to establish a maximum allowable cost, and any provider contract between a carrier and a participating pharmacy provider or its contracting agent, pursuant to which the carrier has the right or obligation to establish a maximum allowable cost, shall contain specific provisions that require the intermediary or carrier to provide a process for an appeal, investigation, and resolution of disputes regarding maximum allowable cost drug pricing that includes:

1. A time period of 14 days from the date of initial claim adjudication for the participating pharmacy provider to file its dispute request;

2. A requirement that the dispute request be investigated and resolved within 14 days of its initiation by the participating pharmacy provider;

3. A telephone number at which the participating pharmacy provider may contact the carrier or its intermediary to speak to a person responsible for processing dispute requests;

4. A requirement that a carrier or its intermediary, if a dispute request is denied, provide (i) a reason for the denial, and (ii) the national drug code of the drug under dispute that the carrier or its intermediary contends may be purchased by the participating pharmacy provider for an amount that is equal to or less than the maximum allowable cost; and

5. A requirement that a carrier or its intermediary, if a dispute is successful, update the maximum allowable cost for the drug under dispute within five days of the determination of the dispute.

D. The Commission shall have no jurisdiction to adjudicate individual controversies arising out of this section.

E. This section shall apply with respect to contracts described in subsections B and C entered into, amended, extended, or renewed on or after January 1, 2016.

2015, c. 518.

§ 38.2-3407.15:4. Limit on copayment for prescription drugs; permitted disclosures.

A. As used in this section:

"Carrier" has the same meaning ascribed thereto in subsection A of § 38.2-3407.15.

"Copayment" means an amount an enrollee is required to pay at the point of sale in order to receive a covered prescription drug.

"Enrollee" means a policyholder, subscriber, participant, or other individual covered by a health benefit plan.

"Health plan" means any health benefit plan, as defined in § 38.2-3438, that provides coverage for prescription drugs.

"Pharmacy benefits management" means the administration or management of prescription drug benefits provided by a carrier for the benefit of enrollees.

"Pharmacy benefits manager" means an entity that performs pharmacy benefits management. The term includes a person or entity acting for a pharmacy benefits manager in a contractual or employment relationship in the performance of pharmacy benefits management for a carrier.

"Provider contract" has the same meaning ascribed thereto in subsection A of § 38.2-3407.15.

B. No provider contract between a health carrier or its pharmacy benefits manager and a pharmacy or its contracting agent shall contain a provision (i) authorizing the carrier or its pharmacy benefits manager to charge, (ii) requiring the pharmacy or pharmacist to collect, or (iii) requiring an enrollee to make, a copayment for a covered prescription drug in an amount that exceeds the least of:

1. The applicable copayment for the prescription drug that would be payable in the absence of this section; or

2. The cash price the enrollee would pay for the prescription drug if the enrollee purchased the prescription drug without using the enrollee's health plan.

C. Provider contracts between a health carrier or its pharmacy benefits manager and a pharmacy or its contracting agent shall contain specific provisions that allow a pharmacy to:

1. Disclose to an enrollee information relating to (i) the provisions of this section and (ii) the availability of a more affordable therapeutically equivalent prescription drug;

2. Sell a more affordable therapeutically equivalent prescription drug to an enrollee if one is available in accordance with § 54.1-3408.03; and

3. Offer and provide direct and limited delivery services to an enrollee as an ancillary service of the pharmacy in accordance with § 54.1-3420.2.

D. A pharmacy shall not be penalized by a pharmacy benefits manager or a carrier for discussing information or for selling a more affordable alternative as described in subsection C.

E. Provider contracts between a health carrier or its pharmacy benefits manager and a pharmacy or its contracting agent shall contain specific provisions that prohibit the carrier or the pharmacy benefit manager from charging a fee to a pharmacy or otherwise holding a pharmacy responsible for a fee relating to the adjudication of a claim unless the fee is reported on the remittance advice of the adjudicated claim or is set out in contract between the pharmacy benefits manager and the pharmacy or its contracting agent.

F. This section shall not apply with respect to claims under an employee benefit plan under the Employee Retirement Income Security Act of 1974, Medicaid, or Medicare Part D.

G. This section shall apply with respect to provider contracts entered into, amended, extended, or renewed on or after January 1, 2019.

H. Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such rules and regulations as it may deem necessary to implement this section.

I. The Commission shall have no jurisdiction to adjudicate individual controversies arising out of this section.

2018, cc. 245, 602.

§ 38.2-3407.15:5. Limit on cost-sharing payments for prescription insulin drugs.

A. As used in this section:

"Carrier" has the same meaning ascribed thereto in subsection A of § 38.2-3407.15.

"Cost-sharing payment" means the total amount a covered person is required to pay at the point of sale in order to receive a prescription drug that is covered under the covered person's health plan.

"Covered person" means a policyholder, subscriber, participant, or other individual covered by a health plan.

"Health plan" means any health benefit plan, as defined in § 38.2-3438, that provides coverage for a prescription insulin drug.

"Pharmacy benefits manager" means an entity that engages in the administration or management of prescription drug benefits provided by a carrier for the benefit of its covered persons.

"Prescription insulin drug" means a prescription drug that contains insulin and is used to treat diabetes.

"Provider contract" has the same meaning ascribed thereto in subsection A of § 38.2-3407.15.

B. Every health plan offered by a carrier shall set the cost-sharing payment that a covered person is required to pay for a covered prescription insulin drug at an amount that does not exceed $50 per 30-day supply of the prescription insulin drug, regardless of the amount or type of insulin needed to fill the covered person's prescription.

C. Nothing in this section shall prevent a carrier from setting a covered person's cost-sharing payment for a covered prescription insulin drug at an amount that is less than the maximum amount permitted pursuant to subsection B.

D. No provider contract between a carrier or its pharmacy benefits manager and a pharmacy or its contracting agent shall contain a provision (i) authorizing the carrier's pharmacy benefits manager or the pharmacy to charge, (ii) requiring the pharmacy to collect, or (iii) requiring a covered person to make a cost-sharing payment for a covered prescription insulin drug in an amount that exceeds the amount of the cost-sharing payment for the covered prescription insulin drug established by the carrier pursuant to subsection B.

E. This section shall apply with respect to health plans and provider contracts entered into, amended, extended, or renewed on or after January 1, 2021.

F. Pursuant to the authority granted by § 38.2-223, the Commission may adopt such rules and regulations as it may deem necessary to implement this section.

2020, c. 881.

§ 38.2-3407.15:6. Prescription drug price transparency.

A. As used in this section:

"Carrier" has the same meaning as set forth in § 38.2-3407.10.

"Health benefit plan" has the same meaning as set forth in § 38.2-3438.

"Manufacturer" has the same meaning as set forth in § 54.1-3401.

"Nonprofit data services organization" has the same meaning as set forth in § 32.1-23.4.

"Pharmacy benefits management" has the same meaning as set forth in § 38.2-3407.15:4.

"Pharmacy benefits manager" has the same meaning as set forth in § 38.2-3407.15:4.

B. Every carrier offering a health benefit plan shall report annually by April 1 to the nonprofit data services organization with which the Department of Health has entered into a contract or agreement pursuant to § 32.1-23.4 the following information on spending on prescription drugs in total, before enrollee cost sharing, for each health benefit plan offered by the carrier in the Commonwealth:

1. For covered outpatient prescription drugs that were prescribed to enrollees during the calendar year, the names of (i) the 25 most frequently prescribed outpatient prescription drugs, (ii) the names of the 25 outpatient prescription drugs covered at the greatest cost, calculated using the total annual spending by such health benefit plan for each outpatient prescription drug covered by the health benefit plan; and (iii) the 25 outpatient prescription drugs that experienced the greatest year-over-year increase in cost, calculated using the total annual spending by such health benefit plan for each outpatient prescription drug covered by the health benefit plan;

2. The percent increase in annual net spending for prescription drugs after accounting for aggregated rebates, discounts, or other reductions in price;

3. The percent increase in premiums that were attributable to each health care service, including prescription drugs;

4. The percentage of specialty drugs with utilization management requirements; and

5. The premium reductions that were attributable to specialty drug utilization management.

C. A report submitted by a carrier pursuant to this section shall not disclose the identity of a specific health benefit plan or the price charged for a specific prescription drug or class of prescription drugs.

D. Every carrier offering a health benefit plan shall require each pharmacy benefits manager with which it enters into a contract for pharmacy benefits management to report annually by April 1 to the nonprofit data services organization with which the Department has entered into a contract or agreement pursuant to § 32.1-23.2 the following information for each drug specified by the Department of Health:

1. The aggregate amount of rebates received by the pharmacy benefits manager;

2. The aggregate amount of rebates distributed to the relevant health benefit plan; and

3. The aggregate amount of rebates passed on to enrollees of each health benefit plan at the point of sale that reduced the enrollees' applicable deductible, copayment, coinsurance, or other cost-sharing amount.

E. A report submitted by a pharmacy benefits manager pursuant to subsection D shall not disclose the identity of a specific health benefit plan or covered person, the price charged for a specific prescription drug or class of prescription drugs, or the amount of any rebate or fee provided for a specific prescription drug or class of prescription drugs.

2021, Sp. Sess. I, c. 304.

§ 38.2-3407.15:7. Carrier provision of certain information.

A. As used in this section:

"Carrier" has the same meaning as provided in § 38.2-3407.15.

"Enrollee" has the same meaning as provided in § 38.2-3407.10.

"Pharmacy benefits manager" has the same meaning as provided in § 38.2-3465.

"Provider" has the same meaning as provided in § 38.2-3407.10.

B. Beginning July 1, 2025, any carrier or its pharmacy benefits manager shall provide real-time patient-specific benefit information to enrollees and contracted providers for the office visit, including any out-of-pocket costs and more affordable medication alternatives or prior authorization requirements, and shall ensure that the data is accurate. Such cost information data shall be available to the provider at the point of prescribing in an accessible and understandable format, such as through the

provider's e-prescribing system or electronic health record system that the carrier or pharmacy benefits manager or its designated subcontractor has adopted that utilizes the National Council for Prescription Drug Programs SCRIPT standard and the National Council for Prescription Drug Programs Real Time Benefit Standard from which the provider makes the request.

2023, cc. 474, 475.

§ 38.2-3407.16. Requirements for obstetrical care.

A. Each (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, (ii) corporation providing individual or group accident and sickness subscription contracts, and (iii) health maintenance organization providing a health care plan for health care services, whose policies, contracts, or plans, including any certificate or evidence of coverage issued in connection with such policies, contracts or plans, include coverage for obstetrical services as an inpatient in a general hospital or obstetrical services by a physician shall provide such benefits with durational limits, deductibles, coinsurance factors, and copayments that are no less favorable than for physical illness generally.

B. The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, renewed, or extended or at any time when any term of any such policy, contract, or plan is changed or any premium adjustment is made, on and after the effective date of this section. The provisions of this section shall not apply to short-term travel, accident only, or limited or specified disease policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

1999, c. 923; 2014, c. 814.

§ 38.2-3407.17. Payment for services by dentists and oral surgeons.

A. As used in this section:

"Covered services" means the health care services for which benefits under a policy, contract, or evidence of coverage are payable by a dental plan, including services paid by the insureds, subscribers, or enrollees because the annual or periodic payment maximum established by the dental plan has been met.

"Dental plan" includes (i) an insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical, and surgical or major medical coverage on an expense-incurred basis, (ii) an entity providing individual or group accident and sickness subscription contracts, (iii) a dental services plan offering or administering prepaid dental services, (iv) a health maintenance organization providing a health care plan, and (v) a dental plan organization.

B. No contract between a dental plan and a dentist or oral surgeon may establish the fee or rate that the dentist or oral surgeon is required to accept for the provision of health care services, or require that

a dentist or oral surgeon accept the reimbursement paid as payment in full, unless the services are covered services under the applicable dental plan.

C. A reimbursement payable or paid by a dental plan for covered services shall be reasonable and not provide nominal reimbursement in order to claim that services are covered services under the applicable dental plan. For purposes of this subsection, "reasonable" means the negotiated fee, rate, or reimbursement methodology that is set forth in the contract between a dental plan and a dentist or oral surgeon and is acceptable to the provider.

D. This section, except subsection C, shall apply to any contract between a dental plan and a dentist or oral surgeon for the provision of health care to patients that is entered into, amended, extended, or renewed on or after July 1, 2010. The provisions of subsection C shall apply to any contract between a dental plan and a dentist or oral surgeon for the provision of health care to patients that is entered into, amended, extended, or renewed on or after January 1, 2017.

E. The Commission shall have no jurisdiction to adjudicate individual controversies arising out of this section.

2010, cc. 583, 734; 2016, c. 556.

§ 38.2-3407.17:1. Payment and reimbursement practices for dental services; network access.

A. As used in this section, unless the context requires a different meaning:

"Brand licensing program" means the process of creating and managing contracts or agreements between a person who owns a brand and a third party who uses the brand in connection with the provision of insurance for dental services in a specific geographic territory.

"Carrier" means (i) any health carrier that proposes to issue individual or group health benefit plans that provide coverage for dental services, (ii) any nonstock corporation that offers or administers dental services plans as defined in § 38.2-4501, or (iii) a dental plan organization as defined in § 38.2-6101.

"Contracting entity" means a carrier or other person that enters into a provider contract with a provider.

"Enrollee" means any person entitled to coverage for dental services (i) under an individual or group health benefit plan that provides coverage for dental services, (ii) under a dental services plan, or (iii) under a dental plan organization.

"Health benefit plan" and "health carrier" have the meaning ascribed to those terms in § 38.2-3438.

"Network plan" means coverage by a carrier for dental services under which the financing and delivery of dental services are provided, in whole or in part, through a defined set of providers under contract with the carrier.

"Participating provider" means a provider that has entered into a provider contract with a contracting entity.

"Preferred provider organization" or "PPO" means a health benefit plan that contracts with providers to create a network of participating providers that have agreed to provide dental services at contracted rates to the PPO's enrollees.

"PPO network" means the multiple provider contracts available to a person pursuant to a PPO network arrangement.

"PPO network arrangement" means an arrangement under which the contracting entity or third-party administrator sells, conveys, or otherwise transfers to a person the ability to discount payments or reimbursements to a provider pursuant to the terms of multiple provider contracts to which the contracting entity or third-party administrator is a direct party.

"Provider" means a dentist or oral surgeon licensed to provide covered dental services to an enrollee.

"Provider contract" means an agreement between a contracting entity and a provider pursuant to which the provider agrees to provide dental services to an enrollee in exchange for payment or reimbursement of an agreed-upon amount.

"Third-party administrator" means a person that administers, processes, handles, or pays claims to providers on behalf of a carrier.

"Third-party carrier" means a carrier that is not a party to a provider contract. "Third-party carrier" includes a network plan under which the carrier is not a party to such provider contract.

B. A contracting entity or third-party administrator shall not sell, lease, assign, or otherwise grant to a third-party carrier access as provided in a provider contract unless:

1. The contracting entity or third-party administrator is expressly authorized to do so by the provider contract. A provider contract shall expressly authorize access as provided in a provider contract only if the provider contract explicitly states that the selling, leasing, assigning, or granting of access as provided in a provider contract is permitted; and

2. The contracting entity or third-party administrator has notified, pursuant to § 38.2-3407.15, all of the affected participating providers that a third-party carrier is being granted access as provided in a provider contract of the participating provider. Such notification shall be sent to the affected participating provider either (i) by first-class mail in an envelope not containing any other enclosure or (ii) if the participating provider has agreed in advance with the contracting entity or third-party administrator to authorize communication by electronic means, by such means.

C. If the requirements of subsection B are satisfied, the contracting entity or third-party administrator may sell, lease, assign, or otherwise grant to a third-party carrier access as provided in a provider contract.

D. Each third-party carrier that is granted access as provided in a provider contract in accordance with subdivision B 1 to have dental services provided by a participating provider to enrollees of the third-party carrier under the terms of a provider contract shall:

1. Abide by the fee schedule set forth in the provider contract applicable to the enrollee that is in effect on the date treatment was rendered to the third-party carrier's enrollee by the provider. However, if the provider has a contract directly with the entity to whom the contract is sold, leased, or assigned, then the fee schedule in such contract shall apply; and

2. Disclose the name of the participating provider in all directories, websites, or other forms of communications by which the third-party carrier advises or directs its enrollees to providers with which the third-party carrier contracted directly. Such disclosure shall be made in a manner that displays the same information and font size that the third-party carrier makes available to its enrollees about the providers with which the third-party carrier contracted directly as it does about the providers for which it has been granted access as provided in a provider contract.

E. The contracting entity or carrier shall inform participating providers, upon request, which network plans have been granted access to the contract by the contracting entity.

F. A contracting entity or third-party administrator that sells, leases, assigns, or otherwise grants access as provided in a provider contract shall:

1. Maintain a website and a toll-free telephone number through which a participating provider may obtain information that identifies each third-party carrier or other person to which access has been granted as provided in a provider contract to which the participating provider is a party; and

2. Ensure that remittance advice furnished to the participating provider that delivers the dental services under the contract identifies the contract source relied upon to discount a payment or reimbursement to the provider. Such remittance advice shall also include (i) the name of the provider, contracting entity, and third-party administrator with whom the contract was originally negotiated and (ii) a calculation of how the payment or reimbursement was determined.

G. All third-party carriers that have contracted with the contracting entity to purchase, lease, be assigned, or otherwise be granted access as provided in a provider contract to the participating provider's services, payment, or reimbursement rate shall comply with the participating provider's contract, including all requirements to encourage enrollees to access the participating provider, or to pay or reimburse the participating provider pursuant to the rates and payment methodology at the time treatment is rendered as set forth in the contract, unless otherwise agreed to by the participating provider.

H. A third-party carrier may comply with this section by providing enrollees with an identification card that (i) identifies the carrier to be used to pay or reimburse the participating provider for the covered dental services and (ii) identifies the contracting entity through which the third-party carrier has obtained access. A contracting entity or third-party carrier or administrator may provide the information described in clauses (i) and (ii) through an electronic equivalent or provider portal if the participating provider has agreed to electronic communications as provided for in subdivision B 2. The remittance advice shall include the information described in clauses (i) and (ii).

I. This section shall not apply to access as provided in a provider contract that is granted or permitted to an entity operating under the same brand licensing program, including authorized affiliates, provided that the third-party carrier or third-party administrator adheres to all terms, provisions, and conditions of the provider contract and administers such terms, provisions, and conditions in accordance with the member's contract. A listing of all affiliates shall be available to the provider under the provisions of subsection E or subdivision F 1.

J. The Commission shall have no jurisdiction to adjudicate controversies arising out of this section.

2019, c. 655.

§ 38.2-3407.18. Requirements for orally administered cancer chemotherapy drugs.

A. Each (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; (ii) corporation providing individual or group accident and sickness subscription contracts; and (iii) health maintenance organization providing a health care plan for health care services, whose policies, contracts, or plans, including any certificate or evidence of coverage issued in connection with such policies, contracts, or plans, include coverage for cancer chemotherapy drugs administered orally and intravenously or by injection shall provide that the criteria for establishing cost sharing applicable to orally administered cancer chemotherapy drugs and cancer chemotherapy drugs that are administered intravenously or by injection shall be consistently applied within the same plan.

B. The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, renewed, or extended or at any time when any term of any such policy, contract, or plan is changed or any premium adjustment is made, on and after the effective date of this section. The provisions of this section shall not apply to short-term travel, accident only, or limited or specified disease policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

C. This section shall apply to health coverage offered to state employees pursuant to § 2.2-2818 and to health insurance coverage offered to employees of local governments, local officers, teachers, and retirees, and the dependents of such employees, local officers, teachers and retirees pursuant to § 2.2-1204. In administering such coverage, the criteria for establishing the level of copayments or coinsurance for orally administered cancer treatment drugs and cancer chemotherapy drugs that are administered intravenously or by injection shall be consistently applied within the same plan.

2012, cc. 634, 641; 2014, c. 814.

§ 38.2-3407.19. Payment for services by optometrists and ophthalmologists.

A. As used in this section, unless the context requires a different meaning:

"Covered materials" means lenses, devices containing lenses, prisms, lens treatments and coatings, contact lenses, and devices to correct, relieve, or treat defects or abnormal conditions of the human eye and its adnexa for which benefits under a policy, contract, or evidence of coverage are payable by

a vision care plan carrier, including materials paid by the insureds, subscribers, or enrollees because the annual or periodic payment maximum established by the vision care plan has been met.

"Covered services" means the health care services for which benefits under a policy, contract, or evidence of coverage are payable by a vision care plan carrier, including services paid by the insureds, subscribers, or enrollees because the annual or periodic payment maximum established by the vision care plan has been met.

"Enrollee" means any person entitled to health care services under a vision care plan.

"Optometric services plan" has the same meaning ascribed thereto in § 38.2-4501.

"Participating provider agreement" means a contract or agreement between an optometrist or ophthalmologist and a vision care plan carrier in which the optometrist or ophthalmologist has agreed to provide vision-related health care services to enrollees and to hold those enrollees harmless from payment with an expectation of receiving payment, other than copayments or deductibles, directly or indirectly from a vision care plan.

"Vision care plan" means (i) an individual or group accident and sickness insurance policy providing hospital, medical, and surgical or major medical coverage on an expense-incurred basis; (ii) an individual or group accident and sickness subscription contract; (iii) an optometric services plan; (iv) a health care plan provided by a health maintenance organization; or (v) an integrated or stand-alone vision benefit plan or a vision care insurance policy or contract that provides vision benefits to an enrollee pertaining to the provision of covered services or covered materials, under which policy, contract, or plan an enrollee is eligible to receive a benefit for covered services or covered materials.

"Vision care plan carrier" means (i) an insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical, and surgical or major medical coverage on an expense-incurred basis; (ii) a nonstock corporation providing individual or group accident and sickness subscription contracts; (iii) a nonstock corporation offering an optometric services plan; (iv) a health maintenance organization providing a health care plan; and (v) an entity that creates, promotes, sells, provides, advertises, or administers (a) an integrated or stand-alone vision benefit plan or (b) a vision care insurance policy or contract that provides vision benefits to an enrollee pertaining to the provision of covered services or covered materials.

B. No participating provider agreement shall establish the fee or rate that the optometrist or ophthalmologist is required to accept for the provision of health care materials or services, or require that an optometrist or ophthalmologist accept the reimbursement paid as payment in full, unless the health care materials and services are covered materials or covered services under the applicable vision care plan.

C. Reimbursement paid by the vision care plan carrier for covered services and covered materials shall be reasonable and shall not provide nominal reimbursement in order to claim that services and materials are covered services or covered materials under the applicable vision care plan. For the

purposes of this subsection, "reasonable" means the negotiated fee or rate that is set forth in the participating provider agreement and is acceptable to the provider.

D. No vision care plan shall require an optometrist or ophthalmologist to use a particular optical laboratory, manufacturer of eyeglass frames or contact lenses, or third-party supplier as a condition of participation in a vision care plan.

E. Any changes to a participating provider agreement proposed by the vision care plan carrier shall be submitted in writing to the optometrist or ophthalmologist at least 30 days prior to the effective date of such proposed changes.

F. This section shall apply with respect to any participating provider agreement that is entered into, amended, extended, or renewed on or after January 1, 2016.

G. The Commission shall have no jurisdiction to adjudicate individual controversies arising out of this section.

H. The provisions of subsections B through G, as related to covered materials only, shall be applicable to licensed opticians practicing in the Commonwealth.

2015, c. 723.

§ 38.2-3407.20. Calculation of enrollee's contribution to out-of-pocket maximum or cost-sharing requirement.

A. As used in this section:

"Carrier" shall have the meaning set forth in § 38.2-3407.10; however, "carrier" also includes any person required to be licensed under this title that offers or operates a managed care health insurance plan subject to Chapter 58 (§ 38.2-5800 et seq.) or that provides or arranges for the provision of health care services, health plans, networks, or provider panels that are subject to regulation as the business of insurance under this title.

"Cost sharing" means any coinsurance, copayment, or deductible.

"Enrollee" means any person entitled to health care services from a carrier.

"Health care services" means items or services furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability.

"Health plan" means any individual or group health care plan, subscription contract, evidence of coverage, certificate, health services plan, medical or hospital services plan, accident and sickness insurance policy or certificate, managed care health insurance plan, or other similar certificate, policy, contract, or arrangement, and any endorsement or rider thereto, to cover all or a portion of the cost of persons receiving covered health care services, that is subject to state regulation and that is required to be offered, arranged, or issued in the Commonwealth by a carrier licensed under this title. "Health plan" does not mean (i) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid) or

Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq. (CHIP), 5 U.S.C. § 8901 et seq. (federal employees), or 10 U.S.C. § 1071 et seq. (TRICARE); or (ii) accident only, credit or disability insurance, long-term care insurance, TRICARE supplement, Medicare supplement, or workers' compensation coverages.

B. To the extent permitted by federal law and regulation and except as provided in subsection C, when calculating an enrollee's overall contribution to any out-of-pocket maximum or any cost-sharing requirement under a health plan, a carrier shall include any amounts paid by the enrollee or paid on behalf of the enrollee by another person.

C. If the application of the provisions of subsection B would result in a health plan's ineligibility to qualify as a Health Savings Account-qualified High Deductible Health Plan under 26 U.S.C. § 223, then the requirements of subsection B shall not apply with respect to the deductible of such health plan until after the enrollee has satisfied the minimum deductible under 26 U.S.C § 223. However, with respect to items or services that are preventive care pursuant to 26 U.S.C. § 223 (c)(2)(C), the provisions of subsection B shall apply regardless of whether the minimum deductible under 26 U.S.C. § 223 has been satisfied.

D. This section shall apply with respect to health plans that are entered into, amended, extended, or renewed on or after January 1, 2020.

E. Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such rules and regulations as it may deem necessary to implement this section.

2019, cc. 661, 662; 2022, cc. 133, 134.

§ 38.2-3407.21. Short-term limited-duration medical plans.

A. As used in this section:

"Carrier" means any entity that is authorized to sell, offer, or provide a short-term limited-duration medical plan.

"Covered person" means a policyholder, subscriber, enrollee, participant, or other individual who is entitled to health care services provided, arranged for, paid for, or reimbursed pursuant to a short-term limited-duration medical plan.

"PPACA" has the meaning ascribed thereto in § 38.2-3438.

"Short-term limited-duration medical plan" has the same meaning as short-term limited-duration insurance as used in 26 C.F.R. § 54.9801-2, 29 C.F.R. § 2590.701-2 and 45 C.F.R. § 144.103 except as described in subsection B.

B. No carrier shall issue, deliver, issue for delivery, reissue, or extend in the Commonwealth on and after July 1, 2021, any short-term limited-duration medical plan:

1. With a duration that exceeds three months;

2. That can be renewed or extended if the renewal or extension would result in such coverage being effective for more than six months, notwithstanding § 38.2-3514.2; or

3. If the issuance, delivery, reissuance, or extension of the short-term limited-duration medical plan would result in a covered person being covered by a short-term limited-duration medical plan for more than six months in any 12-month period.

C. No carrier shall issue a short-term limited-duration medical plan during an annual open enrollment period.

D. Any certificate delivered in the Commonwealth that is issued under a short-term limited-duration medical plan in any other jurisdiction shall comply with the requirements of this section.

2020, cc. 1076, 1077.

§ 38.2-3407.22. Option for rebates to enrollees; protected information.

A. As used in this section:

"Carrier" has the same meaning as set forth in § 38.2-3407.10; however, "carrier" also includes any person required to be licensed pursuant to this title that offers or operates a managed care health insurance plan subject to the requirements of Chapter 58 (§ 38.2-5800 et seq.) or that provides or arranges for the provision of health care services, health plans, networks, or provider panels that are subject to regulation as the business of insurance. "Carrier" also includes any health insurance issuer that offers health insurance coverage, as defined in § 38.2-3431.

"Enrollee" means any person entitled to health care services from a carrier.

"Health care services" means items or services furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability.

"Health plan" means any individual or group health care plan, subscription contract, evidence of coverage, certificate, health services plan, medical or hospital services plan, accident or sickness insurance policy or certificate, managed care health insurance plan, or other similar certificate, policy, contract, or arrangement, and any endorsement or rider thereto, to cover all or a portion of the cost of persons receiving covered health care services, that is subject to state regulation and that is required to be offered, arranged, or issued in the Commonwealth by a carrier licensed under this title. "Health plan" includes a state or local government employer plan. "Health plan" does not mean (i) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid), Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq. (CHIP), 5 U.S.C. § 8901 et seq. (federal employees), or 10 U.S.C. § 1071 et seq. (TRICARE) or (ii) accident only, credit or disability insurance, long-term care insurance, TRICARE supplement, Medicare Supplement, or workers' compensation coverages.

"Pharmacy benefits manager" has the same meaning as set forth in § 38.2-3407.15:4.

"Rebate" means (i) negotiated price concessions, including base price concessions and reasonable estimates of any price protection rebates and performance-based price concessions, that may accrue directly or indirectly to a carrier, health plan, or pharmacy benefits manager during the coverage year from a manufacturer, dispensing pharmacy, or other party in connection with the dispensing or administration of a prescription drug and (ii) reasonable estimates of any negotiated price concessions, fees, or other administrative costs that are passed through, or are reasonably anticipated to be passed through, to the carrier, health plan, or pharmacy benefits manager and serve to reduce the liability of a carrier, health plan, or pharmacy benefits manager for a prescription drug.

B. When contracting with a carrier or health plan to administer pharmacy benefits, a pharmacy benefits manager shall offer the carrier or health plan the option of extending point-of-sale rebates to enrollees of the plan.

C. The provisions of this section shall only apply to a carrier, health plan, or pharmacy benefits manager to the extent permissible under applicable law.

D. In complying with the provisions of this section, a carrier, health plan, pharmacy benefits manager, or its respective agents shall not publish or otherwise reveal information regarding the actual amount of rebates a carrier, health plan, or pharmacy benefits manager receives on a product-specific, manufacturer-specific, or pharmacy-specific basis. Such information shall be protected as a trade secret and shall not be public record or disclosed, directly or indirectly. A carrier, health plan, or pharmacy benefits manager shall require any vendor or third party with which the carrier, health plan, or pharmacy benefits manager contracts for health care or administrative services on behalf of the carrier, health plan, or pharmacy benefits manager that may receive or have access to rebate information to comply with the provisions of this subsection related to protection of information regarding the amount of rebates a carrier, health plan, or pharmacy benefits manager receives on a product-specific, manufacturer-specific, or pharmacy-specific basis.

E. The Commission may, pursuant to the provisions of § 38.2-223, adopt such rules and regulations as may be necessary to implement and enforce the provisions of this section.

2021, Sp. Sess. I, c. 304.

Article 2 - Mandated Benefits

§ 38.2-3408. Policy providing for reimbursement for services that may be performed by certain practitioners other than physicians.

A. If an accident and sickness insurance policy provides reimbursement for any service that may be legally performed by a person licensed in this Commonwealth as a chiropractor, optometrist, optician, professional counselor, psychologist, clinical social worker, podiatrist, physical therapist, chiropodist, clinical nurse specialist, audiologist, speech pathologist, certified nurse midwife or other advanced practice registered nurse, marriage and family therapist, athletic trainer, or licensed acupuncturist, reimbursement under the policy shall not be denied because the service is rendered by the licensed

practitioner, provided that, for services performed by an athletic trainer, such service is performed in an office setting.

B. If an accident and sickness insurance policy provides reimbursement for a service that may be legally performed by a licensed pharmacist, reimbursement under the policy shall not be denied because the service is rendered by the licensed pharmacist, provided that (i) the service is performed for an insured for a condition under the terms of a collaborative agreement, as defined in § 54.1-3300, (ii) the service is for the administration of vaccines for immunization, or (iii) the service is provided in accordance with § 54.1-3303.1.

C. This section shall not apply to Medicaid, or any state fund.

1968, c. 588, § 38.1-347.1; 1973, c. 428; 1979, c. 13; 1986, c. 562; 1987, cc. 549, 551, 557; 1989, cc. 7, 201; 1997, c. 203; 1998, c. 146; 2001, cc. 102, 475; 2019, cc. 332, 333; 2020, cc. 726, 731; 2022, cc. 440, 441; 2023, c. 183.

§ 38.2-3409. Coverage of dependent children.

A. Any group or individual accident and sickness insurance policy or subscription contract delivered or issued for delivery in the Commonwealth which provides that coverage of a dependent child shall terminate upon that child's attainment of a specified age, shall also provide in substance that attainment of the specified age shall not terminate the child's coverage during the continuance of the policy while the dependent child is and continues to be both: (i) incapable of self-sustaining employment by reason of intellectual or physical disability and (ii) chiefly dependent upon the policyowner for support and maintenance.

B. Proof of incapacity and dependency shall be furnished to the insurer by the policyowner within 31 days of the child's attainment of the specified age. Subsequent proof may be required by the insurer but not more frequently than annually after the two-year period following the child's attainment of the specified age.

C. The insurer may charge an additional premium for any continuation of coverage beyond the specified age. The additional premium shall be determined by the insurer on the basis of the class of risks applicable to the child.

1968, c. 411, § 38.1-348.1; 1974, c. 95; 1986, c. 562; 2012, cc. 476, 507; 2023, cc. 148, 149.

§ 38.2-3410. Construction of policy generally; words "physician" and "doctor" to include dentist.

Each accident and sickness insurance policy or subscription contract shall be construed according to the entirety of its terms and conditions as set forth in the policy and as amplified, extended or modified by any rider, endorsement, or application attached to and made a part of the policy. However, the word "physician" or "doctor" when used in any accident or sickness insurance policy, or subscription contract shall be construed to include a dentist performing covered services within the scope of his professional license.

1968, c. 292, § 38.1-348.5; 1986, c. 562.

§ 38.2-3411. Coverage of newborn children required.

A. Each individual and group accident and sickness insurance policy or individual and group subscription contract providing coverage on an expense incurred basis, and each health maintenance organization providing a health care plan for health care services that provides coverage for a family member of the insured or the subscriber shall, as to the family members' coverage, also provide that the accident and sickness 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.

B. Coverage for newly born children shall be identical to coverage provided to the insured or subscriber except that, regardless of whether such coverage would otherwise be provided under the terms and conditions of the insurance policy, subscription contract, or health care plan, coverage shall be provided for:

1. Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, with coverage limits no more restrictive than for any injury or sickness covered under the insurance policy, subscription contract, or health care plan; and

2. Inpatient and outpatient dental, oral surgical, and orthodontic services that are medically necessary for the treatment of medically diagnosed cleft lip, cleft palate or ectodermal dysplasia. Such coverage shall be subject to any deductible, cost-sharing, and policy, contract, or health care plan maximum provisions, provided they are no more restrictive for such services than for any injury or sickness covered under the insurance policy, subscription contract, or health care plan.

C. If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy, subscription contract, or health care plan may require that notification of birth of a newly born child and payment of the required premium or fees shall be furnished to the insurer issuing the policy or health care plan or corporation issuing the subscription contract within 31 days after the date of birth in order to have the coverage continue beyond the 31-day period.

1975, c. 281, § 38.1-348.6; 1976, c. 342; 1986, c. 562; 1993, c. 263; 2013, c. 653.

§ 38.2-3411.1. Coverage for child health supervision services.

A. Every individual or group accident and sickness insurance policy, subscription contract providing coverage under a health services plan, or evidence of coverage of a health care plan delivered or issued for delivery in the Commonwealth or renewed, reissued, or extended if already issued, shall offer and make available coverage under such policy or plan for child health supervision services to provide for the periodic examination of children covered under such policy or plan.

B. As used in this section, the term "child health supervision services" means the periodic review of a child's physical and emotional status by a licensed and qualified physician or pursuant to a physician's supervision. A review shall include but not be limited to a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests in keeping with prevailing medical standards.

C. Each such policy or plan, offering and making available such coverage, shall, at a minimum, provide benefits for child health supervision services at approximately the following age intervals: birth, two months, four months, six months, nine months, 12 months, 15 months, 18 months, two years, three years, four years, five years, and six years. A policy or plan may provide that child health supervision services which are rendered during a periodic review shall only be covered to the extent that such services are provided by or under the supervision of a single physician during the course of one visit.

D. Benefits for coverage for child health supervision services shall be exempt from any copayment, coinsurance, deductible, or other dollar limit provision in the policy or plan. Such exemption shall be expressly stated on the policy, plan, rider, endorsement, or other attachment providing such coverage.

E. The premiums for such coverage shall take into consideration (i) the cost of providing such coverage, (ii) cost savings realized or likely to be realized as a consequence of such coverage, (iii) a reasonable profit for the insurer, and (iv) any other relevant information or data the Commission deems appropriate.

F. This section shall not apply (i) to any insurer or health services plan having fewer than 1,000 covered individuals insured or covered in Virginia or less than $500,000 in premiums in Virginia as of its last annual statement, (ii) to short-term travel or accident only policies, (iii) to short-term nonrenewable policies of not more than six months' duration, or (iv) to specified disease, hospital indemnity or other limited benefit policies issued to provide supplemental benefits to a policy providing primary care benefits.

G. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

1990, c. 901; 2000, c. 118; 2011, c. 882.

§ 38.2-3411.2. Coverage of adopted children required.

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis, each corporation providing individual or group accident and sickness subscription contracts, and each health maintenance organization providing a health care plan for health care services that offers coverage for a family member of the insured, subscriber, or plan enrollee, shall, as to the family members' coverage, also provide that the accident and sickness insurance benefits applicable for children shall be payable with respect to adopted children of the insured, subscriber, or plan enrollee.

B. The coverage of such policy, subscription, or plan, applicable to family members of the insured, subscriber or enrollee, shall apply in the same manner and to the same but no greater extent to adopted children of the insured, subscriber or enrollee.

C. An adopted child shall be eligible for the coverage required by this section from the date of adoptive or parental placement with an insured, subscriber or plan enrollee for the purpose of adoption; and, in addition as to a child whose adoptive or parental placement has occurred within thirty-one days of birth, such child shall be considered a newborn child of the insured, subscriber or plan enrollee as of the date of adoptive or parental placement. Once coverage is in effect, it shall continue according to the terms of the policy, subscription contract, or plan, unless the said placement is disrupted prior to final decree of adoption, and the child is removed from placement with the insured, subscriber or plan enrollee.

D. If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or subscription contract may require notification of the placement of an adoptive child and payment of the required premium or fees shall be furnished to the insurer issuing the policy or corporation issuing the subscription contract within thirty-one days after the date of parental or adoptive placement in order to have the coverage continue beyond the thirty-one-day period.

E. No insurer, health services plan or health maintenance organization shall restrict coverage for any dependent child adopted or placed for adoption solely because of a preexisting condition of such child at the time that such child would otherwise become eligible for coverage under the plan.

1991, c. 103; 1994, c. 213.

§ 38.2-3411.3. Coverage for childhood immunizations.

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for all routine and necessary immunizations for newborn children under such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 2000.

B. The required benefits shall apply to immunizations administered to each newborn child from birth to thirty-six months of age.

C. For the purpose of this section, "routine and necessary immunizations" means immunizations against diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella, and other such immunizations as may be prescribed by the Commissioner of Health.

D. The provisions of this section shall not apply to any policy, contract or plan under which the policyholder has elected to obtain coverage for child health supervision services offered and made available under § 38.2-3411.1 or to short-term travel, accident-only, limited or specified disease policies, or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans, or to short-term nonrenewable policies of not more than six months' duration.

2000, cc. 460, 496.

§ 38.2-3411.4. Coverage for infant hearing screening and related diagnostics.

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for infant hearing screenings and all necessary audiological examinations provided pursuant to § 32.1-64.1 and as prescribed herein for newborn children under each such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 2001.

B. For purposes of this section, such coverage shall provide coverage for infant hearing screenings and all necessary audiological examinations provided pursuant to § 32.1-64.1 using any technology approved by the United States Food and Drug Administration, and as recommended by the national Joint Committee on Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. Such coverage shall include benefits for any follow-up audiological examinations as recommended by a physician or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss.

C. Nothing contained in this section shall abrogate any obligation to provide coverage for hearing screening tests or any other hearing screening test or audiological diagnostic procedure pursuant to this section or any other law or regulation of the Commonwealth or of the United States or under the terms or provisions of any policy or plan issued, renewed, reissued or extended in the Commonwealth.

D. The provisions of this section shall not apply to short-term travel, accident only, limited or specified disease policies, or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans, or to short-term nonrenewable policies of not more than six months' duration.

2001, c. 663.

§ 38.2-3412. Repealed.

Repealed by Acts 1993, c. 132.

§ 38.2-3412.1. Coverage for mental health and substance use disorders.

A. As used in this section:

"Adult" means any person who is 19 years of age or older.

"Alcohol or drug rehabilitation facility" means a facility in which a state-approved program for the treatment of alcoholism or drug addiction is provided. The facility shall be either (i) licensed by the State Board of Health pursuant to Chapter 5 (§ 32.1-123 et seq.) of Title 32.1 or by the Department of Behavioral Health and Developmental Services pursuant to Article 2 (§ 37.2-403 et seq.) of Chapter 4 of Title 37.2 or (ii) a state agency or institution.

"Child or adolescent" means any person under the age of 19 years.

"Inpatient treatment" means mental health or substance abuse services delivered on a 24-hour per day basis in a hospital, alcohol or drug rehabilitation facility, an intermediate care facility or an inpatient unit of a mental health treatment center.

"Intermediate care facility" means a licensed, residential public or private facility that is not a hospital and that is operated primarily for the purpose of providing a continuous, structured 24-hour per day, state-approved program of inpatient substance abuse services.

"Medication management visit" means a visit no more than 20 minutes in length with a licensed physician or other licensed health care provider with prescriptive authority for the sole purpose of monitoring and adjusting medications prescribed for mental health or substance abuse treatment.

"Mental health services" or "mental health benefits" means benefits with respect to items or services for mental health conditions as defined under the terms of the health benefit plan. Any condition defined by the health benefit plan as being or as not being a mental health condition shall be defined to be consistent with generally recognized independent standards of current medical practice.

"Mental health treatment center" means a treatment facility organized to provide care and treatment for mental illness through multiple modalities or techniques pursuant to a written plan approved and monitored by a physician, clinical psychologist, or a psychologist licensed to practice in this Commonwealth. The facility shall be (i) licensed by the Commonwealth, (ii) funded or eligible for funding under federal or state law, or (iii) affiliated with a hospital under a contractual agreement with an established system for patient referral.

"Mobile crisis response services" means services delivered to provide for rapid response to, assessment of, and early intervention for individuals experiencing an acute mental health crisis that are deployed at the location of the individual.

"Network adequacy" means access to services by measure of distance, time, and average length of referral to scheduled visit.

"Outpatient treatment" means mental health or substance abuse treatment services rendered to a person as an individual or part of a group while not confined as an inpatient. Such treatment shall not include services delivered through a partial hospitalization or intensive outpatient program as defined herein.

"Partial hospitalization" means a licensed or approved day or evening treatment program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for patients with mental, emotional, or nervous disorders, and alcohol or other drug dependence who require coordinated, intensive, comprehensive and multi-disciplinary treatment. Such a program shall provide treatment over a period of six or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients. Such term shall also include intensive outpatient programs for the treatment of alcohol or other drug dependence which provide treatment over a

period of three or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients.

"Residential crisis stabilization unit" means a short-term residential program providing support and stabilization for individuals who are experiencing an acute mental health crisis.

"Substance abuse services" or "substance use disorder benefits" means benefits with respect to items or services for substance use disorders as defined under the terms of the health benefit plan. Any disorder defined by the health benefit plan as being or as not being a substance use disorder shall be defined to be consistent with generally recognized independent standards of current medical practice.

"Treatment" means services including diagnostic evaluation, medical, psychiatric and psychological care, and psychotherapy for mental, emotional or nervous disorders or alcohol or other drug dependence rendered by a hospital, alcohol or drug rehabilitation facility, intermediate care facility, mental health treatment center, a physician, psychologist, clinical psychologist, licensed clinical social worker, licensed professional counselor, licensed substance abuse treatment practitioner, licensed marriage and family therapist or clinical nurse specialist. Treatment for physiological or psychological dependence on alcohol or other drugs shall also include the services of counseling and rehabilitation as well as services rendered by a state certified alcoholism, drug, or substance abuse counselor or substance abuse counseling assistant, limited to the scope of practice set forth in § 54.1-3507.1 or 54.1-3507.2, respectively, employed by a facility or program licensed to provide such treatment.

B. Except as provided in subsections C and D, group and individual health insurance coverage, as defined in § 38.2-3431, shall provide coverage for mental health and substance use disorder benefits. Such benefits shall be in parity with the medical and surgical benefits contained in the coverage in accordance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), P.L. 110-343, even where those requirements would not otherwise apply directly. Coverage required under this subsection shall include mobile crisis response services and support and stabilization services provided in a residential crisis stabilization unit to the extent that such services are covered in other settings or modalities, regardless of any difference in billing codes.

C. Any grandfathered plan as defined in § 38.2-3438 in the small group market shall either continue to provide benefits in accordance with subsection B or continue to provide coverage for inpatient and partial hospitalization mental health and substance abuse services as follows:

1. Treatment for an adult as an inpatient at a hospital, inpatient unit of a mental health treatment center, alcohol or drug rehabilitation facility or intermediate care facility for a minimum period of 20 days per policy or contract year.

2. Treatment for a child or adolescent as an inpatient at a hospital, inpatient unit of a mental health treatment center, alcohol or drug rehabilitation facility or intermediate care facility for a minimum period of 25 days per policy or contract year.

3. Up to 10 days of the inpatient benefit set forth in subdivisions 1 and 2 of this subsection may be converted when medically necessary at the option of the person or the parent, as defined in § 16.1-336, of a child or adolescent receiving such treatment to a partial hospitalization benefit applying a formula which shall be no less favorable than an exchange of 1.5 days of partial hospitalization coverage for each inpatient day of coverage. An insurance policy or subscription contract described herein that provides inpatient benefits in excess of 20 days per policy or contract year for adults or 25 days per policy or contract year for a child or adolescent may provide for the conversion of such excess days on the terms set forth in this subdivision.

4. The limits of the benefits set forth in this subsection shall not be more restrictive than for any other illness, except that the benefits may be limited as set out in this subsection.

5. This subsection shall not apply to any excepted benefits policy as defined in § 38.2-3431, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

D. Any grandfathered plan as defined in § 38.2-3438 in the small group market shall also either continue to provide benefits in accordance with subsection B or continue to provide coverage for outpatient mental health and substance abuse services as follows:

1. A minimum of 20 visits for outpatient treatment of an adult, child or adolescent shall be provided in each policy or contract year.

2. The limits of the benefits set forth in this subsection shall be no more restrictive than the limits of benefits applicable to physical illness; however, the coinsurance factor applicable to any outpatient visit beyond the first five of such visits covered in any policy or contract year shall be at least 50 percent.

3. For the purpose of this section, medication management visits shall be covered in the same manner as a medication management visit for the treatment of physical illness and shall not be counted as an outpatient treatment visit in the calculation of the benefit set forth herein.

4. For the purpose of this subsection, if all covered expenses for a visit for outpatient mental health or substance abuse treatment apply toward any deductible required by a policy or contract, such visit shall not count toward the outpatient visit benefit maximum set forth in the policy or contract.

5. This subsection shall not apply to any excepted benefits policy as defined in § 38.2-3431, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

E. The requirements of this section shall apply to all insurance policies and subscription contracts delivered, issued for delivery, reissued, renewed, or extended, or at any time when any term of the policy or contract is changed or any premium adjustment made.

F. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

G. The Bureau of Insurance, in consultation with health carriers providing coverage for mental health and substance use disorder benefits pursuant to this section, shall develop reporting requirements regarding denied claims, complaints, appeals, and network adequacy involving such coverage set forth in this section. By November 1 of each year, the Bureau shall compile the information for the preceding year into a report that ensures the confidentiality of individuals whose information has been reported and is written in nontechnical, readily understandable language. The Bureau shall include in the report a summary of all comparative analyses prepared by health carriers pursuant to 42 U.S.C. § 300gg-26(a)(8) that the Bureau requested during the reporting period. This summary shall include the Bureau's explanation of whether the analyses were accepted as compliant, rejected as noncompliant, or are in process of review. For analyses that were noncompliant, the report shall include the corrective actions that the Bureau required the health carrier to take to come into compliance. The Bureau shall make the report available to the public by, among such other means as the Bureau finds appropriate, posting the reports on the Bureau's website and submit the report to the House Committee on Commerce and Energy and the Senate Committee on Commerce and Labor.

1993, c. 132; 1995, c. 270; 1996, c. 41; 1997, c. 901; 1999, c. 941; 2001, c. 460; 2004, c. 156; 2006, c. 638; 2009, cc. 813, 840; 2010, c. 693; 2013, c. 751; 2015, c. 649; 2020, cc. 726, 847; 2022, c. 544; 2023, cc. 186, 187.

§ 38.2-3412.1:01. Repealed.

Repealed by Acts 2015, c. 649, cl. 2.

§ 38.2-3413. Repealed.

Repealed by Acts 1993, c. 132.

§ 38.2-3414. Optional coverage for obstetrical services.

A. Each insurer proposing to issue a group hospital policy or a group major medical policy in this Commonwealth and each corporation proposing to issue group hospital, group medical or group major medical subscription contracts shall provide coverage for obstetrical services as an option available to the group policyholder or the contract holder in the case of benefits based upon treatment as an inpatient in a general hospital. The reimbursement for obstetrical services by a physician shall be based on the charges for the services determined according to the same formula by which the charges are developed for other medical and surgical procedures. Such coverage shall have durational limits, dollar limits, deductibles and coinsurance factors that are no less favorable than for physical illness generally.

B. This section shall not apply to short-term travel, accident only, or limited or specified disease policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

1978, c. 375, § 38.1-348.9; 1986, c. 562; 2014, c. 814.

§ 38.2-3414.1. Obstetrical benefits; coverage for postpartum services.

A. Each insurer proposing to issue an individual or group hospital policy or major medical policy in this Commonwealth, each corporation proposing to issue an individual or group hospital, medical or major medical subscription contract, and each health maintenance organization providing a health care plan for health care services that provides benefits for obstetrical services shall provide coverage for postpartum services as provided in this section.

B. Such coverage shall include benefits for inpatient care and a home visit or visits which shall be in accordance with the medical criteria, outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Such coverage shall be provided incorporating any changes in such Guidelines or Standards within six months of the publication of such Guidelines or Standards or any official amendment thereto.

C. The requirements of this section shall apply to all insurance policies, contracts and plans delivered, issued for delivery, reissued, or extended on and after July 1, 1996, or at any time thereafter when any term of the policy, contract or plan is changed or any premium adjustment is made.

D. This section shall not apply to short-term travel, accident only, or limited or specified disease policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

1996, cc. 155, 201; 2014, c. 814.

§ 38.2-3415. Exclusion or reduction of benefits for certain causes prohibited.

No group accident and sickness insurance policy, nor any group subscription contract, delivered or issued for delivery in this Commonwealth or renewed, reissued or extended if already issued, shall contain any provision excluding or reducing the benefits of any insured or subscriber because benefits have been paid or are payable under any individually underwritten and individually issued policy or subscription contract providing exclusively for accident and sickness benefits and for which the entire premium has been paid by the insured, a member of the insured's family, or the insured's guardian or conservator.

1978, c. 496, § 38.1-348.10; 1986, c. 562; 1997, c. 801.

§ 38.2-3416. Repealed.

Repealed by Acts 2014, c. 814, cl. 2.

§ 38.2-3417. Deductibles and coinsurance options required.

A. An insurer issuing accident and sickness insurance or a corporation issuing subscription contracts on an expense incurred basis shall make available in offering such coverage or contract to the

potential insured or contract holder one or more of the following options under which the individual insured or group certificate holder pays for:

1. The first $100 of the cost of the services covered or benefits payable by the policy or contract during a 12-month period;

2. Twenty percent of the first $1,000 of the cost of the services covered or benefits payable by the policy or contract during a 12-month period;

3. The first $100 and 20 percent of the next $1,000 of the cost of the services covered or benefits payable by the policy or contract during a 12-month period; or

4. Any other option containing a greater deductible, coinsurance, or cost-sharing provision. However, the option shall not be inconsistent with standards established with respect to deductibles, coinsurance, or cost-sharing pursuant to § 38.2-3519.

B. As used in this section, "make available" means that the insurer or corporation shall disseminate information concerning the option or options and make a policy or contract containing the option or options available to potential insureds or contract holders at the same time and in the same manner as the insurer or corporation disseminates information concerning other policies or contracts and coverage options and makes other policies or contracts and coverage options available.

C. This section shall not apply to short-term travel, accident only, or limited or specified disease policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

D. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

1981, c. 322, § 38.1-348.12:1; 1986, c. 562; 2013, c. 751; 2014, c. 814.

§ 38.2-3418. Coverage for victims of rape or incest.

Each hospital expense, medical-surgical expense, major medical expense or hospital confinement indemnity insurance policy issued by an insurer, each individual and group subscription contract providing hospital, medical, or surgical benefits issued by a corporation, and each contract issued by a health maintenance organization which provide benefits as a result of an "accident" or "accidental injury" shall be construed to include benefits for pregnancy following an act of rape of an insured or subscriber which was reported to the police within seven days following its occurrence, to the same extent as any other covered accident. The 7-day requirement shall be extended to 180 days in the case of an act of rape or incest of a female under 13 years of age.

1981, c. 42, § 38.1-348.13; 1986, c. 562.

§ 38.2-3418.1. Coverage for mammograms.

A. 1. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major

medical coverage on an expense incurred basis, each corporation providing individual or group accident and sickness subscription contracts and each health maintenance organization providing a health care plan for health care services shall provide coverage under such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 1996, for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age thirty-five through thirty-nine, one such mammogram biennially to persons age forty through forty-nine, one such mammogram annually to persons age fifty and over and may be limited to a benefit of fifty dollars per mammogram subject to such dollar limits, deductibles and coinsurance factors as are no less favorable than for physical illness generally.

2. The term "mammogram" shall mean an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast.

B. In order to be considered a screening mammogram for which coverage shall be made available under this section:

1. The mammogram must be (i) ordered by a health care practitioner acting within the scope of his licensure and, in the case of an enrollee of a health maintenance organization, by the health maintenance organization physician, (ii) performed by a registered technologist, (iii) interpreted by a qualified radiologist, (iv) performed under the direction of a person licensed to practice medicine and surgery and certified by the American Board of Radiology or an equivalent examining body and (v) a copy of the mammogram report must be sent or delivered to the health care practitioner who ordered it;

2. The equipment used to perform the mammogram shall meet the standards set forth by the Virginia Department of Health in its radiation protection regulations; and

3. The mammography film shall be retained by the radiologic facility performing the examination in accordance with the American College of Radiology guidelines or state law.

C. The provisions of this section shall not apply to short-term travel, accident only, limited or specified disease policies, or to short-term nonrenewable policies of not more than six months' duration.

1989, c. 646; 1990, c. 284; 1996, c. 610.

§ 38.2-3418.1:1. Repealed.

Repealed by Acts 2008, c. 420, cl. 2.

§ 38.2-3418.1:2. Coverage for pap smears.

A. Notwithstanding the provisions § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, each corporation providing individual or group accident and sickness subscription contracts and each health maintenance organization providing a health care

plan for health care services shall provide coverage under such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 1996, for annual pap smears, including coverage, on and after July 1, 1999, for annual testing performed by any FDA-approved gynecologic cytology screening technologies.

B. The provisions of this section shall not apply to short-term travel, accident only, limited or specified disease policies, or to short-term nonrenewable policies of not more than six months' duration.

1996, c. 611; 1999, c. 921.

§ 38.2-3418.2. Coverage of procedures involving bones and joints.

A. Each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, each corporation providing individual or group accident and sickness subscription contracts, and each health maintenance organization providing a health care plan for health care services that provides coverage under such policy, contract or plan for diagnostic and surgical treatment involving any bone or joint of the skeletal structure shall not, under such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 1995, exclude coverage for such diagnostic and surgical treatment involving any bone or joint of the head, neck, face or jaw or impose limits that are more restrictive than limits on coverage applicable to such treatment involving any bone or joint of the skeletal structure if the treatment is required because of a medical condition or injury which prevents normal function of the joint or bone and is deemed medically necessary to attain functional capacity of the affected part.

B. The provisions of this section shall not apply to short-term travel, accident-only, limited or specified disease policies, or to short-term nonrenewable policies of not more than six months' duration.

1995, c. 537.

§ 38.2-3418.3. Coverage for hemophilia and congenital bleeding disorders.

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for hemophilia and congenital bleeding disorders under such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 1998.

B. For the purpose of this section:

"Blood infusion equipment" includes, but is not limited to, syringes and needles.

"Blood product" includes, but is not limited to, Factor VII, Factor VIII, Factor IX, and cryoprecipitate.

"Hemophilia" means a lifelong hereditary bleeding disorder usually affecting males that results in prolonged bleeding primarily into joints and muscles.

"Home treatment program" means a program where individuals or family members are trained to provide infusion therapy at home in order to achieve optimal health and cost effectiveness.

"State-approved hemophilia treatment center" means a hospital or clinic which receives federal or state Maternal and Child Health Bureau, and/or Centers for Disease Control funds to conduct comprehensive care for persons with hemophilia and other congenital bleeding disorders.

C. The benefits to be provided shall include coverage for expenses incurred in connection with the treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders. The benefits to be provided shall include coverage for the purchase of blood products and blood infusion equipment required for home treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders when the home treatment program is under the supervision of the state-approved hemophilia treatment center.

D. The provisions of this section shall not apply to short-term travel, accident only, limited or specified disease policies, policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or to any other similar coverage under state or federal governmental plans, or to short-term nonrenewable policies of not more than six months' duration.

1998, cc. 43, 120.

§ 38.2-3418.4. Coverage for reconstructive breast surgery; notice; eligibility.

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for reconstructive breast surgery under such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth.

B. The reimbursement for reconstructive breast surgery shall be determined according to the same formula by which charges are developed for other medical and surgical procedures. Such coverage shall have durational limits, dollar limits, deductibles and coinsurance factors that are no less favorable than for physical illness generally. Coverage shall be provided in a manner determined in consultation with the attending physician and the patient.

C. For purposes of this section, "mastectomy" means the surgical removal of all or part of the breast and "reconstructive breast surgery" means surgery performed (i) coincident with or following a mastectomy or (ii) following a mastectomy to reestablish symmetry between the two breasts, for reconstructive breast surgery performed on or after October 21, 1998, and while the patient is or was a covered person under the policy, contract or plan. Reconstructive breast surgery shall also include coverage for prostheses, determined as necessary in consultation with the attending physician and patient, and physical complications of mastectomy, including medically necessary treatment of lymphedemas.

D. Written notice of the availability of this coverage shall be provided to the subscribers upon enrollment in the policy and annually thereafter. Such notice shall be prominently positioned in any literature or correspondence provided to the subscribers.

E. Eligibility for coverage shall not be denied solely for the purpose of avoiding the requirements of this section, nor shall an attending provider be penalized or have the reimbursement reduced or incentives, monetary or otherwise, provided to induce such provider to provide care in a manner inconsistent with this section.

F. The provisions of this section shall not apply to short-term travel, accident only, limited or specified disease policies (except policies issued for cancer), policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans or to short-term nonrenewable policies of not more than six months' duration.

1998, c. 56; 2002, c. 415; 2003, c. 250.

§ 38.2-3418.5. Coverage for early intervention services.

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for medically necessary early intervention services under such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 1998. Such coverage shall be limited to a benefit of $5,000 per insured or member per policy or calendar year and, except as set forth in subsection C, shall be subject to such dollar limits, deductibles and coinsurance factors as are no less favorable than for physical illness generally.

B. For the purpose of this section, "early intervention services" means medically necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for dependents from birth to age three who are certified by the Department of Behavioral Health and Developmental Services as eligible for services under Part H of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.). "Medically necessary early intervention services for the population certified by the Department of Behavioral Health and Developmental Services" shall mean those services designed to help an individual attain or retain the capability to function age-appropriately within his environment, and shall include services that enhance functional ability without effecting a cure.

C. The cost of early intervention services shall not be applied to any contractual provision limiting the total amount of coverage paid by the insurer, corporation or health maintenance organization to or on behalf of the insured or member during the insured's or member's lifetime.

D. "Financial costs," as used in this section, shall mean any copayment, coinsurance, or deductible in the policy or plan. Financial costs may be paid through the use of federal Part H program funds, state general funds, or local government funds appropriated to implement Part H services for families who may refuse the use of their insurance to pay for early intervention services due to a financial cost.

E. The provisions of this section shall not apply to short-term travel, accident only, limited or specified disease policies, policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or governmental plans or to short-term nonrenewable policies of not more than six months' duration.

F. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

1998, c. 625; 2009, cc. 813, 840; 2011, c. 882.

§ 38.2-3418.6. Minimum hospital stay for mastectomy and certain lymph node dissection patients.

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage providing a minimum stay in the hospital of not less than forty-eight hours for a patient following a radical or modified radical mastectomy and not less than twenty-four hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for the treatment of breast cancer. Nothing in this section shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate. Such provision shall be included under any policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 1998.

The provisions of this section shall not apply to short-term travel, accident only, limited or specified disease policies, policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans, or to short-term nonrenewable policies of not more than six months' duration.

1998, c. 631.

§ 38.2-3418.7. Coverage for PSA testing.

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage to (i) persons age fifty and over and (ii) persons age forty and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society, for one PSA test in a twelve-month period and digital

rectal examinations, all in accordance with American Cancer Society guidelines under any such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 1998.

B. For the purpose of this section, "PSA testing" means the analysis of a blood sample to determine the level of prostate specific antigen.

C. The provisions of this section shall not apply to (i) short-term travel, accident only, limited or specified disease policies other than cancer policies, (ii) short-term nonrenewable policies of not more than six months' duration, or (iii) policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

1998, cc. 709, 858.

§ 38.2-3418.7:1. Coverage for colorectal cancer screening.

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for colorectal cancer screening under any such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth, on and after July 1, 2000.

B. Coverage for colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, shall be provided in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations.

C. The coverage provided under this section shall not be more restrictive than or separate from coverage provided for any other illness, condition or disorder for purposes of determining deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits, copayment and coinsurance factors, and benefit year maximum for deductibles and copayments and coinsurance factors.

D. The provisions of this section shall not apply to (i) short-term travel, accident only, limited or specified disease policies, other than cancer policies, (ii) short-term nonrenewable policies of not more than six months duration, or (iii) policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

2000, c. 888.

§ 38.2-3418.8. Coverage for clinical trials for treatment studies on cancer.

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for patient costs incurred during participation in clinical trials for treatment studies on cancer, including ovarian cancer trials, under any such policy, contract or plan delivered, issued for delivery, or renewed in this Commonwealth on and after July 1, 1999.

B. The reimbursement for patient costs incurred during participation in clinical trials for treatment studies on cancer shall be determined in the same manner as reimbursement is determined for other medical and surgical procedures. Such coverage shall have durational limits, dollar limits, deductibles, copayments and coinsurance factors that are no less favorable than for physical illness generally.

C. For purposes of this section:

"Cooperative group" means a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group. "Cooperative group" includes (i) the National Cancer Institute Clinical Cooperative Group and (ii) the National Cancer Institute Community Clinical Oncology Program.

"FDA" means the Federal Food and Drug Administration.

"Member" means a policyholder, subscriber, insured, or certificate holder or a covered dependent of a policyholder, subscriber, insured or certificate holder.

"Multiple project assurance contract" means a contract between an institution and the federal Department of Health and Human Services that defines the relationship of the institution to the federal Department of Health and Human Services and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.

"NCI" means the National Cancer Institute.

"NIH" means the National Institutes of Health.

"Patient cost" means the cost of a medically necessary health care service that is incurred as a result of the treatment being provided to the member for purposes of a clinical trial. "Patient cost" does not include (i) the cost of nonhealth care services that a patient may be required to receive as a result of the treatment being provided for purposes of a clinical trial, (ii) costs associated with managing the research associated with the clinical trial, or (iii) the cost of the investigational drug or device.

D. Coverage for patient costs incurred during clinical trials for treatment studies on cancer shall be provided if the treatment is being conducted in a Phase II, Phase III, or Phase IV clinical trial. Such treatment may, however, be provided on a case-by-case basis if the treatment is being provided in a Phase I clinical trial.

E. The treatment described in subsection D shall be provided by a clinical trial approved by:

1. The National Cancer Institute;

2. An NCI cooperative group or an NCI center;

3. The FDA in the form of an investigational new drug application;

4. The federal Department of Veterans Affairs; or

5. An institutional review board of an institution in the Commonwealth that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NCI.

F. The facility and personnel providing the treatment shall be capable of doing so by virtue of their experience, training, and expertise.

G. Coverage under this section shall apply only if:

1. There is no clearly superior, noninvestigational treatment alternative;

2. The available clinical or preclinical data provides a reasonable expectation that the treatment will be at least as effective as the noninvestigational alternative; and

3. The member and the physician or health care provider who provides services to the member under the insurance policy, subscription contract or health care plan conclude that the member's participation in the clinical trial would be appropriate, pursuant to procedures established by the insurer, corporation or health maintenance organization and as disclosed in the policy and evidence of coverage.

H. The provisions of this section shall not apply to short-term travel, accident-only, limited or specified disease policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or governmental plans or to short-term nonrenewable policies of not more than six months' duration.

I. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

1999, cc. 643, 649; 2013, c. 751.

§ 38.2-3418.9. Minimum hospital stay for hysterectomy.

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue an individual or group hospital policy or major medical policy in this Commonwealth, each corporation proposing to issue an individual or group hospital, medical or major medical subscription contract, and each health maintenance organization providing a health care plan for health care shall provide coverage for laparoscopy-assisted vaginal hysterectomy and vaginal hysterectomy as provided in this section.

B. Such coverage shall include benefits for a minimum stay in the hospital of not less than 23 hours for a laparoscopy-assisted vaginal hysterectomy and 48 hours for a vaginal hysterectomy. Nothing in this subsection shall be construed as requiring the provision of the total hours referenced when the attend-

ing physician, in consultation with the patient, determines that a shorter period of hospital stay is appropriate.

C. The requirements of this section shall apply to all insurance policies, contracts and plans delivered, issued for delivery, reissued, or extended on and after July 1, 1999, or at any time thereafter when any term of the policy, contract or plan is changed or any premium adjustment is made.

D. This section shall not apply to short-term travel, accident-only, or limited or specified disease policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

1999, cc. 643, 649; 2000, c. 922; 2014, c. 814.

§ 38.2-3418.10. Coverage for diabetes.

A. Each insurer proposing to issue an individual or group hospital policy or major medical policy in this Commonwealth, each corporation proposing to issue an individual or group hospital, medical or major medical subscription contract, and each health maintenance organization providing a health care plan for health care services shall provide coverage for diabetes as provided in this section.

B. Such coverage shall include benefits for equipment, supplies and in-person outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law. As used herein, the terms "equipment" and "supplies" shall not be considered durable medical equipment.

C. To qualify for coverage under this section, diabetes in-person outpatient self-management training and education shall be provided by a certified, registered or licensed health care professional. A managed care health insurance plan, as defined in Chapter 58 (§ 38.2-5800 et seq.) of this title, may require such health care professional to be a member of the plan's provider network; provided that such network includes sufficient health care professionals who are qualified by specific education, experience, and credentials to provide the covered benefits described in this section.

D. No insurer, corporation, or health maintenance organization shall impose upon any person receiving benefits pursuant to this section any copayment, fee or condition that is not equally imposed upon all individuals in the same benefit category, nor shall any insurer, corporation or health maintenance organization impose any policy-year or calendar-year dollar or durational benefit limitations or maximums for benefits or services provided under this section.

E. The requirements of this section shall apply to all insurance policies, contracts and plans delivered, issued for delivery, reissued, or extended on and after July 1, 2000, or at any time thereafter when any term of the policy, contract or plan is changed or any premium adjustment is made.

F. This section shall not apply to short-term travel, accident only, or limited or specified disease policies or contracts, nor to policies or contracts designed for issuance to persons eligible for

coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

1999, c. 35; 2000, cc. 1025, 1060; 2014, c. 814.

§ 38.2-3418.11. Coverage for hospice care.

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for hospice services under such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 1999.

B. As used in this section:

"Hospice services" shall mean a coordinated program of home and inpatient care provided directly or under the direction of a hospice licensed under Article 7 (§ 32.1-162.1 et seq.) of Chapter 5 of Title 32.1, and shall include palliative and supportive physical, psychological, psychosocial and other health services to individuals with a terminal illness utilizing a medically directed interdisciplinary team.

"Individuals with a terminal illness" shall mean individuals whose condition has been diagnosed as terminal by a licensed physician, whose medical prognosis is death within six months, and who elect to receive palliative rather than curative care.

"Medicare" shall mean Title XVIII of the Social Security Act.

"Palliative care" shall mean treatment directed at controlling pain, relieving other symptoms, and focusing on the special needs of the patient as he experiences the stress of the dying process, rather than treatment aimed at investigation and intervention for the purpose of cure or prolongation of life.

C. For the purposes of this section, documentation requirements shall be no greater than those required for the same services under Medicare.

D. Nothing in this section shall prohibit an insurer, corporation, or health maintenance organization from offering or providing coverage for hospice services when it cannot be demonstrated that the illness is terminal or for individuals with life expectancies of longer than six months.

E. The provisions of this section shall not apply to short-term travel, accident only, short-term nonrenewable policies of not more than six months' duration, or to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

1999, c. 858.

§ 38.2-3418.12. Coverage for hospitalization and anesthesia for dental procedures.

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for medically necessary general anesthesia and hospitalization or facility charges of a facility licensed to provide outpatient surgical procedures for dental care provided to a covered person who is determined by a licensed dentist in consultation with the covered person's treating physician to require general anesthesia and admission to a hospital or outpatient surgery facility to effectively and safely provide dental care and (i) is under the age of five, or (ii) is severely disabled, or (iii) has a medical condition and requires admission to a hospital or outpatient surgery facility and general anesthesia for dental care treatment. For purposes of this section, a determination of medical necessity shall include but not be limited to a consideration of whether the age, physical condition or mental condition of the covered person requires the utilization of general anesthesia and the admission to a hospital or outpatient surgery facility to safely provide the underlying dental care.

B. Such insurer, corporation or health maintenance organization may require prior authorization for general anesthesia and hospitalization or surgical facility charges for dental procedures in the same manner that prior authorization is required for other covered benefits.

C. Such insurer, corporation or health maintenance organization shall restrict coverage for general anesthesia expenses to those health care providers who are licensed to provide anesthesia services and shall restrict coverage for facility charges to facilities licensed to provide surgical services.

D. The provisions of this section shall not be construed to require coverage for dental care incident to the coverage provided in this section.

E. The provisions of this section are applicable to any policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 2000.

F. The provisions of this section shall not apply to short-term travel, accident-only, limited or specified disease policies, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

2000, c. 157.

§ 38.2-3418.13. Coverage for the treatment of morbid obesity.

A. Notwithstanding the provisions of § 38.2-3419, in the large group market, each insurer proposing to issue accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall offer and make available coverage under any such policy, contract or plan for the

treatment of morbid obesity through gastric bypass surgery or such other methods as may be recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity.

B. The reimbursement for the treatment of morbid obesity shall be determined according to the same formula by which charges are developed for other medical and surgical procedures. Such coverage shall have durational limits, dollar limits, deductibles, copayments and coinsurance factors that are no less favorable than for physical illness generally. Standards and criteria, including those related to diet, used by insurers to approve or restrict access to surgery for morbid obesity shall be based upon current clinical guidelines recognized by the National Institutes of Health.

C. For purposes of this section, "morbid obesity" means (i) a weight that is at least 100 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance tables, (ii) a body mass index (BMI) equal to or greater than 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes, or (iii) a BMI of 40 kilograms per meter squared without such comorbidity. As used herein, BMI equals weight in kilograms divided by height in meters squared.

D. The provisions of this section shall not apply to short-term travel, accident-only, limited or specified disease policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or governmental plans or to short-term nonrenewable policies of not more than six months' duration; health care plans, contracts, or policies issued in the individual or small group market; or a qualified health plan when the plan is offered in the Commonwealth by a health carrier through a health benefit exchange established under § 1311 of the federal Patient Protection and Affordable Care Act (P.L. 111-148).

2000, c. 465; 2003, c. 462; 2014, c. 814.

§ 38.2-3418.14. Coverage for lymphedema.

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical, coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for lymphedema as provided in this section.

B. Coverage under this section shall include benefits for equipment, supplies, complex decongestive therapy, and outpatient self-management training and education for the treatment of lymphedema, if prescribed by a health care professional legally authorized to prescribe or provide such items under law.

C. A managed care health insurance plan, as defined in Chapter 58 (§ 38.2-5800 et seq.) of this title, may require such health care professional to be a member of the plan's provider network, provided that such network includes sufficient health care professionals who are qualified by specific education, experience, and credentials to provide the covered benefits described in this section.

D. No insurer, corporation, or health maintenance organization shall impose upon any person receiving benefits pursuant to this section any copayment, fee, policy year or calendar year, or durational benefit limitation or maximum for benefits or services that is not equally imposed upon all individuals in the same benefit category.

E. The requirements of this section shall apply to all insurance policies, contracts and plans delivered, issued for delivery, reissued, or extended in this Commonwealth on and after January 1, 2004, or at any time thereafter when any term of the policy, contract or plan is changed or any premium adjustment is made.

F. This section shall not apply to short-term travel, accident only, or limited or specified disease policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

2003, c. 243; 2014, c. 814.

§ 38.2-3418.15. Coverage for prosthetic devices and components.

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall offer and make available coverage for medically necessary prosthetic devices, their repair, fitting, replacement, and components, as follows:

1. As used in this section:

"Component" means the materials and equipment needed to ensure the comfort and functioning of a prosthetic device.

"Limb" means an arm, a hand, a leg, a foot, or any portion of an arm, a hand, a leg, or a foot.

"Prosthetic device" means an artificial device to replace, in whole or in part, a limb.

2. Prosthetic device coverage does not include repair and replacement due to enrollee neglect, misuse, or abuse. Coverage also does not include prosthetic devices designed primarily for an athletic purpose.

3. An insurer shall not impose any annual or lifetime dollar maximum on coverage for prosthetic devices other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy. The coverage may be made subject to, and no more restrictive than, the provisions of a health insurance policy that apply to other benefits under the policy.

4. An insurer shall not apply amounts paid for prosthetic devices to any annual or lifetime dollar maximum applicable to other durable medical equipment covered under the policy other than an annual or

lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy.

5. No insurer, corporation, or health maintenance organization shall impose upon any person receiving benefits pursuant to this section any coinsurance in excess of 30 percent of the carrier's allowable charge for such prosthetic device or services when such device or service is provided by an in-network provider.

6. An insurer, corporation, or health maintenance organization may require preauthorization to determine medical necessity and the eligibility of benefits for prosthetic devices and components, in the same manner that prior authorization is required for any other covered benefit.

B. The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, or extended in the Commonwealth on and after January 1, 2010, or at any time thereafter when any term of the policy, contract, or plan is changed or any premium adjustment is made.

C. This section shall not apply to short-term travel, accident-only, or limited or specified disease policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

2009, c. 839; 2014, c. 814.

§ 38.2-3418.15:1. Coverage for prosthetic devices and components.

A. As used in this section:

"Component" means the materials and equipment needed to ensure the comfort and functioning of a prosthetic device.

"Limb" means an arm, a hand, a leg, a foot, or any portion of an arm, a hand, a leg, or a foot.

"Medically necessary prosthetic device" includes any myoelectric, biomechanical, or microprocessor-controlled prosthetic device that peer-reviewed medical literature has determined to be medically appropriate on the basis of the clinical assessment of the enrollee's rehabilitation potential.

"Prosthetic device" means an artificial device to replace, in whole or in part, a limb.

B. Notwithstanding the provisions of § 38.2-3418.15 or 38.2-3419, each insurer proposing to issue group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis, each corporation providing group accident and sickness subscription contracts, and each health maintenance organization providing a health care plan for health care services shall provide coverage for medically necessary prosthetic devices and their repair, fitting, replacement, and components.

C. The coverage required under subsection B shall be subject to the following:

1. Coverage for medically necessary prosthetic devices does not include:

a. The cost of repair and replacement due to enrollee neglect, misuse, or abuse; or

b. Prosthetic devices designed primarily for an athletic purpose.

2. An insurer shall not impose any annual or lifetime dollar maximum on coverage for prosthetic devices other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy. The coverage may be made subject to, and no more restrictive than, the provisions of a health insurance policy that apply to other benefits under the policy.

3. An insurer, corporation, or health maintenance organization shall not apply amounts paid for prosthetic devices to any annual or lifetime dollar maximum applicable to other durable medical equipment covered under the policy other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy.

4. An insurer, corporation, or health maintenance organization shall not impose upon any person receiving benefits pursuant to this section any coinsurance in excess of 30 percent of the carrier's allowable charge for such prosthetic device or service when such device or service is provided by an in-network provider.

5. An insurer, corporation, or health maintenance organization may require preauthorization to determine medical necessity and the eligibility of benefits for prosthetic devices and components in the same manner that prior authorization is required for any other covered benefit.

D. The provisions of this section shall apply to any policy, contract, or plan delivered, issued for delivery, or renewed in the Commonwealth on and after January 1, 2023, or at any time thereafter when any term of the policy, contract, or plan is changed or any premium adjustment is made.

E. The provisions of this section shall not apply to (i) short-term travel, accident-only, or limited or specified disease policies; (ii) policies, contracts, or plans issued in the individual market or small group markets; (iii) contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, Title XIX of the Social Security Act, known as Medicaid, Title XXI of the Social Security Act, or any other similar coverage under state or federal governmental plans; or (iv) short-term nonrenewable policies of not more than six months' duration.

2022, cc. 598, 599.

§ 38.2-3418.16. Coverage for telemedicine services.

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for the cost of such health care services provided through telemedicine services, as provided in this section.

B. As used in this section:

"Originating site" means the location where the patient is located at the time services are provided by a health care provider through telemedicine services.

"Remote patient monitoring services" means the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload.

"Telemedicine services" as it pertains to the delivery of health care services, means the use of electronic technology or media, including interactive audio or video, for the purpose of diagnosing or treating a patient, providing remote patient monitoring services, or consulting with other health care providers regarding a patient's diagnosis or treatment, regardless of the originating site and whether the patient is accompanied by a health care provider at the time such services are provided. "Telemedicine services" does not include an audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire. Nothing in this section shall preclude coverage for a service that is not a telemedicine service, including services delivered through real-time audio-only telephone.

C. An insurer, corporation, or health maintenance organization shall not exclude a service for coverage solely because the service is provided through telemedicine services and is not provided through face-to-face consultation or contact between a health care provider and a patient for services appropriately provided through telemedicine services.

D. An insurer, corporation, or health maintenance organization shall not be required to reimburse the treating provider or the consulting provider for technical fees or costs for the provision of telemedicine services; however, such insurer, corporation, or health maintenance organization shall reimburse the treating provider or the consulting provider for the diagnosis, consultation, or treatment of the insured delivered through telemedicine services on the same basis that the insurer, corporation, or health maintenance organization is responsible for coverage for the provision of the same service through face-to-face consultation or contact. No insurer, corporation, or health maintenance organization shall require a provider to use proprietary technology or applications in order to be reimbursed for providing telemedicine services.

E. Nothing shall preclude the insurer, corporation, or health maintenance organization from undertaking utilization review to determine the appropriateness of telemedicine services, provided that such appropriateness is made in the same manner as those determinations are made for the treatment of any other illness, condition, or disorder covered by such policy, contract, or plan. Any such utilization review shall not require pre-authorization of emergent telemedicine services.

F. An insurer, corporation, or health maintenance organization may offer a health plan containing a deductible, copayment, or coinsurance requirement for a health care service provided through telemedicine services, provided that the deductible, copayment, or coinsurance does not exceed the

deductible, copayment, or coinsurance applicable if the same services were provided through face-to-face diagnosis, consultation, or treatment.

G. No insurer, corporation, or health maintenance organization shall impose any annual or lifetime dollar maximum on coverage for telemedicine services other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy, or impose upon any person receiving benefits pursuant to this section any copayment, coinsurance, or deductible amounts, or any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the policy, contract, or plan.

H. The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, or extended in the Commonwealth on and after January 1, 2021, or at any time thereafter when any term of the policy, contract, or plan is changed or any premium adjustment is made.

I. This section shall not apply to short-term travel, accident-only, or limited or specified disease policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under federal governmental plans.

J. The coverage required by this section shall include the use of telemedicine technologies as it pertains to medically necessary remote patient monitoring services to the full extent that these services are available.

K. Prescribing of controlled substances via telemedicine shall comply with the requirements of § 54.1-3303 and all applicable federal law.

2010, c. 222; 2014, c. 814; 2015, cc. 32, 115; 2019, cc. 211, 219; 2020, Sp. Sess. I, cc. 44, 53; 2021, Sp. Sess. I, cc. 301, 302.

§ 38.2-3418.17. Coverage for autism spectrum disorder.

A. Notwithstanding the provisions of § 38.2-3419 and any other provision of law, each insurer proposing to issue accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall, as provided in this section, provide coverage for the diagnosis of autism spectrum disorder and the treatment of autism spectrum disorder, in individuals (i) from January 1, 2012, until January 1, 2016, from age two years through age six years; (ii) from January 1, 2016, until January 1, 2020, from age two years through age 10 years; and (iii) from and after January 1, 2020, of any age, subject to the annual maximum benefit limitation set forth in subsection K and to the provisions of subsection G. If an individual who is being treated for autism spectrum disorder becomes older than the applicable maximum age set forth in the preceding sentence and continues to need treatment, this section does not preclude coverage of treatment and services. In addition to the

requirements imposed on health insurance issuers by § 38.2-3436, an insurer shall not terminate coverage or refuse to deliver, issue, amend, adjust, or renew coverage of an individual solely because the individual is diagnosed with autism spectrum disorder or has received treatment for autism spectrum disorder.

B. For purposes of this section:

"Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

"Autism spectrum disorder" means any pervasive developmental disorder or autism spectrum disorder, as defined in the most recent edition or the most recent edition at the time of diagnosis of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

"Behavioral health treatment" means professional, counseling, and guidance services and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.

"Diagnosis of autism spectrum disorder" means medically necessary assessments, evaluations, or tests to diagnose whether an individual has an autism spectrum disorder.

"Medically necessary" means in accordance with the generally accepted standards of mental disorder or condition care and clinically appropriate in terms of type, frequency, site, and duration, based upon evidence and reasonably expected to do any of the following: (i) prevent the onset of an illness, condition, injury, or disability; (ii) reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability; or (iii) assist to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and the functional capacities that are appropriate for individuals of the same age.

"Pharmacy care" means medications prescribed by a licensed physician and any health-related services deemed medically necessary to determine the need or effectiveness of the medications.

"Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

"Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

"Therapeutic care" means services provided by licensed or certified speech therapists, occupational therapists, physical therapists, or clinical social workers.

"Treatment for autism spectrum disorder" shall be identified in a treatment plan and includes the following care prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist who determines the care to be medically necessary: (i)

behavioral health treatment, (ii) pharmacy care, (iii) psychiatric care, (iv) psychological care, (v) therapeutic care, and (vi) applied behavior analysis when provided or supervised by a board certified behavior analyst who shall be licensed by the Board of Medicine. The prescribing practitioner shall be independent of the provider of applied behavior analysis.

"Treatment plan" means a plan for the treatment of autism spectrum disorder developed by a licensed physician or a licensed psychologist pursuant to a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report or recommendation of the American Academy of Pediatrics or the American Academy of Child and Adolescent Psychiatry.

C. Except for inpatient services, if an individual is receiving treatment for an autism spectrum disorder, an insurer, corporation, or health maintenance organization shall have the right to request a review of that treatment, including an independent review, not more than once every 12 months unless the insurer, corporation, or health maintenance organization and the individual's licensed physician or licensed psychologist agree that a more frequent review is necessary. The cost of obtaining any review, including an independent review, shall be covered under the policy, contract, or plan.

D. Coverage under this section will not be subject to any visit limits, and shall be neither different nor separate from coverage for any other illness, condition, or disorder for purposes of determining deductibles, lifetime dollar limits, copayment and coinsurance factors, and benefit year maximum for deductibles and copayment and coinsurance factors.

E. Nothing shall preclude the undertaking of usual and customary procedures, including prior authorization, to determine the appropriateness of, and medical necessity for, treatment of autism spectrum disorder under this section, provided that all such appropriateness and medical necessity determinations are made in the same manner as those determinations are made for the treatment of any other illness, condition, or disorder covered by such policy, contract, or plan.

F. The provisions of this section shall not apply to (i) short-term travel, accident only, limited, or specified disease policies; (ii) short-term nonrenewable policies of not more than six months' duration; or (iii) policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

G. The requirements of this section requiring that coverage be provided with regard to individuals from age two years through age six years shall apply to all insurance policies, subscription contracts, and health care plans delivered, issued for delivery, reissued, or extended on or after January 1, 2012, but prior to January 1, 2016; the requirements of this section requiring that coverage be provided with regard to individuals from age two years through age 10 years shall apply to all insurance policies, subscription contracts, and health care plans delivered, issued for delivery, reissued, or extended on or after January 1, 2016, but prior to January 1, 2020; the requirements of this section requiring that coverage be provided with regard to individuals of any age shall apply to all insurance policies, subscription contracts, and health care plans delivered, issued for delivery, reissued, or extended on or

after January 1, 2020, and to all such policies, contracts, or plans to which a term is changed or any premium adjustment is made on or after such date; and the requirements of this section requiring that coverage be provided by policies, contracts, or plans issued in the individual market or small group markets shall apply to all insurance policies, subscription contracts, and health care plans in the individual and small group markets delivered, issued for delivery, reissued, or extended on or after January 1, 2021, and to all such policies, contracts, or plans to which a term is changed or any premium adjustment is made on or after such date.

H. Any coverage required pursuant to this section shall be in addition to the coverage required by § 38.2-3418.5 and other provisions of law. This section shall not be construed as diminishing any coverage required by § 38.2-3412.1. This section shall not be construed as affecting any obligation to provide services to an individual under an individualized family service plan, an individualized education program, or an individualized service plan.

I. Pursuant to the provisions of § 2.2-2818.2, this section shall apply to health coverage offered to state employees pursuant to § 2.2-2818 and to health insurance coverage offered to employees of local governments, local officers, teachers, and retirees, and the dependents of such employees, teachers, and retirees pursuant to § 2.2-1204.

J. Notwithstanding any provision of this section to the contrary:

1. An insurer, corporation, or health maintenance organization, or a governmental entity providing coverage for such treatment pursuant to subsection I, is exempt from providing coverage for behavioral health treatment required under this section and not covered by the insurer, corporation, health maintenance organization, or governmental entity providing coverage for such treatment pursuant to subsection I as of December 31, 2011, if:

a. An actuary, affiliated with the insurer, corporation, or health maintenance organization, who is a member of the American Academy of Actuaries and meets the American Academy of Actuaries' professional qualification standards for rendering an actuarial opinion related to health insurance rate making, certifies in writing to the Commissioner of Insurance that:

(1) Based on an analysis to be completed no more frequently than one time per year by each insurer, corporation, or health maintenance organization, or such governmental entity, for the most recent experience period of at least one year's duration, the costs associated with coverage of behavioral health treatment required under this section, and not covered as of December 31, 2011, exceeded one percent of the premiums charged over the experience period by the insurer, corporation, or health maintenance organization; and

(2) Those costs solely would lead to an increase in average premiums charged of more than one percent for all insurance policies, subscription contracts, or health care plans commencing on inception or the next renewal date, based on the premium rating methodology and practices the insurer, corporation, or health maintenance organization, or such governmental entity, employs; and

b. The Commissioner approves the certification of the actuary;

2. An exemption allowed under subdivision 1 shall apply for a one-year coverage period following inception or next renewal date of all insurance policies, subscription contracts, or health care plans issued or renewed during the one-year period following the date of the exemption, after which the insurer, corporation, or health maintenance organization, or such governmental entity, shall again provide coverage for behavioral health treatment required under this section;

3. An insurer, corporation, or health maintenance organization, or such governmental entity, may claim an exemption for a subsequent year, but only if the conditions specified in subdivision 1 again are met; and

4. Notwithstanding the exemption allowed under subdivision 1, an insurer, corporation, or health maintenance organization, or such a governmental entity, may elect to continue to provide coverage for behavioral health treatment required under this section.

K. Coverage for applied behavior analysis under this section will be subject to an annual maximum benefit of $35,000, unless the insurer, corporation, or health maintenance organization elects to provide coverage in a greater amount.

L. As of January 1, 2014, to the extent that this section requires benefits that exceed the essential health benefits specified under § 1302(b) of the federal Patient Protection and Affordable Care Act (H.R. 3590), as amended (the ACA), the specific benefits that exceed the specified essential health benefits shall not be required of a qualified health plan when the plan is offered in the Commonwealth by a health carrier through a health benefit exchange established under § 1311 of the ACA. Nothing in this subsection shall nullify application of this section to plans offered outside such an exchange.

2011, cc. 876, 878; 2015, cc. 649, 650; 2019, cc. 451, 452; 2020, cc. 305, 613; 2022, cc. 101, 102.

§ 38.2-3418.18. (Effective until January 1, 2025) Coverage for formula and enteral nutrition products as medicine.

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services, whose policy, contract, or plan, including any certificate or evidence of coverage issued in connection with such policy, contract, or plan, includes coverage for medicines shall:

1. Classify medically necessary formula and enteral nutrition products as medicine; and

2. Include coverage for medically necessary formula and enteral nutrition products on the same terms and subject to the same conditions imposed on other medicines covered under the policy, contract, or plan.

B. As used in this section:

"Inherited metabolic disorder" means an inherited enzymatic disorder caused by single gene defects involved in the metabolism of amino, organic, or fatty acids.

"Medically necessary formula and enteral nutrition products" means any liquid or solid formulation of formula and enteral nutrition products for covered individuals requiring treatment for an inherited metabolic disorder and for which the covered individual's physician has issued a written order stating that the formula or enteral nutrition product is medically necessary and has been proven effective as a treatment regimen for the covered individual and that the formula or enteral nutrition product is a critical source of nutrition as certified by the physician by diagnosis. The medically necessary formula or enteral products do not need to be the covered individual's primary source of nutrition.

C. The coverage required by this section shall:

1. Apply to the partial or exclusive feeding of a covered individual by means of oral intake or enteral feeding by tube;

2. Include coverage for any medical equipment, supplies, and services that are required to administer the covered formula or enteral nutrition products;

3. Apply only when the formula and enteral nutrition products are (i) furnished pursuant to the prescription or order of a physician or other health care professional qualified to make such prescription or order for the management of an inherited metabolic disorder and (ii) used under medical supervision, which may include a home setting; and

4. Not apply to nutritional supplements taken electively.

D. No insurer, corporation, or health maintenance organization shall impose upon any person receiving benefits for any formula and enteral nutrition products pursuant to this section any (i) copayment, coinsurance payment, or fee that is not equally imposed upon all individuals in the same benefit category, class, coinsurance level, or copayment level receiving benefits for medicines or (ii) reduction in allowable reimbursement for medicine.

E. The provisions of this section shall apply to any policy, contract, or plan delivered, issued for delivery, or renewed in the Commonwealth on and after January 1, 2021.

F. The provisions of this section shall not apply to short-term travel, accident-only, or limited or specified disease policies, contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans, or short-term nonrenewable policies of not more than six months' duration.

2020, cc. 214, 215.

§ 38.2-3418.18. (For effective date, see Acts 2023, cc. 271 and 272, cl. 2) Coverage for formula and enteral nutrition products as medicine.

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical

coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services, whose policy, contract, or plan, including any certificate or evidence of coverage issued in connection with such policy, contract, or plan, includes coverage for medicines shall:

1. Classify medically necessary formula and enteral nutrition products as medicine; and

2. Include coverage for medically necessary formula and enteral nutrition products on the same terms and subject to the same conditions imposed on other medicines covered under the policy, contract, or plan.

B. As used in this section:

"Inherited metabolic disorder" means an inherited enzymatic disorder caused by single gene defects involved in the metabolism of amino, organic, or fatty acids.

"Medically necessary formula and enteral nutrition products" means any liquid or solid formulation of formula and enteral nutrition products for covered individuals requiring treatment for an inherited metabolic disorder and for which the covered individual's physician has issued a written order stating that the formula or enteral nutrition product is medically necessary and has been proven effective as a treatment regimen for the covered individual and that the formula or enteral nutrition product is a critical source of nutrition as certified by the physician by diagnosis. The medically necessary formula or enteral products do not need to be the covered individual's primary source of nutrition.

C. The coverage required by this section shall:

1. Apply to the partial or exclusive feeding of a covered individual by means of oral intake or enteral feeding by tube;

2. Include coverage for any medical equipment, supplies, and services that are required to administer the covered formula or enteral nutrition products;

3. Apply only when the formula and enteral nutrition products are (i) furnished pursuant to the prescription or order of a physician or other health care professional qualified to make such prescription or order for the management of an inherited metabolic disorder and (ii) used under medical supervision, which may include a home setting; and

4. Not apply to nutritional supplements taken electively.

D. No insurer, corporation, or health maintenance organization shall impose upon any person receiving benefits for any formula and enteral nutrition products pursuant to this section any (i) copayment, coinsurance payment, or fee that is not equally imposed upon all individuals in the same benefit category, class, coinsurance level, or copayment level receiving benefits for medicines or (ii) reduction in allowable reimbursement for medicine.

E. The provisions of this section shall apply to any policy, contract, or plan delivered, issued for delivery, or renewed in the Commonwealth on and after January 1, 2021.

F. The provisions of this section shall not apply to short-term travel, accident-only, or limited or specified disease policies, contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans, or short-term nonrenewable policies of not more than six months' duration. The provisions of this section shall not apply to policies, contracts, or plans issued in the individual market or small group markets.

2020, cc. 214, 215; 2023, cc. 271, 272.

§ 38.2-3418.19. Coverage for organ, eye or tissue transplant.

A. Notwithstanding the provisions of § 38.2-4319, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services, whose policy, contract, or plan, including any certificate of evidence of coverage issued in connection with such policy, contract, or plan, includes coverage for services related to organ, eye, or tissue transplantation as defined in § 32.1-297.2 shall not:

1. Deny coverage to a covered person solely on the basis of the person's disability;

2. Deny a person eligibility or continued eligibility to enroll in or to renew coverage under the policy, contract, or plan for the purpose of avoiding the requirements of § 32.1-297.2;

3. Penalize a health care provider, reduce or limit the reimbursement of a health care provider, or provide monetary or nonmonetary incentives to a health care provider to induce such health care provider to act in a manner inconsistent with the requirements of § 32.1-297.2; or

4. Reduce or limit coverage for services related to organ, eye, or tissue transplant as defined in § 32.1-297.2 for an eligible individual with a disability as defined in § 32.1-297.2.

B. The provisions of this section shall apply to any policy, contract, or plan delivered, issued for delivery, or renewed in the Commonwealth on and after January 1, 2021.

C. The provisions of this section shall not apply to short-term travel, accident-only, or limited or specified disease policies; contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal government plans; or short-term nonrenewable policies of not more than six months' duration.

D. Nothing in this section shall require an insurer to provide coverage for a medically inappropriate organ, eye or tissue transplant.

2020, cc. 217, 218, § 38.2-3418.18.

§ 38.2-3418.20. Coverage for hearing aids and related services [Not in effect].

A. As used in this section:

"Hearing aid" means any wearable, nondisposable instrument or device designed or offered to aid or compensate for impaired human hearing and any parts, attachments, or accessories, including earmolds, but excluding batteries and cords. Hearing aids are not to be considered durable medical equipment.

"Related services" includes earmolds, initial batteries, and other necessary equipment, maintenance, and adaptation training.

B. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for hearing aids and related services for children 18 years of age or younger under any policy, contract, or plan delivered, issued for delivery, or renewed in the Commonwealth. The coverage shall include payment of the cost of one hearing aid per hearing-impaired ear every 24 months, up to $1,500 per hearing aid. The insured may choose a higher-priced hearing aid and may pay the difference in cost above $1,500, with no financial or contractual penalty to the insured or to the provider of the hearing aid.

C. No insurer, corporation, or health maintenance organization shall impose upon any person receiving benefits pursuant to this section any copayment or fee, and no condition may be applied to the person that is not equally imposed upon all individuals in the same benefit category.

D. Coverage shall be available under this section only for services and equipment recommended by an otolaryngologist. Such recommended services and equipment may be provided or dispensed by an otolaryngologist, licensed audiologist, or licensed hearing aid specialist.

E. The provisions of this section shall apply to any policy, contract, or plan delivered, issued for delivery, or renewed in the Commonwealth on and after January 1, 2021.

F. The provisions of this section shall not apply to short-term travel, accident-only, limited or specified disease policies, or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans or to short-term nonrenewable policies of not more than six months' duration.

2020, c. 1094, see 2020, c. 1289, item 487, subdivs. C1, C2, and C3.

§ 38.2-3418.21. Coverage for hearing aids and related services.

A. As used in this section:

"Hearing aid" means any wearable, nondisposable instrument or device designed or offered to aid or compensate for impaired human hearing and any parts, attachments, or accessories, including earmolds, but excluding batteries and cords. Hearing aids are not to be considered durable medical equipment.

"Related services" includes earmolds, initial batteries, and other necessary equipment, maintenance, and adaptation training.

B. Notwithstanding the provisions of § 38.2-3419, subdivision A 1 of § 38.2-6506, or any other provision of law, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for hearing aids and related services for children 18 years of age or younger under any policy, contract, or plan delivered, issued for delivery, or renewed in the Commonwealth. The coverage shall include payment of the cost of one hearing aid per hearing-impaired ear every 24 months, up to $1,500 per hearing aid. The insured may choose a higher-priced hearing aid and may pay the difference in cost above $1,500, with no financial or contractual penalty to the insured or to the provider of the hearing aid.

C. No insurer, corporation, or health maintenance organization shall impose upon any person receiving benefits pursuant to this section any copayment or fee, and no condition may be applied to the person that is not equally imposed upon all individuals in the same benefit category.

D. Coverage shall be available under this section only for services and equipment recommended by an otolaryngologist. Such recommended services and equipment may be provided or dispensed by an otolaryngologist, licensed audiologist, or licensed hearing aid specialist.

E. The provisions of this section shall apply to any policy, contract, or plan delivered, issued for delivery, or renewed in the Commonwealth on and after January 1, 2024.

F. The provisions of this section shall not apply to short-term travel, accident-only, limited or specified disease policies, or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans or to short-term nonrenewable policies of not more than six months' duration.

G. The Commission shall not use any special fund revenues dedicated to its other functions and duties, including revenues from utility consumer taxes or fees from licensees regulated by the Commission or fees paid to the office of the clerk of the Commission, to fund the defrayal of costs for the coverage provided pursuant to subsection B as required by 42 U.S.C. § 18031 or any successor provision. The Commission shall not pay any funds beyond the moneys appropriated for the defrayal of costs related to such coverage. Appropriated funds remaining at year end shall not revert to the general fund but shall remain with the Commission for defrayal of costs related to this coverage.

2023, c. 473.

§ 38.2-3419. Additional mandated coverage made optional to group policy or contract holder.
Any new or existing group policy or contract holder for whom coverage under an accident and sickness insurance policy is issued or renewed by an insurer or for whom coverage under a contract is

issued or renewed by a corporation licensed pursuant to Chapter 42 (§ 38.2-4200 et seq.) of this title, shall be given the option to purchase any coverage, benefits or services first mandated under this chapter on or after July 1, 1982, provided that all mandated coverages as of June 30, 1982, will not be affected.

1982, c. 577, § 38.1-348.14; 1986, c. 562.

§ 38.2-3419.1. Report of costs and utilization of mandated benefits.

A. Beginning with the calendar year 1991, every insurer, health services plan, and health maintenance organization from which a report is deemed necessary under regulations adopted by the Commission shall report to the Commission cost and utilization information for each of the mandated benefits and providers set forth in this article. The reporting period shall be as determined by the Commission in its regulations, but not less often than biennially. Each report shall be submitted no later than the next May 1 following the reporting period. The reports shall be in detail and form as required under regulations adopted by the Commission so as to provide the information deemed necessary by the Commission to determine the financial impact of each mandated benefit and provider.

B. The Commission shall prepare a consolidation of these reports to provide to the General Assembly such information concerning the costs of mandated benefits, the utilization of services under mandated benefits, and such other information as the Commission or the General Assembly may deem appropriate. Such consolidated reports shall be submitted to the General Assembly no later than the next October 31 following the reporting period.

1990, cc. 393, 439; 1994, c. 316.

Article 3 - Jurisdiction over Providers of Health Care Services

§ 38.2-3420. Authority and jurisdiction of Commission; exception.

A. Except as provided in subsection C, any person offering or providing coverage in the Commonwealth for health care services, whether the coverage is by direct payment, reimbursement, or otherwise, shall be presumed to be subject to the jurisdiction of the Commission to the extent the person is not regulated by another agency of the Commonwealth, any subdivision of the Commonwealth, or the federal government relating to the offering or providing of coverage for health care services.

B. As used in this subsection:

"Health benefit plan" has the same meaning as described in § 38.2-3431.

"Self-funded multiple employer welfare arrangement" or "self-funded MEWA" means any multiple employer welfare arrangement that is not fully insured by a licensed insurance company. This term includes a benefit consortium established under Chapter 55 (§ 59.1-589 et seq.) of Title 59.1.

1. No self-funded multiple employer welfare arrangement shall issue health benefit plans in the Commonwealth until it has obtained a license pursuant to regulations promulgated by the Commission. No provision of this subsection shall authorize a self-funded MEWA domiciled outside of the Com-

monwealth to operate in the Commonwealth without obtaining a license pursuant to the regulations promulgated by the Commission.

2. Notwithstanding any other section of this title or Chapter 55 (§ 59.1-589 et seq.) of Title 59.1 to the contrary, all financial and solvency requirements imposed by provisions of this title upon domestic insurers shall apply to domestic self-funded MEWAs unless domestic self-funded MEWAs are otherwise specifically exempted. For the purposes of handling the rehabilitation, liquidation, or conservation of a domestic self-funded MEWA, the provisions of Chapter 15 (§ 38.2-1500 et seq.) shall apply.

3. Notwithstanding any other section of this title or Chapter 55 (§ 59.1-589 et seq.) of Title 59.1 to the contrary, any health benefit plan issued by a self-funded MEWA, including a trust, benefits consortium, or other arrangement, that covers one or more employees of one or more small employers shall (i) provide essential health benefits and cost-sharing requirements as set forth in § 38.2-3451; (ii) offer a minimum level of coverage designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan; (iii) not limit or exclude coverage for an individual by imposing a preexisting condition exclusion on that individual pursuant to § 38.2-3444; (iv) not establish discriminatory rules based on health status related to eligibility or premium or contribution requirements as imposed on health carriers pursuant to § 38.2-3432.2; (v) meet the renewability standards set forth for health insurance issuers in § 38.2-3432.1; (vi) establish base rates formed on an actuarially sound, modified community rating methodology that considers the pooling of all participant claims; and (vii) utilize each employer member's specific risk profile to determine premiums by actuarially adjusting above or below established base rates, and utilize either pooling or reinsurance of individual large claimants to reduce the adverse impact on any specific employer member's premiums.

4. The Commission shall have authority to adopt regulations applicable to self-funded MEWAs, whether domiciled inside or outside of the Commonwealth, including regulations addressing the self-funded MEWA's financial condition, solvency requirements, and insolvency plan and its exclusion, pursuant to § 59.1-592, from the Virginia Life, Accident and Sickness Insurance Guaranty Association established under Chapter 17 (§ 38.2-1700 et seq.).

C. Neither the provisions of this section nor any other provision of this title shall be construed to affect or apply to a multiple employer welfare arrangement (MEWA) composed only of banks together with their plan-sponsoring organization, and their respective employees, provided the multiple employer welfare arrangement (i) is duly licensed as a MEWA by the insurance regulatory agency of a state contiguous to the Commonwealth, (ii) files with the Commission a copy of its certificate of authority or other proper license from the contiguous state, (iii) has no more than 500 Virginia residents who are employees of its member banks enrolled in or receiving accident and sickness benefits as insureds, members, enrollees, or subscribers of the MEWA, and (iv) is subject to solvency examination authority and reserve adequacy requirements determined by sound actuarial principles by such domiciliary contiguous state. For purposes of this subsection:

"Bank" means an institution that has or is eligible for insurance of deposits by the Federal Deposit Insurance Corporation.

"Plan-sponsoring organization" means an association that (i) sponsors a MEWA composed only of banks; (ii) has been actively in existence for at least five years; (iii) has been formed and maintained in good faith for purposes other than obtaining insurance; (iv) does not condition membership in the association on any health status-related factor relating to an individual, including an employee of an employer or a dependent of an employee; (v) makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members or individuals eligible for coverage through a member; (vi) does not make health insurance coverage offered through the association available other than in connection with a member of the association; and (vii) meets such additional requirements as may be imposed under the laws of the Commonwealth, and includes any subsidiary of such an association.

1983, c. 417, § 38.1-43.7; 1986, c. 562; 1990, c. 477; 2004, c. 236; 2011, c. 329; 2012, c. 589; 2022, cc. 404, 405.

§ 38.2-3421. How to show jurisdiction of other state agency or federal government.

A person may show that it is regulated by another agency of this Commonwealth, any subdivision of this Commonwealth, or the federal government by providing to the Commission the appropriate certificate, license or other document issued by the other governmental agency that permits or qualifies it to provide those services set forth in § 38.2-3420. Provided, however, in lieu of such certificate, license or other documentation, the Commission may determine that such person is not subject to the jurisdiction of the Commission if the Commission is otherwise satisfied that such person is regulated by another agency of this Commonwealth, any subdivision of this Commonwealth or the federal government relating to the offering or providing of coverage for health care services. Any person who has provided such certificate, license, or other document shall immediately notify the Commission if such person ceases to be regulated by the governmental agency as stated in the certificate, license, or other document provided to the Commission. Any other person who is otherwise determined by the Commission not to be subject to the jurisdiction of the Commission shall also notify the Commission of any change in its circumstances which may materially affect such determination of the Commission.

1983, c. 417, § 38.1-43.8; 1986, c. 562; 1990, c. 477.

§ 38.2-3422. Examination.

Any person that fails to show that it is regulated by another agency of this Commonwealth, any subdivision of this Commonwealth, or the federal government as provided by § 38.2-3421 shall be subject to an examination by the Commission to determine the organization and solvency of the person and whether or not the person is in compliance with the applicable provisions of this title.

1983, c. 417, § 38.1-43.9; 1986, c. 562; 1990, c. 477.

§ 38.2-3423. When subject to this title.

Any person that fails to show that it is regulated by another agency of this Commonwealth, any subdivision of this Commonwealth, or the federal government as provided by § 38.2-3421 shall be subject to all appropriate provisions of this title regarding the operation of its business.

1983, c. 417, § 38.1-43.10; 1986, c. 562; 1990, c. 477.

§ 38.2-3424. Disclosure of extent and elements of coverage.

A. Any agent, agency, administrator, or other person that advertises, sells, transacts, or administers coverage for health care services in this Commonwealth where that coverage is provided by any person subject to the provisions of this article shall inform any purchaser, prospective purchaser, or covered person of (i) the lack of insurance or other coverage, unless that coverage is fully insured or otherwise fully covered by an admitted life insurer, accident and sickness insurer, health services plan, dental or optometric services plan, or health maintenance organization and (ii) if the coverage is fully insured or otherwise fully covered, the terms, coverages, limits, and deductibles including the amount of "stop-loss" insurance in effect.

B. No person, including an administrator, insurer, agent, or affiliate of an insurer shall make, publish, disseminate, circulate, or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in any newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio station or television station, or in any other way, any advertisement, announcement, or statement soliciting membership, offering coverage, or evidencing coverage in any health care plan or arrangement which is subject to regulation by the Commission under this article and not otherwise regulated by this title, unless such advertisement, announcement, or statement contains the following disclosure:

Your plan of coverage is not protected under the Virginia Life, Accident and Sickness Insurance Guaranty Association Act. Therefore:

1. In the event of an insolvency of your plan, you may be unable to collect any amount you are owed for covered claims, regardless of the coverage provided under the plan;

2. The payment of premiums into your plan does not guarantee payment of claims under your plan, regardless of the coverage provided under the plan.

When such disclosure is contained in print, it shall be no smaller than boldfaced ten-point type.

1983, c. 417, § 38.1-43.11; 1986, c. 562; 1990, c. 477.

§ 38.2-3424.1. Applicability.

Nothing contained in this article shall be construed to apply to any plan for providing health insurance coverage established pursuant to § 2.2-2818.

1990, c. 477.

Article 4 - LIMITED MANDATED BENEFIT ACCIDENT AND SICKNESS INSURANCE POLICIES AND SUBSCRIPTION CONTRACTS

§§ 38.2-3425 through 38.2-3430. Expired.

Expired.

Article 4.1 - INDIVIDUAL HEALTH INSURANCE COVERAGE

§ 38.2-3430.1. Application of article.

This article applies to individual health insurance coverage offered, sold, issued, or renewed in this Commonwealth, but shall not apply to any individual health insurance coverage for any of the "excepted benefits" defined in § 38.2-3431. In the event of conflict between the provisions in this article and other provisions of this title, the provisions of this article shall be controlling.

1997, cc. 807, 913.

§ 38.2-3430.1:1. Health insurance coverage not required.

No resident of this Commonwealth, regardless of whether he has or is eligible for health insurance coverage under any policy or program provided by or through his employer, or a plan sponsored by the Commonwealth or the federal government, shall be required to obtain or maintain a policy of individual insurance coverage except as required by a court or the Department of Social Services where an individual is named a party in a judicial or administrative proceeding. No provision of this title shall render a resident of this Commonwealth liable for any penalty, assessment, fee, or fine as a result of his failure to procure or obtain health insurance coverage. This section shall not apply to individuals voluntarily applying for coverage under a state-administered program pursuant to Title XIX or Title XXI of the Social Security Act. This section shall not apply to students being required by an institution of higher education to obtain and maintain health insurance as a condition of enrollment. Nothing herein shall impair the rights of persons to privately contract for health insurance for family members or former family members.

2010, cc. 106, 107, 108, 818.

§ 38.2-3430.2. Definitions.

A. The terms defined in § 38.2-3431 that are used in this article shall have the meanings set forth in that section.

B. For purposes of this article:

"Eligible individual" means an individual:

1. (i) for whom, as of the date on which the individual seeks coverage under this section, the aggregate of the periods of creditable coverage is 18 or more months and (ii) whose most recent prior creditable coverage was under individual health insurance coverage, a group health plan, governmental plan, church plan, or a state plan under Title XIX of the Social Security Act (42 U.S.C. § 1396 et seq.), or health insurance coverage offered in connection with any such plan;

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

3. With respect to whom the most recent coverage within the coverage period described in subdivision 1 was not terminated based on a factor described in subdivision B 1 or B 2 of § 38.2-3430.7 relating to nonpayment of premiums or fraud;

4. If the individual had been offered the option of continuation coverage under a COBRA continuation provision or under a similar state program, who elected such coverage;

5. Who, if the individual elected such continuation coverage, has exhausted such continuation coverage under such provision or program; and

6. In the case where individual health insurance coverage is the most recent creditable coverage, the coverage was nonrenewed by the health insurance issuer under the conditions allowed in subdivision C 2 of § 38.2-3430.7, in which case the aggregate period of creditable coverage required is reduced to 12 months.

For the purposes of determining the aggregate of the periods of creditable coverage under subdivision B 1 (i) of this section, a period of creditable coverage shall not be counted with respect to enrollment of an individual under a health benefit plan if, after such period, there was a 63-day period during all of which the individual was not covered under any creditable coverage or was not serving a waiting period for coverage under a group health plan, or for group health insurance coverage or was in an affiliation period. This period shall begin on the day following an individual's termination of coverage and shall continue until the date an individual submits an application for coverage. In those cases where an application is submitted by mail, the date of postmark shall be deemed to be the date the application is submitted.

1997, cc. 807, 913; 1998, c. 24; 1999, c. 1004; 2010, cc. 225, 642.

§ 38.2-3430.3. Guaranteed availability of individual health insurance coverage to certain individuals with prior group coverage.

A. Guaranteed availability.

1. All eligible individuals shall be provided a choice of all individual health insurance coverage currently being offered by a health insurance issuer and the chosen coverage shall be issued.

2. The coverage provided as required in subdivision A 1 shall not impose any preexisting condition exclusion or affiliation period with respect to the coverage.

B. Health insurance issuers are prohibited from imposing any limitations or exclusions based upon named conditions that apply to eligible individuals.

C. Health insurance issuers shall include on all applications for health insurance coverage questions which will enable the health insurance issuer to determine if an applicant is applying for coverage as

an eligible individual as defined in § 38.2-3430.2. This requirement shall not apply to applications used in connection with managed health care plans administering and providing care to Medicare beneficiaries in exchange for preestablished compensation from Medicare, as permitted under applicable state and federal guidelines.

D. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

1997, cc. 807, 913; 1999, c. 1004; 2000, c. 136; 2005, c. 335; 2013, c. 751.

§ 38.2-3430.3:1. Expired.

Expired.

§ 38.2-3430.4. Special rules for network plans.

A health insurance issuer that offers health insurance coverage in the individual market may:

1. Limit the eligible individuals who may be enrolled under such coverage to those who live, reside, or work within the service area for such network plan;

2. Within the service area of such plan, deny such coverage to such individuals if the health insurance issuer has demonstrated to the Commission that: (i) it will not have the capacity to deliver services adequately to additional individual enrollees because of its obligations to existing group contract holders, enrollees and enrollees covered under individual contracts; and (ii) it is applying this section uniformly to individuals without regard to any health status-related factor of such individuals and without regard to whether the individuals are eligible individuals;

3. A health insurance issuer, upon denying health insurance coverage in any service area in accordance with subdivision 2, may not offer coverage in the individual market within such service area for a period of 180 days after such coverage is denied.

1997, cc. 807, 913; 1998, c. 24.

§ 38.2-3430.5. Application of financial capacity limits.

A. A health insurance issuer may deny health insurance coverage in the individual market to an eligible individual if the health insurance issuer has demonstrated to the satisfaction of the Commission that:

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

2. It is applying this section uniformly to all individuals in the individual market in the Commonwealth consistent with the laws of this Commonwealth and without regard to any health status-related factor of such individuals and without regard to whether the individuals are eligible individuals.

B. A health insurance issuer, upon denying individual health insurance coverage in any service area in accordance with subsection A, may not offer such coverage in the individual market within such service area for a period of 180 days after the date such coverage is denied or until the health insurance

issuer has demonstrated to the satisfaction of the Commission that the health insurance issuer has sufficient financial reserves to underwrite additional coverage, whichever is later.

1997, cc. 807, 913.

§ 38.2-3430.6. Market requirements.

The provisions of § 38.2-3430.3 shall not be construed to require that a health insurance issuer offering health insurance coverage only in connection with group health plans or through one or more bona fide associations, or both, offer such health insurance coverage in the individual market.

1997, cc. 807, 913; 1998, c. 24; 2014, c. 814.

§ 38.2-3430.7. Renewability of individual health insurance coverage.

A. Except as provided in this section, a health insurance issuer that provides individual health insurance coverage shall renew or continue in force such coverage at the option of the individual.

B. A health insurance issuer may nonrenew or discontinue health insurance coverage of an individual in the individual market based on one or more of the following:

1. The individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer 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 the coverage;

3. The issuer is ceasing to offer coverage in the individual market in accordance with subsection C and applicable state law;

4. In the case of a health insurance issuer that offers health insurance coverage in the individual market through a network plan, the individual no longer resides, lives, or works in the service area, or in an area for which the health insurance issuer is authorized to do business but only if such coverage is terminated under this section uniformly without regard to any health status-related factor of covered individuals; or

5. In the case of health insurance coverage that is made available in the individual market only through one or more bona fide associations, the membership of the individual in the association (on the basis of which the coverage is provided) ceases but only if such coverage is terminated under this section uniformly without regard to any health status-related factor of covered individuals.

C. Requirements for uniform termination of coverage.

1. In any case in which a health insurance issuer decides to discontinue offering a particular type of health insurance coverage offered in the individual market, coverage of such type may be discontinued by the health insurance issuer only if:

a. The health insurance issuer provides notice to each covered individual provided coverage of this type in such market of such discontinuation at least ninety days prior to the date of the discontinuation of such coverage;

b. The health insurance issuer offers to each individual in the individual market provided coverage of this type, the option to purchase any other individual health insurance coverage currently being offered by the health insurance issuer for individuals in such market; and

c. In exercising the option to discontinue coverage of this type and in offering the option of coverage under subdivision 1 b of this subsection, the health insurance issuer acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for such coverage.

2. Discontinuance of all coverage.

a. Subject to subdivision 1 c of this subsection, in any case in which a health insurance issuer elects to discontinue offering all health insurance coverage in the individual market in the Commonwealth, health insurance coverage may be discontinued by the health insurance issuer only if: (i) the health insurance issuer provides notice to the Commission and to each individual of such discontinuation at least 180 days prior to the date of the expiration of such coverage, and (ii) all health insurance issued or delivered for issuance in this Commonwealth in such market is discontinued and coverage under such health insurance coverage in such market is not renewed.

b. In the case of discontinuation under subdivision 2 a of this subsection in the individual market, the health insurance issuer may not provide for the issuance of any health insurance coverage in the individual market in this Commonwealth during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

D. At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a policy form offered to individuals in the individual market so long as such modification is consistent with the laws of this Commonwealth and effective on a uniform basis among all individuals with that policy form.

E. In applying this section in the case of health insurance coverage that is made available by health insurance issuers in the individual market to individuals only through one or more associations, a reference to an "individual" is deemed to include a reference to such an association of which the individual is a member.

1997, cc. 807, 913.

§ 38.2-3430.8. Certification of coverage.

The provisions of § 38.2-3432.3 shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as they apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.

1997, cc. 807, 913; 1999, c. 1004.

§ 38.2-3430.9. Regulations establishing standards.

A. The Commission may adopt regulations to enable it to establish and administer such standards relating to the provisions of this article and Article 5 (§ 38.2-3431 et seq.) of this chapter as may be necessary to (i) implement the requirements of this article and (ii) assure that the Commonwealth's regulation of health insurance issuers is not preempted pursuant to P. L. 104-191 (The Health Insurance Portability & Accountability Act of 1996).

B. The Commission may revise or amend such regulations and may increase the scope of the regulations to the extent necessary to maintain federal approval of the Commonwealth's program for regulation of health insurance issuers pursuant to the requirements established by the United States Department of Health and Human Services.

C. The Commission shall annually advise the standing committees of the General Assembly having jurisdiction over insurance matters of revisions and amendments made pursuant to subsection B.

1997, cc. 807, 913.

§ 38.2-3430.10. Effective date.

The provisions of this article shall be effective on July 1, 1997, with the exception of § 38.2-3430.3 which shall be effective on January 1, 1998.

1997, cc. 807, 913.

Article 5 - Group Market Reforms and Individual Coverage Offered to Employees of Small Employers

§ 38.2-3431. Application of article; definitions.

A. This article applies to group health plans and to health insurance issuers offering group health insurance coverage, and individual policies offered to employees of small employers.

Each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis, each corporation providing individual or group accident and sickness subscription contracts, and each health maintenance organization or multiple employer welfare arrangement providing health care plans for health care services that offers individual or group coverage to the small employer market in the Commonwealth shall be subject to the provisions of this article. Any issuer of individual coverage to employees of a small employer shall be subject to the provisions of this article if any of the following conditions are met:

1. Any portion of the premiums or benefits is paid by or on behalf of the employer;

2. The eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the employer for any portion of the premium;

3. The employer has permitted payroll deduction for the covered individual and any portion of the premium is paid by the employer, provided that the health insurance issuer providing individual coverage under such circumstances shall be registered as a health insurance issuer in the small group

market under this article, and shall have offered small employer group insurance to the employer in the manner required under this article; or

4. The health benefit plan is treated by the employer or any of the covered individuals as part of a plan or program for the purpose of § 106, 125, or 162 of the United States Internal Revenue Code.

B. For the purposes of this article:

"Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Commission that a health insurance issuer is in compliance with the provisions of this article based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the health insurance issuer in establishing premium rates for applicable insurance coverage.

"Affiliation period" means a period which, under the terms of the health insurance coverage offered by a health maintenance organization, must expire before the health insurance coverage becomes effective. The health maintenance organization is not required to provide health care services or benefits during such period and no premium shall be charged to the participant or beneficiary for any coverage during the period.

1. Such period shall begin on the enrollment date.

2. An affiliation period under a plan shall run concurrently with any waiting period under the plan.

"Beneficiary" has the meaning given such term under section 3(8) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (8)).

"Bona fide association" means, with respect to health insurance coverage offered in the Commonwealth, an association which:

1. Has been actively in existence for at least five years;

2. Has been formed and maintained in good faith for purposes other than obtaining insurance;

3. Does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee);

4. Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member);

5. Does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

6. Meets such additional requirements as may be imposed under the laws of the Commonwealth.

"Certification" means a written certification of the period of creditable coverage of an individual under a group health plan and coverage provided by a health insurance issuer offering group health insurance coverage and the coverage if any under such COBRA continuation provision, and the waiting

period if any and affiliation period if applicable imposed with respect to the individual for any coverage under such plan.

"Church plan" has the meaning given such term under section 3(33) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (33)).

"COBRA continuation provision" means any of the following:

1. Section 4980B of the Internal Revenue Code of 1986 (26 U.S.C. § 4980B), 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 (29 U.S.C. § 1161 et seq.), other than section 609 of such Act; or

3. Title XXII of P.L. 104-191.

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

1. A group health plan;

2. Health insurance coverage;

3. Part A or B of Title XVIII of the Social Security Act (42 U.S.C. § 1395c or § 1395);

4. Title XIX of the Social Security Act (42 U.S.C. § 1396 et seq.), other than coverage consisting solely of benefits under section 1928;

5. Chapter 55 of Title 10, United States Code (10 U.S.C. § 1071 et seq.);

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

7. A state health benefits risk pool;

8. A health plan offered under Chapter 89 of Title 5, United States Code (5 U.S.C. § 8901 et seq.);

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

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

11. Individual health insurance coverage.

Such term does not include coverage consisting solely of coverage of excepted benefits.

"Dependent" means the spouse or child of an eligible employee, subject to the applicable terms of the policy, contract or plan covering the eligible employee.

"Eligible employee" means an employee who works for a small group employer on a full-time basis, has a normal work week of 30 or more hours, has satisfied applicable waiting period requirements, and is not a part-time, temporary or substitute employee. At the employer's sole discretion, the eligibility criterion may be broadened to include part-time employees.

"Eligible individual" means such an individual in relation to the employer as shall be determined:

1. In accordance with the terms of such plan;

2. As provided by the health insurance issuer under rules of the health insurance issuer which are uniformly applicable to employers in the group market; and

3. In accordance with all applicable law of the Commonwealth governing such issuer and such market.

"Employee" has the meaning given such term under section 3(6) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (6)).

"Employer" has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (5)), except that such term shall include only employers of two or more employees.

"Enrollment date" means, with respect to an eligible individual covered under a group health plan or health insurance coverage, the date of enrollment of the eligible individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment.

"Excepted benefits" means benefits under one or more (or any combination thereof) of the following:

1. Benefits not subject to requirements of this article:

a. Coverage only for accident, or disability income insurance, or any combination thereof;

b. Coverage issued as a supplement to liability insurance;

c. Liability insurance, including general liability insurance and automobile liability insurance;

d. Workers' compensation or similar insurance;

e. Medical expense and loss of income benefits;

f. Credit-only insurance;

g. Coverage for on-site medical clinics; and

h. Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

2. Benefits not subject to requirements of this article if offered separately:

a. Limited scope dental or vision benefits;

b. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and

c. Such other similar, limited benefits as are specified in regulations.

3. Benefits not subject to requirements of this article if offered as independent, noncoordinated benefits:

a. Coverage only for a specified disease or illness; and

b. Hospital indemnity or other fixed indemnity insurance.

4. Benefits not subject to requirements of this article if offered as separate insurance policy:

a. Medicare supplemental health insurance (as defined under section 1882 (g)(1) of the Social Security Act (42 U.S.C. § 1395ss (g)(1));

b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 U.S.C. § 1071 et seq.); and

c. Similar supplemental coverage provided to coverage under a group health plan.

"Federal governmental plan" means a governmental plan established or maintained for its employees by the government of the United States or by an agency or instrumentality of such government.

"Governmental plan" has the meaning given such term under section 3(32) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (32)) and any federal governmental plan.

"Group health insurance coverage" means in connection with a group health plan, health insurance coverage offered in connection with such plan.

"Group health plan" means an employee welfare benefit plan (as defined in section 3 (1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (1)), to the extent that the plan provides medical care and including items and services paid for as medical care to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

"Health benefit plan" means any accident and health insurance policy or certificate, health services plan contract, health maintenance organization subscriber contract, plan provided by a MEWA or plan provided by another benefit arrangement. "Health benefit plan" does not mean accident only, credit, or disability insurance; coverage of Medicare services or federal employee health plans, pursuant to contracts with the United States government; Medicare supplement or long-term care insurance; Medicaid coverage; dental only or vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; medical expense and loss of income benefits; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

"Health 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 or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

"Health insurance issuer" means an insurance company, or insurance organization (including a health maintenance organization) which is licensed to engage in the business of insurance in the

Commonwealth and which is subject to the laws of the Commonwealth which regulate insurance within the meaning of section 514 (b)(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1144 (b)(2)). Such term does not include a group health plan.

"Health maintenance organization" means:

1. A federally qualified health maintenance organization;

2. An organization recognized under the laws of the Commonwealth as a health maintenance organization; or

3. A similar organization regulated under the laws of the Commonwealth for solvency in the same manner and to the same extent as such a health maintenance organization.

"Health status-related factor" means the following in relation to the individual or a dependent eligible for coverage under a group health plan or health insurance coverage offered by a health insurance issuer:

1. Health status;

2. Medical condition (including both physical and mental illnesses);

3. Claims experience;

4. Receipt of health care;

5. Medical history;

6. Genetic information;

7. Evidence of insurability (including conditions arising out of acts of domestic violence); or

8. Disability.

"Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, but does not include coverage defined as excepted benefits. Individual health insurance coverage does not include short-term limited duration coverage.

"Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

"Large employer" means, in connection with a group health plan or health insurance coverage with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year.

"Large group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer.

"Late enrollee" means, with respect to coverage under a group health plan or health insurance coverage provided by a health insurance issuer, a participant or beneficiary who enrolls under the plan other than during:

1. The first period in which the individual is eligible to enroll under the plan; or

2. A special enrollment period as required pursuant to subsections J through M of § 38.2-3432.3.

"Medical care" means amounts paid for:

1. The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

2. Transportation primarily for and essential to medical care referred to in subdivision 1; and

3. Insurance covering medical care referred to in subdivisions 1 and 2.

"Network plan" means health insurance coverage of a health insurance issuer 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 defined set of providers under contract with the health insurance issuer.

"Nonfederal governmental plan" means a governmental plan that is not a federal governmental plan.

"Participant" has the meaning given such term under section 3(7) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (7)).

"Placed for adoption," or "placement" or "being placed" for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

"Plan sponsor" has the meaning given such term under section 3(16)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (16)(B)).

"Preexisting condition exclusion" means, with respect to coverage, 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 such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date. Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to such information.

"Premium" means all moneys paid by an employer and eligible employees as a condition of coverage from a health insurance issuer, including fees and other contributions associated with the health benefit plan.

"Rating period" means the 12-month period for which premium rates are determined by a health insurance issuer and are assumed to be in effect.

"Self-employed individual" means an individual who derives a substantial portion of his income from a trade or business (i) operated by the individual as a sole proprietor, (ii) through which the individual has attempted to earn taxable income, and (iii) for which he has filed the appropriate Internal Revenue Service Form 1040, Schedule C or F, for the previous taxable year.

"Service area" means a broad geographic area of the Commonwealth in which a health insurance issuer sells or has sold insurance policies on or before January 1994, or upon its subsequent authorization to do business in Virginia.

"Small employer" means in connection with a group health plan or health insurance coverage with respect to a calendar year and a plan year, an employer who employed an average of at least one but not more than 50 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year. In determining whether a corporation or limited liability company employed an average of at least one individual during the preceding calendar year and employed at least one employee on the first day of the plan year, an individual who performed any service for remuneration under a contract of hire, written or oral, express or implied, for a (i) corporation of which the individual is a shareholder or an immediate family member of a shareholder or (ii) a limited liability company of which the individual is a member shall be deemed to be an employee of the corporation or the limited liability company, respectively. However, a health insurance issuer shall not be required to issue more than one group health plan for each employer identification number issued by the Internal Revenue Service for a business entity, without regard to the number of shareholders or members of such business entity. "Small employer" includes a self-employed individual.

"Small group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer.

"Sponsoring association" means a nonstock corporation formed under the Virginia Nonstock Corporation Act (§ 13.1-801 et seq.) that:

1. Has been formed and maintained in good faith for purposes other than obtaining or providing health benefits;

2. Does not condition membership in the sponsoring association on any factor relating to the health status of an individual, including an employee of an employer member of the sponsoring association or a dependent of such an employee;

3. Makes any health benefit plan available to all members regardless of any factor relating to the health status of such members or individuals eligible for coverage through another member;

4. Does not make any health benefit plan available to any person who is not a member of the association;

5. Makes available health plans or health benefit plans that meet the requirements for health benefit plans set forth in subdivision B 3 of § 38.2-3420;

6. Operates as a nonprofit entity under § 501(c)(5) or 501(c)(6) of the Internal Revenue Code;

7. Has been in active existence for at least five years; and

8. Meets such additional requirements as may be imposed under the laws of the Commonwealth.

"Sponsoring association" includes any wholly owned subsidiary of a sponsoring association.

"State" means each of the several states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

"Waiting period" means, with respect to a group health plan or health insurance coverage provided by a health insurance issuer and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan. If an employee or dependent enrolls during a special enrollment period pursuant to subsections J through M of § 38.2-3432.3 or as a late enrollee, any period before such enrollment is not a waiting period.

C. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

1992, c. 800; 1993, cc. 148, 960; 1994, c. 303; 1996, c. 262; 1997, cc. 415, 807, 913; 1998, cc. 24, 26; 1999, cc. 789, 815, 1004; 2003, c. 645; 2013, cc. 709, 751; 2016, c. 1; 2018, c. 782; 2019, cc. 383, 450; 2022, cc. 404, 405.

§ 38.2-3432. Repealed.

Repealed by Acts 1997, cc. 807 and 913.

§ 38.2-3432.1. Renewability.

A. Every health insurance issuer that offers health insurance coverage in the group market in this Commonwealth shall renew or continue in force such coverage with respect to all insureds at the option of the employer except:

1. For nonpayment of the required premiums by the policyholder, or contract holder, or where the health insurance issuer has not received timely premium payments;

2. When the health insurance issuer is ceasing to offer coverage in the small group market in accordance with subdivisions 9 and 10;

3. For fraud or misrepresentation by the employer, with respect to their coverage;

4. With regard to coverage provided to an eligible employee, for fraud or misrepresentation by the employee with regard to his or her coverage;

5. For failure to comply with contribution and participation requirements defined by the health benefit plan;

6. For failure to comply with health benefit plan provisions that have been approved by the Commission;

7. When a health insurance issuer offers health insurance coverage in the group market through a network plan, and there is no longer an enrollee in connection with such plan who lives, resides, or works in the service area of the health insurance issuer (or in the area for which the health insurance issuer is authorized to do business) and, in the case of the group market, the health insurance issuer would deny enrollment with respect to such plan under the provisions of subdivision 9 or 10;

8. When health insurance coverage is made available in the group market only through one or more bona fide associations, the membership of an employer in the association (on the basis of which the coverage is provided) ceases but only if such coverage is terminated under this subdivision uniformly without regard to any health status related factor relating to any covered individual;

9. When a health insurance issuer decides to discontinue offering a particular type of group health insurance coverage in the group market in this Commonwealth, coverage of such type may be discontinued by the health insurance issuer in accordance with the laws of this Commonwealth in such market only if (i) the health insurance issuer provides notice to each plan sponsor provided coverage of this type in such market (and participants and beneficiaries covered under such coverage) of such discontinuation at least ninety days prior to the date of the discontinuation of such coverage; (ii) the health insurance issuer offers to each plan sponsor provided coverage of this type in such market, the option to purchase any other health insurance coverage currently being offered by the health insurance issuer to a group health plan in such market; and (iii) in exercising the option to discontinue coverage of this type and in offering the option of coverage under this subdivision, the health insurance issuer acts uniformly without regard to the claims experience of those sponsors or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage;

10. In any case in which a health insurance issuer elects to discontinue offering all health insurance coverage in the group market in this Commonwealth, health insurance coverage may be discontinued by the health insurance issuer only in accordance with the laws of this Commonwealth and if: (i) the health insurance issuer provides notice to the Commission and to each plan sponsor (and participants and beneficiaries covered under such coverage) of such discontinuation at least 180 days prior to the date of the discontinuation of such coverage; and (ii) all health insurance issued or delivered for issuance in this Commonwealth in such market (or markets) are discontinued and coverage under such health insurance coverage in such market (or markets) is not renewed;

11. In the case of a discontinuation under subdivision 10 of this subsection in a market, the health insurance issuer may not provide for the issuance of any health insurance coverage in the market and this Commonwealth during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed;

12. At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a product offered to a group health plan or health insurance issuer offering group health insurance coverage in the group market if, for coverage that is available in such market other than only through one or more bona fide associations, such modification is consistent with the laws of this Commonwealth and effective on a uniform basis among group health plans or health insurance issuers offering group health insurance coverage with that product; or

13. In applying this section in the case of health insurance coverage that is made available by a health insurance issuer in the group market to employers only through one or more associations, a reference to "plan sponsor" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such employer.

B. If coverage to the small employer market pursuant to this article ceases to be written, administered or otherwise provided, such coverage shall continue to be governed by this article with respect to business conducted under this article that was transacted prior to the effective date of termination and that remains in force.

1997, cc. 807, 913; 1998, c. 24; 2013, c. 751.

§ 38.2-3432.2. Availability.

A. If coverage is offered under this article in the small employer market:

1. Such coverage shall be offered and made available to all the eligible employees of every small employer and their dependents, including late enrollees, that apply for such coverage. No coverage may be offered only to certain eligible employees or their dependents and no employees or their dependents may be excluded or charged additional premiums because of health status; and

2. All products that are approved for sale in the small group market that the health insurance issuer is actively marketing must be offered to all small employers, and the health insurance issuer must accept any employer that applies for any of those products. This subdivision shall not apply to health insurance coverage or products offered by a health insurance issuer if such coverage or product is made available in the small group market only through one or more bona fide associations.

B. No coverage offered under this article shall exclude an employer based solely on the nature of the employer's business.

C. A health insurance issuer that offers health insurance coverage in a small group market through a network plan may:

1. Limit the employers that may apply for such coverage to those eligible individuals who live, work or reside in the service area for such network plan; and

2. Within the service area of such plan, deny such coverage to such employers if the health insurance issuer has demonstrated, if required, to the satisfaction of the Commission that:

a. It will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees; and

b. It is applying this subdivision uniformly to all employers without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factors relating to such employees and dependents.

3. A health insurance issuer upon denying health insurance coverage in any service area in accordance with subdivision D 1, may not offer coverage in the small group market within such service area for a period of 180 days after the date such coverage is denied.

D. A health insurance issuer may deny health insurance coverage in the small group market if the health insurance issuer has demonstrated, if required, to the satisfaction of the Commission that:

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

2. It is applying this subdivision uniformly to all employers in the small group market in the Commonwealth consistent with the laws of this Commonwealth and without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to such employees and dependents.

E. A health insurance issuer upon denying health insurance coverage in accordance with subsection D in the Commonwealth may not offer coverage in the small group market for a period of 180 days after the date such coverage is denied or until the health insurance issuer has demonstrated to the satisfaction of the Commission that the health insurance issuer has sufficient financial reserves to underwrite additional coverage, whichever is later.

F. Nothing in this article shall be construed to preclude a health insurance issuer from establishing employer contribution rules or group participation rules in connection with a health benefit plan offered in the small group market. As used in this article, the term "employer contribution rule" means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of eligible individuals and the term "group participation rule" means a requirement relating to the minimum number of eligible employees that must be enrolled in relation to a specified percentage or number of eligible employees. Any employer contribution rule or group participation rule shall be applied uniformly among small employers without reference to the size of the small employer group, health status of the small employer group, or other factors.

G. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

1997, cc. 807, 913; 1998, c. 24; 2000, c. 544; 2013, c. 751.

§ 38.2-3432.3. Limitation on preexisting condition exclusion period.

A. Subject to subsection B, a health insurer offering health insurance coverage may, with respect to a participant or beneficiary, impose a preexisting limitation only if:

1. For group health insurance coverage, such exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date;

2. For individual health insurance coverage, such exclusion relates to a condition that, during a 12-month period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek diagnosis, care, or treatment, or for which medical advice, diagnosis, care or treatment was recommended or received within 12 months immediately preceding the effective date of coverage;

3. Such exclusion extends for a period of not more than 12 months (or 12 months in the case of a late enrollee) after the enrollment date; and

4. The period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage, if any, applicable to the participant or beneficiary as of the enrollment date.

B. Exceptions:

1. Subject to subdivision 4, a health insurance issuer offering health insurance coverage may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage;

2. Subject to subdivision 4, a health insurance issuer offering health insurance coverage may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence shall not apply to coverage before the date of such adoption or placement for adoption;

3. A health insurance issuer offering health insurance coverage may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition, except in the case of individual health insurance coverage for a person who is not considered an eligible individual, as defined in § 38.2-3430.2, in which case the health insurance issuer may impose a preexisting condition exclusion for a pregnancy existing on the effective date of coverage;

4. Subdivisions 1 and 2 shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage; and

5. Subdivision A 4 shall not apply to health insurance coverage offered in the individual market on a "guarantee issue" basis without regard to health status including policies, contracts, certificates, or evidences of coverage issued through a bona fide association or to students through school sponsored programs at an institution of higher education unless the person is an eligible individual as defined in § 38.2-3430.2.

C. A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a health benefit plan, if, after such period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

D. For purposes of subdivision B 4 and subsection C, any period that an individual is in a waiting period for any coverage under a group health plan (or for group health insurance coverage) or is in an affiliation period shall not be taken into account in determining the continuous period under subsection C.

E. Methods of crediting coverage:

1. Except as otherwise provided under subdivision 2, a health insurance issuer offering group health coverage shall count a period of creditable coverage without regard to the specific benefits covered during the period;

2. A health insurance issuer offering group health insurance coverage may elect to count a period of creditable coverage based on coverage of benefits within each of several classes or categories of benefits rather than as provided under subdivision 1. Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election a health insurance issuer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category;

3. In the case of an election with respect to a group plan under subdivision 2 (whether or not health insurance coverage is provided in connection with such plan), the plan shall (i) prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made such election and (ii) include in such statements a description of the effect of this election; and

4. In the case of an election under subdivision 2 with respect to health insurance coverage offered by a health insurance issuer in the small or large group market, the health insurance issuer shall (i) prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the health insurance issuer has made such election and (ii) include in such statements a description of the effect of such election.

F. Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in subsection G or in such other manner as may be specified in federal regulations.

G. A health insurance issuer offering group health insurance coverage shall provide for certification of the period of creditable coverage:

1. At the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision;

2. In the case of an individual becoming covered under a COBRA continuation provision, at the time the individual ceases to be covered under such provision; and

3. At the request, or on behalf of, an individual made not later than 24 months after the date of cessation of the coverage described in subdivision 1 or 2, whichever is later. The certification under sub-

division 1 may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

H. To the extent that medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under this section if the health insurance issuer offering the coverage provides for such certification in accordance with this section.

I. In the case of an election described in subdivision E 2 by a health insurance issuer, if the health insurance issuer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under subsection F:

1. Upon request of such health insurance issuer, the entity which issued the certification provided by the individual shall promptly disclose to such requesting group insurance issuer information on coverage of classes and categories of health benefits available under such entity's plan or coverage; and

2. Such entity may charge the requesting health insurance issuer for the reasonable cost of disclosing such information.

J. A health insurance issuer offering group health insurance coverage shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

1. The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent;

2. The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or health insurance issuer (if applicable) required such a statement at such time and provided the employee with notice of such requirement (and the consequences of such requirement) at such time;

3. The employee's or dependent's coverage described in subdivision 1 (i) was under a COBRA continuation provision and the coverage under such provision was exhausted or (ii) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions towards such coverage were terminated; and

4. Under the terms of the plan, the employee requests such enrollment not later than 30 days after the date of exhaustion of coverage described in clause (i) of subdivision 3 or termination of coverage or employer contribution described in clause (ii) of subdivision 3.

K. If (i) a health insurance issuer makes coverage available with respect to a dependent of an individual; (ii) the individual is a participant under the plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period); and (iii) a person becomes such a dependent of the

individual through marriage, birth, or adoption or placement for adoption, the health insurance issuer shall provide for a dependent special enrollment period described in subsection L during which the person (or, if not otherwise enrolled, the individual) may also be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may also be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

L. A dependent special enrollment period under this subsection shall be a period of not less than 30 days and shall begin on the later of:

1. The date dependent coverage is made available; or

2. The date of the marriage, birth, or adoption or placement for adoption (as the case may be) described in subsection K.

M. If an individual seeks to enroll a dependent during the first 30 days of such a dependent special enrollment period, the coverage of the dependent shall become effective:

1. In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

2. In the case of a dependent's birth, as of the date of such birth; or

3. In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

N. A late enrollee may be excluded from coverage for up to 12 months or may have a preexisting condition limitation apply for up to 12 months; however, in no case shall a late enrollee be excluded from some or all coverage for more than 12 months. An eligible employee or dependent shall not be considered a late enrollee if all of the conditions set forth below in subdivisions 1 through 4 are met or one of the conditions set forth below in subdivision 5 or 6 is met:

1. The individual was covered under a public or private health benefit plan at the time the individual was eligible to enroll.

2. The individual certified at the time of initial enrollment that coverage under another health benefit plan was the reason for declining enrollment.

3. The individual has lost coverage under a public or private health benefit plan as a result of termination of employment or employment status eligibility, the termination of the other plan's entire group coverage, death of a spouse, or divorce.

4. The individual requests enrollment within 30 days after termination of coverage provided under a public or private health benefit plan.

5. The individual is employed by a small employer that offers multiple health benefit plans and the individual elects a different plan offered by that small employer during an open enrollment period.

6. A court has ordered that coverage be provided for a spouse or minor child under a covered employee's health benefit plan, the minor is eligible for coverage and is a dependent, and the request for enrollment is made within 30 days after issuance of such court order.

However, such individual may be considered a late enrollee for benefit riders or enhanced coverage levels not covered under the enrollee's prior plan.

O. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

1997, cc. 807, 913; 1998, c. 24; 1999, c. 1004; 2000, c. 136; 2003, c. 221; 2011, c. 882; 2013, cc. 136, 210.

§ 38.2-3433. Repealed.

Repealed by Acts 2013, c. 751, cl. 2, effective January 1, 2014.

§ 38.2-3434. Disclosure of information.

Any health insurance issuer offering health insurance coverage to a employer shall make a reasonable disclosure of the availability of information to such an employer, as part of its solicitation and sales materials, and upon request of such an employer, information concerning: (i) the provisions of such coverage concerning the health insurance issuer's right to change premium rates and the factors that may affect changes in premium rates; (ii) the provisions of such coverage relating to renewability of coverage; (iii) the provisions of such coverage relating to any preexisting condition exclusion; and (iv) the benefits and premiums available under all health insurance coverage for which the employer is qualified.

A health insurance issuer is not required under this article to disclose any information that is proprietary and trade secret information.

1997, cc. 807, 913.

§ 38.2-3435. Exclusions.

The provisions of this article shall not apply to:

1. Any health insurance issuer offering group health insurance coverage for any plan year if, on the first day of such plan year, such plan has less than two participants who are current employees; or

2. Any health insurance issuer offering group health insurance coverage for any of the excepted benefits.

1997, cc. 807, 913; 1998, c. 24.

§ 38.2-3436. Eligibility to enroll.

A. A health insurance issuer offering group health insurance coverage, may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on any of the health status-related factors.

B. The provisions of this section shall not be construed:

1. To require a group health insurance coverage to provide particular benefits other than those provided under the terms of such plan or coverage; or

2. To prevent a health insurance issuer offering group health insurance coverage from establishing limitations or restrictions on the amount, level, extent or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage rules for eligibility to enroll under a plan which includes rules defining any applicable waiting periods for such enrollment.

C. A health insurance issuer offering group health insurance coverage, may not require an individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

D. Nothing in subsection C shall be construed:

1. To restrict the amount that an employee may be charged for coverage under a group health plan or group health insurance coverage; or

2. To prevent a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

E. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

1997, cc. 807, 913; 2013, c. 751.

§ 38.2-3437. Rules used to determine group size.

A. All employers treated as a single employer under subsection (b), (c), (m), or (o) of § 414 of the Internal Revenue Code of 1986 (26 U.S.C. § 414) shall be treated as one employer.

B. In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large group employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

C. Any reference in this section to an employer shall include a reference to any predecessor of such employer.

1997, cc. 807, 913.

Article 6 - Federal Market Reforms

§ 38.2-3438. Definitions.

As used this article, unless the context requires a different meaning:

"Allowed amount" means the maximum portion of a billed charge a health carrier will pay, including any applicable cost-sharing requirements, for a covered service or item rendered by a participating provider or by a nonparticipating provider.

"Balance bill" means a bill sent to an enrollee by an out-of-network provider for health care services provided to the enrollee after the provider's billed amount is not fully reimbursed by the carrier, exclusive of applicable cost-sharing requirements.

"Child" means a son, daughter, stepchild, adopted child, including a child placed for adoption, foster child, or any other child eligible for coverage under the health benefit plan.

"Cost-sharing requirement" means an enrollee's deductible, copayment amount, or coinsurance rate.

"Covered benefits" or "benefits" means those health care services to which an individual is entitled under the terms of a health benefit plan.

"Covered person" means a policyholder, subscriber, enrollee, participant, or other individual covered by a health benefit plan.

"Dependent" means the spouse or child of an eligible employee, subject to the applicable terms of the policy, contract, or plan covering the eligible employee.

"Emergency medical condition" means, regardless of the final diagnosis rendered to a covered person, a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) serious jeopardy to the mental or physical health of the individual, (ii) danger of serious impairment to bodily functions, (iii) serious dysfunction of any bodily organ or part, or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

"Emergency services" means with respect to an emergency medical condition (i) a medical screening examination as required under § 1867 of the Social Security Act (42 U.S.C. § 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition and (ii) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under § 1867 of the Social Security Act (42 U.S.C. § 1395dd (e)(3)) to stabilize the patient.

"ERISA" means the Employee Retirement Income Security Act of 1974.

"Essential health benefits" include the following general categories and the items and services covered within the categories in accordance with regulations issued pursuant to the PPACA as of January 1, 2019: (i) ambulatory patient services; (ii) emergency services; (iii) hospitalization; (iv) laboratory services; (v) maternity and newborn care; (vi) mental health and substance abuse disorder services, including behavioral health treatment; (vii) pediatric services, including oral and vision care;

(viii) prescription drugs; (ix) preventive and wellness services and chronic disease management; and (x) rehabilitative and habilitative services and devices.

"Facility" means an institution providing health care related services or a health care setting, including hospitals and other licensed inpatient centers; ambulatory surgical or treatment centers; skilled nursing centers; residential treatment centers; diagnostic, laboratory, and imaging centers; and rehabilitation and other therapeutic health settings.

"Genetic information" means, with respect to an individual, information about: (i) the individual's genetic tests; (ii) the genetic tests of the individual's family members; (iii) the manifestation of a disease or disorder in family members of the individual; or (iv) any request for, or receipt of, genetic services, or participation in clinical research that includes genetic services, by the individual or any family member of the individual. "Genetic information" does not include information about the sex or age of any individual. As used in this definition, "family member" includes a first-degree, second-degree, third-degree, or fourth-degree relative of a covered person.

"Genetic services" means (i) a genetic test; (ii) genetic counseling, including obtaining, interpreting, or assessing genetic information; or (iii) genetic education.

"Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, if the analysis detects genotypes, mutations, or chromosomal changes. "Genetic test" does not include an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition.

"Grandfathered plan" means coverage provided by a health carrier to (i) a small employer on March 23, 2010, or (ii) an individual that was enrolled on March 23, 2010, including any extension of coverage to an individual who becomes a dependent of a grandfathered enrollee after March 23, 2010, for as long as such plan maintains that status in accordance with federal law.

"Group health insurance coverage" means health insurance coverage offered in connection with a group health benefit plan.

"Group health plan" means an employee welfare benefit plan as defined in § 3(1) of ERISA to the extent that the plan provides medical care within the meaning of § 733(a) of ERISA to employees, including both current and former employees, or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

"Health benefit plan" means a policy, contract, certificate, or agreement offered by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. "Health benefit plan" includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition. "Health benefit plan" does not include the "excepted benefits" as defined in § 38.2-3431.

"Health care professional" means a physician or other health care practitioner licensed, accredited, or certified to perform specified health care services consistent with state law.

"Health care provider" or "provider" means a health care professional or facility.

"Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

"Health carrier" means an entity subject to the insurance laws and regulations of the Commonwealth and subject to the jurisdiction of the Commission that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an insurer licensed to sell accident and sickness insurance, a health maintenance organization, a health services plan, or any other entity providing a plan of health insurance, health benefits, or health care services.

"Health maintenance organization" means a person licensed pursuant to Chapter 43 (§ 38.2-4300 et seq.).

"Health status-related factor" means any of the following factors: health status; medical condition, including physical and mental illnesses; claims experience; receipt of health care services; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; disability; or any other health status-related factor as determined by federal regulation.

"Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, which includes a health benefit plan provided to individuals through a trust arrangement, association, or other discretionary group that is not an employer plan, but does not include coverage defined as "excepted benefits" in § 38.2-3431 or short-term limited duration insurance. Student health insurance coverage shall be considered a type of individual health insurance coverage.

"Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

"In-network" or "participating" means a provider that has contracted with a carrier or a carrier's contractor or subcontractor to provide health care services to enrollees and be reimbursed by the carrier at a contracted rate as payment in full for the health care services, including applicable cost-sharing requirements.

"Managed care plan" means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with, or employed by the health carrier.

"Network" means the group of participating providers providing services to a managed care plan.

"Nonprofit data services organization" means the nonprofit organization with which the Commissioner of Health negotiates and enters into contracts or agreements for the compilation, storage, analysis, and evaluation of data submitted by data suppliers pursuant to § 32.1-276.4.

"Offer to pay" or "payment notification" means a claim that has been adjudicated and paid by a carrier or determined by a carrier to be payable by an enrollee to an out-of-network provider for services described in subsection A of § 38.2-3445.01.

"Open enrollment" means, with respect to individual health insurance coverage, the period of time during which any individual has the opportunity to apply for coverage under a health benefit plan offered by a health carrier and must be accepted for coverage under the plan without regard to a preexisting condition exclusion.

"Out-of-network" or "nonparticipating" means a provider that has not contracted with a carrier or a carrier's contractor or subcontractor to provide health care services to enrollees.

"Out-of-pocket maximum" or "maximum out-of-pocket" means the maximum amount an enrollee is required to pay in the form of cost-sharing requirements for covered benefits in a plan year, after which the carrier covers the entirety of the allowed amount of covered benefits under the contract of coverage.

"Participating health care professional" means a health care professional who, under contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payments, other than coinsurance, copayments, or deductibles, directly or indirectly from the health carrier.

"PPACA" means the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), and as it may be further amended.

"Preexisting condition exclusion" means a limitation or exclusion of benefits, including a denial of coverage, based on the fact that the condition was present before the effective date of coverage, or if the coverage is denied, the date of denial, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before the effective date of coverage. "Preexisting condition exclusion" also includes a condition identified as a result of a pre-enrollment questionnaire or physical examination given to an individual, or review of medical records relating to the pre-enrollment period.

"Premium" means all moneys paid by an employer, eligible employee, or covered person as a condition of coverage from a health carrier, including fees and other contributions associated with the health benefit plan.

"Preventive services" means (i) evidence-based items or services for which a rating of A or B is in effect in the recommendations of the U.S. Preventive Services Task Force with respect to the individual involved; (ii) immunizations for routine use in children, adolescents, and adults for which a recommendation of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is in effect with respect to the individual involved; (iii) evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration with respect to infants, children, and adolescents; and (iv)

evidence-informed preventive care and screenings recommended in comprehensive guidelines supported by the Health Resources and Services Administration with respect to women. For purposes of this definition, a recommendation of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention.

"Primary care health care professional" means a health care professional designated by a covered person to supervise, coordinate, or provide initial care or continuing care to the covered person and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

"Rescission" means a cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect. "Rescission" does not include:

1. A cancellation or discontinuance of coverage under a health benefit plan if the cancellation or discontinuance of coverage has only a prospective effect, or the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage; or

2. A cancellation or discontinuance of coverage when the health benefit plan covers active employees and, if applicable, dependents and those covered under continuation coverage provisions, if the employee pays no premiums for coverage after termination of employment and the cancellation or discontinuance of coverage is effective retroactively back to the date of termination of employment due to a delay in administrative recordkeeping.

"Stabilize" means with respect to an emergency medical condition, to provide such medical treatment as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to a pregnant woman, that the woman has delivered, including the placenta.

"Student health insurance coverage" means a type of individual health insurance coverage that is provided pursuant to a written agreement between an institution of higher education, as defined by the Higher Education Act of 1965, and a health carrier and provided to students enrolled in that institution of higher education and their dependents, and that does not make health insurance coverage available other than in connection with enrollment as a student, or as a dependent of a student, in the institution of higher education, and does not condition eligibility for health insurance coverage on any health status-related factor related to a student or a dependent of the student.

"Surgical or ancillary services" means professional services, including surgery, anesthesiology, pathology, radiology, or hospitalist services and laboratory services.

"Wellness program" means a program offered by an employer that is designed to promote health or prevent disease.

2011, c. 882; 2013, c. 751; 2014, c. 814; 2020, cc. 1080, 1081, 1160.

§ 38.2-3439. Dependent coverage for individuals to age 26.

A. Notwithstanding any provision of § 38.2-3500 or 38.2-3525, or any other section of this title to the contrary, a health carrier that makes available dependent coverage for a child shall make that coverage available for a child until such child attains the age of 26.

1. A health carrier shall not define "dependent" for purposes of eligibility for dependent coverage for a child other than in terms of a relationship between a child and the covered person.

2. A health carrier shall not deny or restrict coverage for a child who has not attained the age of 26 based on the presence or absence of the child's financial dependency on the covered person, residency with the covered person, marital status, student status, employment, or any combination of those factors.

3. Nothing in this section shall be construed to require a health carrier to make coverage available for the child of a child receiving dependent coverage, unless the grandparent becomes the legal guardian or adoptive parent of that grandchild.

4. The terms of coverage in a health benefit plan offered by a health carrier providing dependent coverage may not vary based on age except for children who are 26 years of age or older.

5. A health carrier shall not deny or restrict coverage of a child based on eligibility for other coverage.

B. Any child whose coverage ended, who was denied coverage, or who was not eligible for group or individual health insurance coverage under a health benefit plan because, under the terms of such plan, the availability of dependent coverage of a child ended before the attainment of the age of 26, shall be given written notice of the opportunity to enroll. The child shall be offered all the benefit packages available to, and shall not be required to pay more for coverage than, similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

1. The health carrier shall give such child written notice of the opportunity to enroll not later than the first day of the next plan year or policy year, and shall provide for an enrollment period that continues for at least 30 days.

2. The written notice of opportunity to enroll shall include a statement that a child is eligible to enroll in dependent coverage if coverage ended, coverage was denied, or the child was ineligible for coverage because the availability of dependent coverage for a child ended before the attainment of the age of 26.

a. The notice may be provided to the covered person on behalf of the covered person's child.

b. For group health insurance coverage, the notice may be included with other enrollment materials that the health carrier distributes to employees, provided the statement is prominent.

3. For any child of a covered person who enrolls, the coverage shall take effect not later than the first day of such plan year or policy year.

C. This section shall apply to any health carrier providing individual or group health insurance coverage, except that for plan years beginning before January 1, 2014, a grandfathered group health plan that makes available dependent coverage for a child may exclude a child who has not attained the age of 26 from coverage only if the child is eligible to enroll in an eligible employer-sponsored health benefit plan, as defined in § 5000A(f)(2) of the Internal Revenue Code, other than the group health plan of a parent.

For plan years beginning on or after January 1, 2014, any grandfathered plan shall comply with the requirements of subsections A and B.

2011, c. 882; 2013, c. 751.

§ 38.2-3440. Lifetime and annual limits.

A. Notwithstanding any provision of § 38.2-3406.1, 38.2-3406.2, or 38.2-3418.5, or any other section of this title to the contrary, a health carrier offering group or individual health insurance coverage shall not establish a lifetime limit on the dollar amount of essential health benefits for any covered person.

B. A health carrier shall not establish any annual limit on the dollar amount of essential health benefits for any covered person.

C. The provisions of this section shall not prevent a health carrier from placing annual or lifetime dollar limits for any covered person on specific covered benefits that are not essential health benefits to the extent that such limits are otherwise permitted under applicable federal or state law.

D. This section shall apply to any health carrier providing individual or group health insurance coverage, except that the prohibition and limits on annual limits shall not apply to a grandfathered plan providing individual health insurance coverage.

2011, c. 882; 2013, c. 751.

§ 38.2-3441. Rescissions.

A. Notwithstanding any provision of § 38.2-508.5 or any other section of this title to the contrary, a health carrier shall not rescind coverage under a health benefit plan after an individual is covered under the plan unless the individual or a person seeking coverage on behalf of the individual performs an act, practice, or omission that constitutes fraud, or the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan.

B. A health carrier shall provide at least 30 days' advance written notice or electronic notice to any covered person who would be affected by the proposed rescission of coverage before coverage under the plan may be rescinded, regardless of whether the rescission applies to the entire group or only to an individual within the group. Such notice shall at a minimum contain:

1. Clear identification of the alleged fraudulent act, practice, or omission or the intentional misrepresentation of material fact;

2. An explanation as to why the act, practice, or omission was fraudulent or was an intentional misrepresentation of a material fact;

3. Notice that the covered person or the covered person's authorized representative, prior to the date the advance notice of the proposed rescission ends, may immediately file an internal appeal to request a reconsideration of the rescission;

4. A description of the health carrier's internal appeal process for rescissions, including any time limits applicable to those procedures; and

5. The date when the advance notice ends and the date back to which the coverage will be rescinded.

C. The provisions of this section apply regardless of any applicable contestability period.

D. This section shall apply to any health carrier providing individual or group health insurance coverage, including any grandfathered plan.

2011, c. 882.

§ 38.2-3442. Preventive services.

A. Notwithstanding any provision of § 38.2-3406.1 or 38.2-3411.1 or any other section of this title to the contrary, a health carrier shall provide coverage for preventive services and shall not impose any cost-sharing requirements such as a copayment, coinsurance, or deductible.

B. A health carrier shall provide coverage for any items or services under the most current recommendations and guidelines within the scope of preventive services as required by the PPACA as in effect on January 1, 2019.

C. 1. A health carrier may impose cost-sharing requirements with respect to an office visit if an item or service is billed separately or is tracked as individual encounter data separately from the office visit.

2. A health carrier shall not impose cost-sharing requirements with respect to an office visit if an item or service is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is the delivery of the item or service.

3. A health carrier may impose cost-sharing requirements with respect to an office visit if an item or service is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is not the delivery of the item or service.

D. Nothing in this section shall preclude a health carrier that has a network of providers from imposing cost-sharing requirements for items or services that are delivered by an out-of-network provider.

E. This section shall apply to any health carrier providing individual or group health insurance coverage, except for any grandfathered plan.

2011, c. 882; 2013, c. 751; 2020, c. 1160.

§ 38.2-3443. Choice of a health care professional.

A. Notwithstanding any provision of § 38.2-3407.11, 38.2-4312.3, or any other section of this title to the contrary, if a health carrier providing individual or group health insurance coverage requires or provides for the designation by a covered person of a participating primary care health care professional, the health carrier shall permit each covered person to designate any participating primary

care health care professional who is available to accept the covered person. For a child, a participating health care professional who specializes in pediatrics and is available to accept the child may be designated as the child's primary care health care professional.

B. If a health carrier provides for obstetrical or gynecological care and requires the designation by a covered person of a participating primary care health care professional, the health carrier shall not require any person's prior authorization or referral in the case of a female covered person who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. The provision of obstetrical and gynecological care, and the ordering of related items and services, shall be treated the same as an authorization from a primary care health care professional.

C. A health carrier shall provide notice to a covered person of the terms and conditions of the plan related to the designation of a participating health care professional.

1. Such notice shall be included whenever the health carrier provides a covered person with a summary plan description, policy, certificate, or contract of health insurance.

2. The health carrier may use the model language found in 45 C.F.R. § 147.138(a)(4)(iii) for such notice.

D. This section shall apply to any health carrier providing individual or group health insurance coverage, except for any grandfathered plan.

2011, c. 882.

§ 38.2-3444. Preexisting condition exclusions.

A. Notwithstanding any provision of § 38.2-508.1, 38.2-3432.3, 38.2-3438, 38.2-3503, 38.2-3520, or any other section of this title to the contrary, a health carrier providing individual or group health insurance coverage shall not limit or exclude coverage for an individual by imposing a preexisting condition exclusion on that individual.

B. A health carrier that offers individual health insurance coverage may offer coverage continuously throughout the year or during an open enrollment period.

C. This section shall apply to any health carrier providing individual or group health insurance coverage, including a grandfathered plan for group health insurance coverage, but not including a grandfathered plan for individual health insurance coverage.

2011, c. 882; 2013, cc. 136, 210, 751.

§ 38.2-3445. Patient access to emergency services.

Notwithstanding any provision of § 38.2-3407.11, 38.2-4312.3, or any other section of this title to the contrary, if a health carrier providing individual or group health insurance coverage provides any benefits with respect to services in an emergency department of a hospital, the health carrier shall provide coverage for emergency services:

1. Without the need for any prior authorization determination, regardless of whether the emergency services are provided on an in-network or out-of-network basis;

2. Without regard to the final diagnosis rendered to the covered person or whether the health care provider furnishing the emergency services is a participating health care provider with respect to such services;

3. If such services are provided out-of-network, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to such services received from an in-network provider;

4. If such services are provided out-of-network, the health carrier shall pay the out-of-network provider in accordance with § 38.2-3445.01 less any cost-sharing requirement. Any such cost-sharing requirement shall not exceed the cost-sharing requirement that would apply if such services were provided in-network as provided in § 38.2-3445.01; and

5. Without regard to any term or condition of such coverage other than the exclusion of or coordination of benefits or an affiliation or waiting period.

2011, c. 882; 2020, cc. 1080, 1081.

§ 38.2-3445.01. Balance billing for certain services; prohibited.

A. No out-of-network provider shall balance bill an enrollee for (i) emergency services provided to an enrollee or (ii) nonemergency services provided to an enrollee at an in-network facility if the nonemergency services involve surgical or ancillary services provided by an out-of-network provider.

B. An enrollee that receives services described in subsection A satisfies his obligation to pay for the services if he pays the in-network cost-sharing requirement specified in the enrollee's or applicable group health plan contract. The enrollee's obligation shall be determined using the carrier's median in-network contracted rate for the same or similar service in the same or similar geographical area. The carrier shall provide an explanation of benefits to the enrollee and the out-of-network provider that reflects the cost-sharing requirement determined under this subsection. The obligation of an enrollee in a health benefit plan that uses no median in-network contracted rate for the services provided shall be determined as provided in § 38.2-3407.3.

C. The health carrier and the out-of-network provider shall ensure that the enrollee incurs no greater cost than the amount determined under subsection B and shall not balance bill or otherwise attempt to collect from the enrollee any amount greater than such amount. Additional amounts owed to health care providers through good faith negotiations or arbitration shall be the sole responsibility of the carrier unless the carrier is prohibited from providing the additional benefits under 26 U.S.C. § 223(c)(2) or any other federal or state law. Nothing in this subsection shall preclude a provider from collecting a past due balance on a cost-sharing requirement with interest.

D. The health carrier shall treat any cost-sharing requirement determined under subsection B in the same manner as the cost-sharing requirement for health care services provided by an in-network

provider and shall apply any cost-sharing amount paid by the enrollee for such services toward the in-network maximum out-of-pocket payment obligation.

E. If the enrollee pays the out-of-network provider an amount that exceeds the amount determined under subsection B, the provider shall refund the excess amount to the enrollee within 30 business days of receipt. The provider shall pay the enrollee interest computed daily at the legal rate of interest stated in § 6.2-301 beginning on the first calendar day after the 30 business days for any unrefunded payments.

F. The amount paid to an out-of-network provider for health care services described in subsection A shall be a commercially reasonable amount, based on payments for the same or similar services provided in a similar geographic area. Within 30 calendar days of receipt of a clean claim from an out-of-network provider, the carrier shall offer to pay the provider a commercially reasonable amount. If the out-of-network provider disputes the carrier's payment, the provider shall notify the carrier no later than 30 calendar days after receipt of payment or payment notification from the carrier. If the out-of-network provider disputes the carrier's initial offer, the carrier and provider shall have 30 calendar days from the initial offer to negotiate in good faith. If the carrier and provider do not agree to a commercially reasonable payment amount within 30 calendar days and either party chooses to pursue further action to resolve the dispute, the dispute shall be resolved through arbitration as provided in § 38.2-3445.02.

G. The carrier shall make payments for services described in subsection A directly to the provider.

H. Carriers shall make available through electronic and other methods of communication generally used by a provider to verify enrollee eligibility and benefits information regarding whether an enrollee's health plan is subject to the requirements of this section.

2020, cc. 1080, 1081.

§ 38.2-3445.02. Arbitration.

A. If good faith negotiation, as described in § 38.2-3445.01, does not result in resolution of the dispute, and the carrier or the out-of-network provider chooses to pursue further action to resolve the dispute, the carrier or out-of-network provider shall initiate arbitration to determine a commercially reasonable payment amount. To initiate arbitration, the carrier or provider shall provide written notification to the Commission and the noninitiating party no later than 10 calendar days following completion of the period of good faith negotiation provided in § 38.2-3445.01. Such notification shall state the initiating party's final offer. No later than 30 calendar days following receipt of the notification, the noninitiating party shall provide its final offer to the initiating party. The parties may reach an agreement on reimbursement during this time and before the arbitration proceeding.

B. The parties shall be permitted to bundle claims for arbitration. Multiple claims may be addressed in a single arbitration proceeding if the claims at issue (i) involve identical carrier and provider parties, (ii) involve claims with the same or related current procedural terminology codes relevant to a particular procedure, and (iii) occur within a period of two months of one another.

C. Within seven calendar days of receipt of notification from the initiating party, the Commission shall provide the parties with a list of approved arbitrators or entities that provide arbitrations. The arbitrators on the list shall not have a conflict of interest with the parties and shall be trained and have experience and be selected by the Commission as set out in the standards established by the Commission through regulation. The parties may agree on an arbitrator from the list provided by the Commission. If the parties do not agree on an arbitrator, they shall notify the Commission, and the Commission shall provide the parties with the names of five arbitrators from the list. Each party may veto up to two of the five named arbitrators. If one arbitrator remains, that arbitrator shall be the chosen arbitrator. If more than one arbitrator remains, the Commission shall choose the arbitrator from the remaining arbitrators. The parties and the Commission shall complete this process within 20 calendar days of receipt of the original list from the Commission.

D. No later than 30 days after final selection of the arbitrator pursuant to subsection C, each party shall provide written submissions in support of its position to the arbitrator. The initiating party shall include in its written submission the evidence and methodology for asserting that the amount proposed to be paid is or is not commercially reasonable. A party that fails to make timely written submissions under this subsection without good cause shown shall be considered to be in default, and the arbitrator shall require the defaulting party to pay the final offer of the nondefaulting party and may require the defaulting party to pay the arbitrator's fixed fee. Written submissions required by this subsection may be submitted electronically.

E. No later than 30 calendar days after the receipt of the parties' written submissions, the arbitrator shall (i) issue a written decision requiring payment of the final offer amount of either the initiating or noninitiating party, (ii) notify the parties of the decision, and (iii) provide the decision and the information described in subsection I to the Commission.

F. In reviewing the submissions of the parties and making a decision requiring payment of the final offer amount of either the initiating or noninitiating party, the arbitrator shall consider the following factors:

1. The evidence and methodology submitted by the parties to assert that their final offer amount is reasonable; and

2. Patient characteristics and the circumstances and complexity of the case, including time and place of service and type of facility, that are not already reflected in the provider's billing code for the service.

The arbitrator may also consider other information that a party believes is relevant to the required factors included in this subsection or other information requested by the arbitrator and information provided by the parties that is relevant to such request, including data sets developed pursuant to § 38.2-3445.03. The arbitrator shall not require extrinsic evidence of authenticity for admitting such data sets.

G. The Commission shall establish a schedule of fixed fees for the costs of arbitration. Except as provided in subsection D, such fees shall be divided equally among the parties to the arbitration. The

enrollee shall not be liable for any of the costs of arbitration and shall not be required to participate in the arbitration process as a witness or otherwise.

H. Within 10 business days of a party notifying the Commission and the noninitiating party of intent to initiate arbitrations, both parties shall agree to and execute a nondisclosure agreement. The nondisclosure agreement shall not preclude the arbitrator from submitting the arbitrator's decision to the Commission or impede the Commission's duty to prepare the annual report required by subsection I.

I. The Commission shall prepare an annual report summarizing the dispute resolution information provided by arbitrators, including information related to the matters decided through arbitration as well as the following information for each dispute resolved through arbitration: the name of the carrier, the name of the health care provider, the health care provider's employer or the business entity in which the provider has an ownership interest, the health care facility where the services were provided, and the type of health care services at issues. The Commission shall post the report on the Bureau's website and submit it to the Chairs of the House Committee on Labor and Commerce and Committee on Appropriations and the Senate Committee on Commerce and Labor and Committee on Finance and Appropriations annually by July 1. The provisions of this subsection shall expire on July 1, 2025.

J. The Commission shall establish an appeals process for a party to appeal to the Commission an arbitrator's decision on the grounds that (i) the decision was substantially influenced by corruption, fraud, or other undue means; (ii) there was evident partiality, corruption, or misconduct prejudicing the rights of any party; (iii) the arbitrator exceeded his powers; or (iv) the arbitrator conducted the proceeding contrary to the provisions of this section and Commission regulations, in such a way as to materially prejudice the rights of the party.

K. The provisions of the Uniform Arbitration Act, Article 2 (§ 8.01-581.01 et seq.) of Chapter 21 of Title 8.01, shall not apply to arbitration proceedings initiated pursuant to this section.

2020, cc. 1080, 1081.

§ 38.2-3445.03. Data sets for determining commercially reasonable payments.

A. The Commission shall contract with the nonprofit data services organization to establish a data set and business process to provide health carriers, health care providers, and arbitrators with data to assist in determining commercially reasonable payments and resolving payment disputes for out-of-network medical services rendered by health care providers.

B. Such data set and business protocols shall be (i) developed in collaboration with health carriers and health care providers and (ii) reviewed by the advisory committee established pursuant to § 32.1-276.7:1.

C. The data set shall provide the amounts for the services described in subsection A of § 38.2-3445.01. The data used to calculate the median in-network and out-of-network allowed amounts and the median billed charge amounts by geographic area, for the same or similar services, shall be drawn from commercial health plan claims and shall not include claims paid under Medicare or

Medicaid or other claims paid on other than a fee-for-service basis. The 2020 data set shall be based upon the most recently available full calendar year of claims data. The data set for each subsequent year shall be adjusted by applying the Consumer Price Index-Medical Component as published by the Bureau of Labor Statistics of the U.S. Department of Labor to the previous year's data set.

2020, cc. 1080, 1081.

§ 38.2-3445.04. Transparency.

A. The Commission, in consultation with health carriers, health care providers, and consumers, shall develop standard template language for a notice of consumer rights notifying consumers of the following:

1. The prohibition against balance billing is applicable to health benefit plans issued by health carriers in Virginia and self-funded group health plans issued by entities that elect to participate pursuant to § 38.2-3445.01.

2. Consumers cannot be balance billed for the health care services described in § 38.2-3445.01 and will receive the protections provided for in § 38.2-3445.01.

3. Consumers may be balance billed for health care services under circumstances other than those described in subsection A of § 38.2-3445.01 or if they are enrolled in a health plan to which the provisions of § 38.2-3445.01 do not apply and steps to take if the consumer is balance billed.

4. Consumers may contact the Commission if they believe they have been balance billed in violation of § 38.2-3445.01.

5. The relevant contact information for the Commission.

B. The Commission shall determine, by regulation, when and in what format health carriers, health care providers, and health care facilities shall provide consumers with the notice required by this section.

C. A health care provider shall post the following information on its website, if one is available, or, if one is not available, provide to a consumer upon written or oral request:

1. The listing of the carrier health plan provider networks with which the provider contracts or with which the facility is an in-network provider; and

2. The notice of consumer rights required by subsection A.

Posting or otherwise providing the information required in this subsection shall not relieve a health care provider of its obligation to comply with the provisions of § 38.2-3445.01.

D. Not less than 30 days prior to executing a contract with a carrier, a health care facility shall provide the carrier with a list of the nonemployed providers or provider groups contracted to provide surgical or ancillary services at the facility. The facility shall notify the carrier within 30 days of a removal from or addition to such list and shall provide an updated list of nonemployed providers and provider groups within 14 calendar days of a request for an updated list by a carrier.

E. An in-network provider shall submit accurate information to a carrier regarding the provider's network status in a timely manner, consistent with the terms of the contract between the provider and the carrier.

F. A carrier shall update its website and provider directory no later than 30 days after the addition or termination of a provider.

G. A carrier shall provide an enrollee with (i) a clear description of the health plan's out-of-network health benefits, (ii) the notice of consumer rights required by subsection A, and (iii) notification that if the enrollee receives services from an out-of-network-provider, under circumstances other than those described in subsection A of § 38.2-3445.01, the enrollee shall have the financial responsibility for the applicable services provided outside the health plan's network in excess of applicable cost-sharing amounts and that the enrollee may be responsible for any costs in excess of those allowed by the health plan.

2020, cc. 1080, 1081.

§ 38.2-3445.05. Enforcement.

A. If the Commission has cause to believe that any health care provider has engaged in a pattern of potential violations of § 38.2-3445.01 with no corrective action, the Commission may submit information to the Board of Medicine or the Commissioner of Health for action. Prior to such submission, the Commission may provide the provider with an opportunity to cure the alleged violations or provide an explanation as to why the actions in question were not violations of § 38.2-3445.01.

B. If any health care provider has engaged in a pattern of potential violations of § 38.2-3445.01 with no corrective action, the Board of Medicine or the Commissioner of Health may levy a fine or cost recovery upon the health care provider and take other action as permitted under the authority of the Board of Medicine or Commissioner of Health. Upon completion of its review of any potential violation submitted by the Commission or initiated directly by an enrollee, the Board of Medicine or Commissioner of Health shall notify the Commission of the results of the review, including whether the violation was substantiated and any enforcement action taken as a result of a finding of a substantiated violation.

C. If a carrier has engaged in a pattern of substantiated violations of any provision of § 38.2-3445.01, the Commission may levy a fine or apply remedies authorized pursuant to Chapter 2 (§ 38.2-200 et seq.).

D. No carrier or provider shall initiate arbitration pursuant to § 38.2-3445.02 with such frequency as to indicate a general business practice.

2020, cc. 1080, 1081.

§ 38.2-3445.06. Applicability of certain sections.

A. Except as provided in this section, the provisions of §§ 38.2-3445 through 38.2-3445.05 shall not apply to an entity providing or administering an employee welfare benefit plan, as defined in § 3(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002(1), that is self-insured or

self-funded with respect to such plan. Such an entity may elect to be subject to the provisions of §§ 38.2-3445 through 38.2-3445.06 in the same manner as applied to a health carrier by providing notice to the Commission annually, in a form and manner prescribed by the Commission, attesting to the plan's participation and agreeing to be bound by the provisions of §§ 38.2-3445 through 38.2-3445.06. Such entity shall amend the plan, policies, contracts, and other documents to reflect such election. In addition, the entity that elects to opt in pursuant to this section shall file current plan documentation confirming that the plan accepts the obligations of §§ 38.2-3445 through 38.2-3445.06 and attests that any amended plan documents will be filed with the Commission before the effective date of such amendments. The Commission shall post on its website a list of entities, including relevant plan information, that have elected to be subject to the provisions of §§ 38.2-3445 through 38.2-3445.06. The Commission shall update such list at least once per quarter.

B. The provisions of §§ 38.2-3445.01 and 38.2-3445.02 shall not apply to services when the provider's fees are subject to schedules or other monetary limitations under any other law, including the Virginia Workers' Compensation Act, and such sections shall not preempt any such law.

C. The provisions of §§ 38.2-3445 through 38.2-3445.05 shall apply to health coverage insurance offered to state employees pursuant to § 2.2-2818 and may apply to health insurance coverage offered to employees of local governments, local officers, teachers, and retirees, and the dependents of such employees, officers, teachers, and retirees pursuant to § 2.2-1204.

D. Except for its facilitation of arbitration pursuant to § 38.2-3445.02 and its role in any appeals process established pursuant to subsection J of § 38.2-3445.02, the Commission shall have no jurisdiction to resolve disputes arising out of § 38.2-3445.01.

E. Except for in a provider contract between a carrier and an in-network provider, no person shall waive, be required to waive, or require another person to waive the provisions of §§ 38.2-3445 through 38.2-3445.05.

2020, cc. 1080, 1081.

§ 38.2-3445.07. Rules and regulations.

Pursuant to § 38.2-223, the Commission may adopt rules and regulations to implement and administer the provisions of §§ 38.2-3445 through 38.2-3445.06, including rules and regulations governing the arbitration process established in § 38.2-3445.02.

2020, cc. 1080, 1081.

§ 38.2-3445.1. Repealed.

Repealed by Acts 2020, cc. 1080 and 1081, cl. 2, effective January 1, 2021.

§ 38.2-3445.2. Out-of-network claims; reporting requirements.

A. Any health carrier providing individual or group health insurance coverage shall report to the State Corporation Commission's Bureau of Insurance (the Bureau) no later than September 1, 2020, the number of out-of-network claims for emergency services paid pursuant to subdivision A 4 of § 38.2-

3445 in fiscal years 2017, 2018, and 2019. Thereafter, any health carrier providing individual or group health insurance coverage shall report to the Bureau, no later than November 1 of each year, the number of out-of-network claims for services described in subsection A of § 38.2-3445.01 for the previous fiscal year.

B. Any health carrier providing individual or group health insurance coverage shall report to the Bureau no later than September 1 of each year the number and identity of health care providers in the health carrier's network of emergency services providers and surgical or ancillary providers whose participation in the network was terminated by either the health carrier or the health care provider in the previous year and, if applicable, whether participation was subsequently reinstated in the same year. For any terminated health care providers identified by the health carrier in such report, the health carrier shall include (i) a description of the health care provider's or health carrier's stated reason for terminating participation and (ii) a description of the nature and extent of differences in payment levels for emergency services and surgical or ancillary services prior to termination and after reinstatement, if applicable, including a determination of whether such payment levels after reinstatement were higher or lower than those applied prior to termination.

C. The Bureau shall notify the Chairmen of the House Committee on Labor and Commerce and the Senate Committee on Commerce and Labor of the information reported to the Bureau pursuant to subsections A and B and other information specified in this subsection no later than December 1, 2021, and annually thereafter. Such notice shall include (i) the number of out-of-network claims for services described in subsection A of § 38.2-3445.01 for the previous fiscal year; (ii) the number and identity of health care providers in the health carrier's network of emergency services providers and surgical or ancillary services providers whose participation in the network was terminated by the health carrier or the health care provider in the previous year and whether participation was subsequently reinstated in the same year; (iii) a summary of the stated reasons for terminating participation; (iv) a summary of the nature and extent of differences in payment levels prior to termination and after reinstatement, if applicable, including a determination of whether such payment levels after reinstatement were higher or lower than those applied prior to termination; (v) an assessment by the Bureau of the potential impact of any changes in network participation or payment levels for emergency services on health insurance premiums in the time period to which the report applies; and (vi) the number and type of claims resolved by arbitration and aggregate information on the disposition of those arbitrations, including in which category group's favor the dispute was resolved, and aggregate information on the variation between the initial payment and final settlement amounts.

2020, cc. 1080, 1081.

§ 38.2-3446. Applicability of federal law.

A. The provisions of Title I of the PPACA shall apply to any health carrier that delivers or issues for delivery individual or group health insurance coverage in the Commonwealth.

B. The Commission shall implement and enforce applicable provisions of such federal law in accordance with the provisions of this title.

2011, c. 882.

§ 38.2-3447. (Effective until January 1, 2026) Restrictions relating to premium rates.

A. Notwithstanding any provision of § 38.2-3432.2, 38.2-3501, 38.2-4306, or any other section of this title to the contrary, a health carrier offering a health benefit plan providing individual or small group health insurance coverage shall develop its premium rates based on the following:

1. Whether the health benefit plan covers an individual or family;

2. Rating areas, as may be established by the Commission; and

3. Age, except that the rate shall not vary by more than 3 to 1 for adults.

B. A premium rate shall not vary with respect to any particular health benefit plan by any other factor not described in subsection A.

C. Rating variations for family coverage shall be applied based on the portion of the premium that is attributable to each family member covered under the health benefit plan.

D. If the proposed area rate factors set forth in a rate filing for individual or small group health insurance coverage by a health carrier for a rating area exceed by more than 15 percent the weighted average of the proposed area rate factors among all rating areas in which the health carrier offers health benefit plans in that market, then:

1. The health carrier's rate filing shall include in a publicly available and unredacted form:

a. A comparison of the area rate factor for individual and small group health benefit plans that utilize the same provider network and provider reimbursement levels of the health benefit plans that are subject to the filing;

b. A detailed disclosure of the area rate factor methodology, which disclosure shall include any third-party resources or representations from a person other than the signing actuary, on which the signing actuary relied, provided that disclosure of third-party resources shall address that the source data only reflects differences in unit cost and provider practice patterns; and

c. To the extent that the health carrier is deriving any area rate factor from experience data, by rating area for the experience period used:

(1) The (i) total enrollment; (ii) total premiums; (iii) allowed claims; (iv) incurred claims excluding anticipated or, if available, actual risk adjustment payments or receipts; (v) incurred claims including anticipated or, if available, actual risk adjustment payments or receipts; and (vi) loss ratio for each of their rating areas in that market; and

(2) Aggregated incurred claims for any health system exceeding 30 percent of total incurred claims for that rating area in that market.

2. The Commission shall hold a public hearing on the proposed premium rates prior to the approval of the rate filing.

3. The Commission shall not approve the proposed rate filing if (i) a variance in area rate factors, indexed to the same rating region for both the individual and small group markets, of 15 percent or more exists between health benefit plans a carrier intends to offer in the individual market and health benefit plans intended to be offered in the small group market, when those plans utilize the same provider network and provider reimbursement levels and (ii) the methodologies used to calculate the area rate factors are different between the two markets.

E. Beginning for plan year 2020, a health carrier with an approved rate filing that contains at least one area rate factor that exceeds by more than 25 percent the weighted average of the area rate factors among all rating areas in a market in which the health carrier offers individual or small group health insurance coverage shall file with the Commission for each calendar quarter during that plan year a report that provides, for each rating area within the market in which the health carrier operates, the plan's (i) enrollment; (ii) total premiums; (iii) allowed claims; (iv) incurred claims excluding anticipated or, if available, actual risk adjustment payments or receipts; (v) incurred claims including anticipated or, if available, actual risk adjustment payments or receipts; (vi) loss ratio; and (vii) aggregate incurred claims, for each health system exceeding 25 percent of total incurred claims for that rating area. The health carrier shall make each such quarterly report publicly available, without redaction, not later than 45 days after the end of the calendar quarter.

F. As used in subsections D and E:

"Allowed claims" means the amount of claims of a covered person for health care services that are owed pursuant to the terms of the covered person's health benefits plan, including payment made by the covered person's health carrier, and cost-sharing obligations owed by or on behalf of the covered person.

"Health system" means an organization that consists of either (i) at least one hospital plus at least one group of physicians or (ii) more than one group of physicians.

"Incurred claims" means allowed claims less copayments, deductible amounts, and other cost-sharing obligations owed by or on behalf of a covered person.

"Methodologies," when referring to the calculation of area rate factors, includes (i) the types of inputs, including experience period claims data, third-party database, other sources of data, and (ii) the series of calculations that are used to derive area rate factors. This definition shall not preclude a health carrier from calculating area rate factors for rates for the individual market, based on the cost and care delivery practices associated with the providers expected to be utilized by covered persons that reside in a given rating area, while calculating area rate factors for rates for the small group market, based on those providers that are expected to be utilized by individuals employed by small employers that are located in the rating area without regard to where the covered persons reside.

"Provider" means a health care provider, as defined in § 38.2-3438, that is affiliated or in-network with a health carrier.

"Weighted average," when referring to area rate factors, means the mean of the area rate factors when weighted based on the projected number of covered persons distributed by rating area.

2013, c. 751; 2019, cc. 439, 440; 2023, cc. 682, 683.

§ 38.2-3447. (Effective January 1, 2026) Restrictions relating to premium rates.

A. Notwithstanding any provision of § 38.2-3432.2, 38.2-3501, 38.2-4306, or any other section of this title to the contrary, a health carrier offering a health benefit plan providing individual or small group health insurance coverage shall develop its premium rates based on the following:

1. Whether the health benefit plan covers an individual or family;

2. Rating areas, as may be established by the Commission;

3. Age, except that the rate shall not vary by more than 3 to 1 for adults; and

4. Tobacco use, except that the rate shall not vary by more than 1.5 to 1.

B. A premium rate shall not vary with respect to any particular health benefit plan by any other factor not described in subsection A.

C. Rating variations for family coverage shall be applied based on the portion of the premium that is attributable to each family member covered under the health benefit plan.

D. If the proposed area rate factors set forth in a rate filing for individual or small group health insurance coverage by a health carrier for a rating area exceed by more than 15 percent the weighted average of the proposed area rate factors among all rating areas in which the health carrier offers health benefit plans in that market, then:

1. The health carrier's rate filing shall include in a publicly available and unredacted form:

a. A comparison of the area rate factor for individual and small group health benefit plans that utilize the same provider network and provider reimbursement levels of the health benefit plans that are subject to the filing;

b. A detailed disclosure of the area rate factor methodology, which disclosure shall include any third-party resources or representations from a person other than the signing actuary, on which the signing actuary relied, provided that disclosure of third-party resources shall address that the source data only reflects differences in unit cost and provider practice patterns; and

c. To the extent that the health carrier is deriving any area rate factor from experience data, by rating area for the experience period used:

(1) The (i) total enrollment; (ii) total premiums; (iii) allowed claims; (iv) incurred claims excluding anticipated or, if available, actual risk adjustment payments or receipts; (v) incurred claims including anti-

cipated or, if available, actual risk adjustment payments or receipts; and (vi) loss ratio for each of their rating areas in that market; and

(2) Aggregated incurred claims for any health system exceeding 30 percent of total incurred claims for that rating area in that market.

2. The Commission shall hold a public hearing on the proposed premium rates prior to the approval of the rate filing.

3. The Commission shall not approve the proposed rate filing if (i) a variance in area rate factors, indexed to the same rating region for both the individual and small group markets, of 15 percent or more exists between health benefit plans a carrier intends to offer in the individual market and health benefit plans intended to be offered in the small group market, when those plans utilize the same provider network and provider reimbursement levels and (ii) the methodologies used to calculate the area rate factors are different between the two markets.

E. Beginning for plan year 2020, a health carrier with an approved rate filing that contains at least one area rate factor that exceeds by more than 25 percent the weighted average of the area rate factors among all rating areas in a market in which the health carrier offers individual or small group health insurance coverage shall file with the Commission for each calendar quarter during that plan year a report that provides, for each rating area within the market in which the health carrier operates, the plan's (i) enrollment; (ii) total premiums; (iii) allowed claims; (iv) incurred claims excluding anticipated or, if available, actual risk adjustment payments or receipts; (v) incurred claims including anticipated or, if available, actual risk adjustment payments or receipts; (vi) loss ratio; and (vii) aggregate incurred claims, for each health system exceeding 25 percent of total incurred claims for that rating area. The health carrier shall make each such quarterly report publicly available, without redaction, not later than 45 days after the end of the calendar quarter.

F. As used in subdivisions D and E:

"Allowed claims" means the amount of claims of a covered person for health care services that are owed pursuant to the terms of the covered person's health benefits plan, including payment made by the covered person's health carrier, and cost-sharing obligations owed by or on behalf of the covered person.

"Health system" means an organization that consists of either (i) at least one hospital plus at least one group of physicians or (ii) more than one group of physicians.

"Incurred claims" means allowed claims less copayments, deductible amounts, and other cost-sharing obligations owed by or on behalf of a covered person.

"Methodologies," when referring to the calculation of area rate factors, includes (i) the types of inputs, including experience period claims data, third-party database, other sources of data, and (ii) the series of calculations that are used to derive area rate factors. This definition shall not preclude a health carrier from calculating area rate factors for rates for the individual market, based on the cost and care

delivery practices associated with the providers expected to be utilized by covered persons that reside in a given rating area, while calculating area rate factors for rates for the small group market, based on those providers that are expected to be utilized by individuals employed by small employers that are located in the rating area without regard to where the covered persons reside.

"Provider" means a health care provider, as defined in § 38.2-3438, that is affiliated or in-network with a health carrier.

"Weighted average," when referring to area rate factors, means the mean of the area rate factors when weighted based on the projected number of covered persons distributed by rating area.

2013, c. 751; 2019, cc. 439, 440; 2023, cc. 682, 683.

§ 38.2-3448. Guaranteed availability.

A. Notwithstanding any provision of § 38.2-3430.3, 38.2-3436, or any other section of this title to the contrary, a health carrier offering a health benefit plan providing individual or group health insurance coverage shall issue such coverage to any eligible individual or employer in the Commonwealth that applies for such coverage. For purposes of this section, an "eligible individual" means any individual eligible for either individual or group health insurance coverage in the Commonwealth.

B. A health carrier may restrict enrollment in a health benefit plan to open or special enrollment periods. The Commission may establish open enrollment periods applicable to all health benefit plans.

2013, c. 751.

§ 38.2-3449. Prohibiting discrimination based on health status.

A. Notwithstanding any provision of § 38.2-508.5, 38.2-3431, 38.2-3432.3, 38.2-3521.1, 38.2-3522.1, 38.2-3540.2, 38.2-3551, 38.2-4109, or any other section of this title to the contrary, a health carrier offering a health benefit plan providing individual or group health insurance coverage shall not establish rules for eligibility, including continued eligibility, of any covered person to enroll under the terms of coverage based on any health status-related factor in relation to the covered person.

B. A health carrier shall not require any covered person as a condition of enrollment or continued enrollment under a health benefit plan to pay a premium or contribution that is greater than such premium or contribution for a similarly situated covered person enrolled in the plan on the basis of any health status-related factor in relation to the covered person.

2013, c. 751.

§ 38.2-3449.1. Prohibited discrimination based on gender identity or status as a transgender individual.

A. As used in this section:

"Gender identity" means an individual's internal sense of gender, which may be male, female, neither, or a combination of male and female and which may be different from an individual's sex assigned at birth.

"Medically necessary transition-related care" means any medical treatment prescribed by a licensed physician for treatment of gender dysphoria and includes (i) outpatient psychotherapy and mental health services for gender dysphoria and associated co-morbid psychiatric diagnoses; (ii) continuous hormone replacement therapy; (iii) outpatient laboratory testing to monitor continuous hormone therapy; and (iv) gender reassignment surgeries.

"Transgender individual" means an individual whose gender identity is different from the sex assigned to that individual at birth.

B. A health carrier offering a health benefit plan providing individual or group health insurance coverage shall:

1. Provide coverage under the health benefit plan without discrimination on the basis of gender identity or status as a transgender individual; and

2. Treat covered individuals consistent with their gender identity.

C. A health carrier offering a health benefit plan providing individual or group health insurance coverage shall not deny or limit coverage or impose additional cost sharing or other limitations or restrictions on coverage, under a health benefit plan for health care services that are ordinarily or exclusively available to covered individuals of one sex, to a transgender individual on the basis of the fact that the individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available.

D. An individual shall not be subjected to discrimination under a health benefit plan on the basis of gender identity or being a transgender individual, including by being denied coverage of medically necessary transition-related care.

E. Nothing in this section is intended to determine, or restrict a health carrier from determining, whether a particular health care service is medically necessary or otherwise meets applicable coverage requirements in any individual case.

F. A health carrier shall not require any individual, as a condition of enrollment or continued enrollment under a health benefit plan, to pay a premium or contribution that is greater than such premium or contribution for a similarly situated covered person enrolled in the plan on the basis of the covered person's gender identity or being a transgender individual.

G. Health carriers shall assess medical necessity according to nondiscriminatory criteria that are consistent with current medical standards.

2020, c. 844.

§ 38.2-3450. Genetic information and testing.

A. A health carrier offering a health benefit plan providing individual and group health insurance coverage shall not adjust premium or contribution amounts for a covered person under such plan on the basis of genetic information.

B. A health carrier shall not request or require a covered person to undergo a genetic test, or require or purchase genetic information for underwriting purposes. A health carrier shall not request, require, or purchase genetic information with respect to any covered person prior to the covered person's enrollment under the health benefit plan.

C. Genetic information may be obtained under the following circumstances:

1. A health care professional who is providing health care services to a covered person may request that the covered person undergo a genetic test.

a. A health carrier may obtain and use the results of a genetic test in making a determination regarding payment of a claim.

b. A health carrier may request only the minimum amount of information necessary to accomplish the intended purpose.

2. A health carrier may request, but not require, that a covered person undergo a genetic test if all of the following conditions are met:

a. The request is made pursuant to research that complies with Part 46 of Title 45 of the Code of Federal Regulations or equivalent federal regulations and any applicable state or local law or regulation for the protection of human subjects in research;

b. The health carrier clearly indicates to the covered person, or in the case of a minor child, to the legal guardian of the child, to whom the request is made that:

(1) Compliance with the request is voluntary; and

(2) Noncompliance will have no effect on enrollment status or premium or contribution amounts;

c. No genetic information collected or acquired under this subsection shall be used for underwriting purposes;

d. The health carrier notifies the federal Secretary of Health and Human Services in writing that the health carrier is conducting activities pursuant to the exception provided in this subsection, including a description of all the activities conducted; and

e. The health carrier complies with such other conditions as the Secretary may by regulation require for activities conducted under this subsection.

D. Any reference in this section to genetic information concerning a covered person shall:

1. With respect to the covered person who is a pregnant woman, include genetic information of any fetus carried by the pregnant woman; and

2. With respect to a covered person utilizing an assisted reproductive technology, include genetic information of any embryo legally held by the covered person.

E. This section shall apply to any health carrier providing individual or group health insurance coverage, including any grandfathered plan.

2013, c. 751.

§ 38.2-3451. Essential health benefits.

A. Notwithstanding any provision of law to the contrary, any person offering or providing a health benefit plan providing individual or small group health insurance coverage, including (i) catastrophic health insurance policies, and policies that pay on a cost-incurred basis; (ii) association health plans; and (iii) plans provided by a multiple-employer welfare arrangement, shall provide that such coverage includes essential health benefits. Nothing in this section shall require a health benefit plan providing large group health insurance coverage to provide coverage for essential health benefits in a manner that exceeds the requirements of the PPACA as of January 1, 2019. The essential health benefits package may also include associated cost-sharing requirements or limitations.

B. The provisions of subsection A requiring minimum essential pediatric oral health benefits shall be deemed to be satisfied for health benefit plans made available in the small group market or individual market in the Commonwealth outside an exchange, as defined in § 38.2-3455, issued for policy or plan years beginning on or after January 1, 2015, that do not include the minimum essential pediatric oral health benefits if the health carrier has obtained reasonable assurance that such pediatric oral health benefits are provided to the purchaser of the health benefit plan. The health carrier shall be deemed to have obtained reasonable assurance that such pediatric oral health benefits are provided to the purchaser of the health benefit plan if:

1. At least one qualified dental plan, as defined in § 38.2-3455, (i) offers the minimum essential pediatric oral health benefits and (ii) is available for purchase by the small group or individual purchaser; and

2. The health carrier prominently discloses, in a form approved by the Commission, at the time that it offers the health benefit plan that the plan does not provide the minimum essential pediatric oral health benefits.

2013, c. 751; 2014, cc. 307, 369; 2020, c. 1160; 2021, Sp. Sess. I, cc. 101, 102.

§ 38.2-3452. Waiting periods.

Notwithstanding any provision of § 38.2-3436, 38.2-4216.1, or any other section of this title to the contrary, a health carrier offering a health benefit plan providing group health insurance coverage shall not apply any waiting period that exceeds 90 days.

2013, c. 751.

§ 38.2-3453. Clinical trials.

A. Notwithstanding any provision of § 38.2-3418.8 or any other section of this title to the contrary, if a health carrier offering a health benefit plan providing individual or group health insurance coverage provides coverage to a qualified individual, then such plan shall provide for participation in an approved clinical trial and cover routine patient costs for items and services furnished in connection with participation in such clinical trial. The health carrier shall not discriminate against the qualified individual on the basis of his participation in such clinical trial.

B. For purposes of this section:

1. "Approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and the study or investigation is (i) a federally funded or approved trial, (ii) conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration, or (iii) a drug trial that is exempt from having an investigational new drug application.

2. "Life threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of disease or condition is interrupted.

3. "Qualified individual" means a covered person who is eligible to participate in an approved clinical trial according to the trial protocol, with respect to treatment of cancer or other life-threatening disease or condition, and the referring health care professional has concluded that the individual's participation in such trial is appropriate to treat the disease or condition, or the individual's participation is based on medical and scientific information.

4. "Routine patient costs" means all items and services consistent with the coverage provided under the health benefit plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include the investigational item, device, or service itself; items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

C. Nothing in this section shall preclude a health benefit plan from requiring that a qualified individual participate in an approved clinical trial through a participating provider if such provider will accept the individual as a participant in the trial. However, a health benefit plan may not preclude a qualified individual from participating in an approved clinical trial conducted outside the state in which the individual resides.

This section shall not be construed to require that a health benefit plan provide benefits outside of the plan's health care provider network unless out-of-network benefits are otherwise provided under the plan.

D. This section shall not apply to any grandfathered plan providing individual or group health insurance coverage.

2013, c. 751.

§ 38.2-3454. Wellness programs.

A. A health carrier offering a health benefit plan providing group health insurance coverage may provide for a wellness program if such program is made available to all similarly situated individuals. A wellness program may include:

1. A program that reimburses all or part of the cost for membership to a fitness center;

2. A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes;

3. A program that encourages preventive care related to a health condition through the waiver of the copayment or deductible requirement under a group health plan for the cost of certain items or services related to a health condition, such as prenatal care or well-baby visits;

4. A program that reimburses individuals for the cost of smoking cessation programs without regard to whether the individual quits smoking; or

5. A program that provides a reward to individuals for attending a periodic health education seminar.

B. Notwithstanding any provision of § 38.2-3449, 38.2-3540.2, or any other section of this title to the contrary, a health carrier offering a health benefit plan providing group health insurance coverage shall not create conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program that is based on an individual satisfying a standard related to a health status factor, except in instances where the following requirements are satisfied:

1. The reward for the wellness program, together with the reward for other wellness programs with respect to the plan that requires satisfaction of a standard related to a health status factor, does not exceed 30 percent of the cost of employee-only coverage. If, in addition to employees or individuals, any class of dependents may participate fully in the wellness program, such reward shall not exceed 30 percent of the cost of the coverage in which any employee or individual and any dependents are enrolled;

2. The wellness program is reasonably designed to promote health or prevent disease;

3. The health carrier gives individuals eligible for the program the opportunity to qualify for the reward under the program at least once each year;

4. The full reward under the wellness program is made available to all similarly situated individuals. The reward is not available to all similarly situated individuals for a period unless the wellness program allows for a reasonable alternative standard or waiver of the otherwise applicable standard for obtaining the reward for any individual for whom, for that period, (i) it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard or (ii) it is medically inadvisable to attempt to satisfy the otherwise applicable standard. The health carrier may seek verification, such as a statement from an individual's physician, that a health status factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy or attempt to satisfy the otherwise applicable standard; and

5. The health carrier discloses, in all health benefit plan materials describing the terms of the wellness program, the availability of a reasonable alternative standard or the possibility of waiver of the otherwise applicable standard required under subdivision 4. If plan materials disclose that such a program is available without describing its terms, the disclosure under this subdivision shall not be required.

2013, c. 751.

§ 38.2-3454.1. Renewal of health benefit plans; special exception.

Notwithstanding any other provision of state law, a health carrier may renew any health benefit plan that would otherwise be required to be canceled, discontinued, or terminated, because the health benefit plan does not meet the requirements of Title I of the federal Patient Protection and Affordable Care Act (H.R. 3590), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152)(the PPACA) or regulations promulgated thereunder, to the extent and under the terms that the appropriate federal authority has suspended enforcement of provisions of Title I of the PPACA or regulations promulgated thereunder. This section applies to health benefit plans sold or offered for sale in the individual and group markets.

2014, Sp. Sess. I, cc. 4, 5; 2016, c. 271; 2020, c. 842.

Article 7 - Navigators

§ 38.2-3455. Definitions.

As used in this article, unless the context requires otherwise:

"Exchange" means either a (i) federal health benefit exchange established by the Secretary of the U.S. Department of Health and Human Services pursuant to § 1321 of the Patient Protection and Affordable Care Act codified as 42 U.S.C. § 18041(c) in the Commonwealth or (ii) state-based exchange established pursuant to Chapter 65 (§ 38.2-6500 et seq.) and § 1311 (b) of the Patient Protection and Affordable Care Act codified as 42 U.S.C. § 18031.

"Health carrier" has the same meaning assigned to that term in § 38.2-3438.

"Navigator" means an individual or entity described in 42 U.S.C. § 1311(i)(2) that is selected to perform the activities and duties identified in 42 U.S.C. § 18031 (i) in the Commonwealth. "Navigator" does not include an individual or entity licensed as an agent under Chapter 18 (§ 38.2-1800 et seq.) of this title to sell, solicit, or negotiate contracts of insurance or annuity in the Commonwealth.

"Other affordable care options" means the programs provided under the state plan for medical assistance services pursuant to pursuant to Title XIX of the Social Security Act, as amended, and the Family Access to Medical Insurance Security (FAMIS) Plan developed pursuant to Title XXI of the Social Security Act, as amended.

"Qualified dental plan" means a limited scope dental plan that has in effect a certification that the plan meets the criteria for certification described in § 1311(d)(2)(B)(ii) of the Patient Protection and Affordable Care Act, P.L. 111-148, as amended.

"Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in § 1311(c) of the Patient Protection and Affordable Care Act, P.L. 111-148, as amended.

"Secretary" means the Secretary of the U.S. Department of Health and Human Services.

2013, cc. 595, 791; 2014, cc. 752, 769; 2020, cc. 916, 917.

§ 38.2-3456. Prohibited activities.

A. A navigator shall not:

1. Engage in any activity that would require an insurance agent license under this title;

2. Offer advice about which qualified health plan or qualified dental plan is better or worse for a particular individual or employer;

3. Act as an intermediary between an employer and an insurer that offers a qualified health plan or qualified dental plan offered through an exchange;

4. Violate any unfair trade practice and privacy requirements in §§ 38.2-502, 38.2-503, 38.2-506, 38.2-509, 38.2-512, 38.2-515, 38.2-612.1, 38.2-613, and 38.2-614 to the extent such requirements are applicable to the activities of navigators; or

5. Receive compensation for services or duties as a navigator that are prohibited by federal law, including compensation from a health carrier.

B. An individual or entity shall not claim to be, or otherwise hold himself or itself out as, a navigator or conduct business as a navigator in the Commonwealth without:

1. Having been selected as a navigator in accordance with applicable federal or state law;

2. Having evidence of successful completion of all navigator requirements prescribed by the Secretary or the Exchange; and

3. Having met requirements established pursuant to § 38.2-3457.

C. If an individual or entity has engaged in the Commonwealth in one or more of the prohibited activities identified in this section, a complaint may be filed with the Commission. The Commission, upon investigation and verification of the prohibited activity or activities, may order such individual or entity to cease and desist such prohibited conduct.

2013, cc. 595, 791; 2014, cc. 752, 769; 2020, cc. 916, 917.

§ 38.2-3457. Application for registration.

A. On or after September 1, 2014, no individual or entity shall act as a navigator in the Commonwealth unless such individual or entity has been certified by the U.S. Department of Health and Human Services or the Exchange and registered with the Commission.

B. An application for registration under this article shall be in the form and containing the information the Commission prescribes. Each applicant shall, at the time of applying for registration, pay a nonrefundable application processing fee in an amount and in a manner prescribed by the Commission. A criminal history record report shall accompany each individual registration application.

C. The Commission shall register the applicant if it finds that the character and general fitness of the applicant are such as to warrant belief that the applicant will act as a navigator fairly, in the public interest, and in accordance with law.

2014, cc. 752, 769; 2020, cc. 916, 917.

§ 38.2-3458. Power of Commission to investigate navigators.

A. The Commission shall have the power to examine and investigate the affairs of any person engaged or alleged to be engaged in navigator activities in the Commonwealth to determine whether the individual or entity has engaged or is engaging in any violation of this article.

B. Each registered navigator shall report to the Commission within 30 calendar days the following: (i) any action taken by the U.S. Department of Health and Human Services to decertify the navigator; (ii) upon conviction of a felony, the facts and circumstances surrounding that conviction; and (iii) the disposition of the matter of any administrative action taken against the navigator in another jurisdiction or by another governmental agency in the Commonwealth.

2014, cc. 752, 769.

§ 38.2-3459. Grounds for termination, placing on probation, revocation, or suspension of registration.

A. If the Commission determines that a registered navigator has violated this article, or any order or regulation adopted thereunder, after notice and opportunity to be heard, the Commission may impose a penalty in accordance with §§ 38.2-218 and 38.2-219 and place on probation, suspend, or revoke any individual's or entity's registration.

B. The registration of any navigator shall terminate immediately when such navigator becomes decertified by the U.S. Department of Health and Human Services or the Exchange, as applicable.

2014, cc. 752, 769; 2020, cc. 916, 917.

§ 38.2-3460. Sufficiency of federal requirements; additional standards and qualifications for navigators.

The Commission may determine whether the standards and qualifications for navigators provided by 42 U.S.C. § 18031 and any regulations enacted thereunder are sufficient to ensure that navigators can perform the required duties. If the Commission determines that the standards and qualifications are insufficient, the Commission shall adopt regulations establishing additional standards and qualifications to ensure that navigators can perform their required duties.

2014, cc. 752, 769; 2020, cc. 916, 917.

Article 8 - Health Care Shared Savings

§ 38.2-3461. Definitions.

As used in this article, unless the context requires a different meaning:

"Allowed amount" means the contractually agreed upon amount paid or payable by a health carrier to a health care provider participating in the health carrier's network.

"Average" means mean, median, or mode.

"Comparable health care service" means any (i) physical and occupational therapy service, (ii) radiology and imaging service, (iii) laboratory service, (iv) infusion therapy service, and (v) at the discretion of the health carrier, other health care service, provided that with respect to any service described in clauses (i) through (v) the service (a) is a covered non-emergency health care service or bundle of health care services provided by a network provider and (b) is a service for which the health carrier has not demonstrated that the allowed amount variation among participating providers is less than $50.

"Covered person" means a policyholder, subscriber, participant, or other individual covered by a health benefit plan.

"Health benefit plan" means a policy, contract, certificate, or agreement offered by a health carrier in the small group market to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. "Health benefit plan" does not include the "excepted benefits" as defined in § 38.2-3431. "Health benefit plan" does not include any health insurance plan administered by the Department of Human Resource Management, including the health coverage offered to state employees pursuant to § 2.2-2818; health insurance coverage offered to employees of local governments, local officers, teachers, and retirees, and the dependents of such employees, local officers, teachers and retirees pursuant to § 2.2-1204; or health insurance coverage provided under the Line of Duty Act (§ 9.1-400 et seq.).

"Health care provider" means a health care professional or facility.

"Health care service" means a service for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

"Health carrier" means an entity subject to the insurance laws and regulations of the Commonwealth and subject to the jurisdiction of the Commission that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an insurer licensed to sell accident and sickness insurance, a health maintenance organization, a health services plan, or any other entity providing a plan of health insurance, health benefits, or health care services.

"Network" or "provider network" means the group of participating providers providing services to a health benefit plan under which the financing and delivery of health care services are provided, in whole or in part, through a defined set of health care providers.

"Network provider" means a health care provider that has contracted with the health carrier, or with its contractor or subcontractor, to provide health care services to covered persons as a member of a network.

"Out-of-pocket costs" means any copayment, deductible, or coinsurance that is the responsibility of the covered person with respect to a covered health care service.

"Program" means the comparable health care service incentive program established by a health carrier pursuant to this article.

"Small group market" means the health insurance market under which individuals obtain health insurance coverage, directly or through any arrangement, on behalf of themselves and their dependents through a group health plan maintained by a small employer.

2019, cc. 666, 684.

§ 38.2-3462. Comparable Health Care Service Incentive Program.

A. Beginning with health benefit plans offered or renewed on or after January 1, 2021, each health carrier offering a health benefit plan in the Commonwealth shall develop and implement a program that provides incentives for covered persons in its health benefit plan who elect to receive a comparable health care service that is covered by the health benefit plan from health care providers that are paid less than the average in-network allowed amount paid or payable by that health carrier to network providers for that comparable health care service. A health carrier may base the average paid to a network provider on what that health carrier pays to providers in the network applicable to the covered person's specific health benefit plan, or across all of its health benefit plans offered in the Commonwealth.

B. Incentives may include, but are not limited to, cash payments, gift cards, or credits or reductions of premiums, copayments, or deductibles. Health carriers may let covered persons decide which method they prefer to receive the incentive.

C. The incentive program shall provide covered persons with an incentive for each service or category of comparable health care service resulting from comparison shopping by covered persons. A health carrier is not required to provide a payment or credit to a covered person when the health carrier's saved cost is $25 or less.

D. A health carrier shall determine the allowed amount paid or payable by that health carrier to network providers for that comparable health care service on the basis of the average allowed amount for the procedure or service under the covered person's health benefit plan. Such determination shall be made on the basis of the average of the allowed amounts using data collected over a reasonable period not to exceed one year. A health carrier may determine an alternate methodology for calculating the average allowed amount if approved by the Commission. A health carrier shall, at minimum, inform covered persons of their eligibility for an incentive payment and the process to request the average allowed amount for a procedure or service on the health carrier's website and in health benefit plan materials.

E. Eligibility for an incentive payment may require a covered person to demonstrate, through reasonable documentation such as a quote from the health care provider, that the covered person

shopped prior to receiving care from the health care provider who charges less for the comparable health care service than the average allowed amount paid or payable by that health carrier. Health carriers shall provide additional mechanisms for the covered person to satisfy this requirement by utilizing the health carrier's cost transparency website or toll-free number, established under this article.

F. Each health carrier shall make the program available as a component of all small group health benefit plans offered by the health carrier in the Commonwealth. Annually at enrollment or renewal, each health carrier shall provide to any covered person who is enrolled in a small group health benefit plan eligible for the program (i) notice about the availability of the program, (ii) a description of the incentives available to a covered person, (iii) instructions on how to earn such incentives, and (iv) notification that tax treatment of the shared savings amounts or awards will be compliant with the rules of the Internal Revenue Service and treated as taxable income.

G. A comparable health care service incentive payment made by a health carrier in accordance with this section shall not constitute an administrative expense of the health carrier for rate development or rate filing purposes.

H. Prior to offering the program to any covered person, a health carrier shall file with the Commission a description of the program in the manner determined by the Commission. The description shall include a demonstration by the health carrier that the program is cost-effective, including any data relied upon by the health carrier in making such determination. The Commission may review the filing made by the health carrier to determine if the health carrier's program complies with the requirements of this article.

I. A health carrier may petition the Commission to be excluded from participation in the program. The Commission shall exempt from the program a health plan with a limited provider network that demonstrates that the network is incompatible with a shared savings program. In making its determination, the Commission shall consider the impact on premiums related to the administration of the program.

J. Annually by April 1, each health carrier shall file with the Commission, for the most recent calendar year, the total number of comparable health care service incentive payments made pursuant to this article, the use of comparable health care services by category of service for which comparable health care service incentives are made, the total payments made to covered persons, the average amount of incentive payments made by service for such transactions, the total savings achieved below the average allowed amount by service for such transactions, and the total number and percentage of a health carrier's covered persons in small group health benefit plans that participated in such transactions.

K. Beginning no later than 18 months after implementation of comparable health care service incentive programs under this section and annually by November 1 of each year thereafter, the Commission shall submit an aggregate report for all health carriers filing the information required by this section to the chairs of the House Committee on Labor and Commerce and Senate Committee on Commerce and Labor.

2019, cc. 666, 684.

§ 38.2-3463. Health care price transparency tools.

Beginning with health benefit plans offered or renewed on or after July 1, 2020, each health carrier offering a health benefit plan in the Commonwealth shall comply with the following requirements:

1. A health carrier shall establish an interactive mechanism on its website that enables a covered person to request and obtain from the health carrier the estimated out-of-pocket cost to the covered person for comparable health care services from network providers, as well as quality data for those providers, to the extent available. The interactive mechanism shall allow a covered person seeking information about the cost of a comparable health care service to compare estimated out-of-pocket costs applicable to that covered person's health benefit plan. The out-of-pocket estimate shall provide a good faith estimate of the amount the covered person will be responsible to pay out-of-pocket for a proposed comparable health care service or service that is a medically necessary covered benefit from a health carrier's network provider, including any copayment, deductible, coinsurance, or other out-of-pocket amount for any covered benefit, based on the information available to the health carrier at the time the request is made. A health carrier may contract with a third-party vendor to satisfy the requirements of this subdivision.

2. Nothing in this section shall prohibit a health carrier from imposing cost-sharing requirements disclosed in the covered person's covered benefit plan for unforeseen health care services that arise out of the comparable health care service or for a procedure or service provided to a covered person that was not included in an original estimate provided under subdivision 1.

3. A health carrier shall notify a covered person that an estimate provided under subdivision 1 is an estimate of costs and that the actual amount the covered person will be responsible to pay may vary due to the need for unforeseen services that arise out of the proposed comparable health care service.

2019, cc. 666, 684.

§ 38.2-3464. Rules and regulations; orders.

The Commission, after notice and opportunity for all interested parties to be heard, may issue any rules and regulations necessary or appropriate for the administration and enforcement of this article.

2019, cc. 666, 684.

Article 9 - Pharmacy Benefits Managers

§ 38.2-3465. Definitions.

A. As used in this article, unless the context requires a different meaning:

"Carrier" has the same meaning ascribed thereto in subsection A of § 38.2-3407.15. However, "carrier" does not include a nonprofit health maintenance organization that operates as a group model whose internal pharmacy operation exclusively serves the members or patients of the nonprofit health maintenance organization.

"Claim" means a request from a pharmacy or pharmacist to be reimbursed for the cost of administering, filling, or refilling a prescription for a drug or for providing a medical supply or device.

"Claims processing services" means the administrative services performed in connection with the processing and adjudicating of claims relating to pharmacist services that include (i) receiving payments for pharmacist services, (ii) making payments to pharmacists or pharmacies for pharmacist services, or (iii) both receiving and making payments.

"Contract pharmacy" means a pharmacy operating under contract with a 340B-covered entity to provide dispensing services to the 340B-covered entity, as described in 75 Fed. Reg. 10272 (March 5, 2010) or any superseding guidance published thereafter.

"Covered entity" means an entity described in § 340B(a)(4) of the federal Public Health Service Act, 42 U.S.C. § 256B(a)(4). "Covered entity" does not include a hospital as defined in § 32.1-123 or 37.2-100.

"Covered individual" means an individual receiving prescription medication coverage or reimbursement provided by a pharmacy benefits manager or a carrier under a health benefit plan.

"Health benefit plan" has the same meaning ascribed thereto in § 38.2-3438.

"Mail order pharmacy" means a pharmacy whose primary business is to receive prescriptions by mail or through electronic submissions and to dispense medication to covered individuals through the use of the United States mail or other common or contract carrier services and that provides any consultation with covered individuals electronically rather than face-to-face.

"Pharmacy benefits management" means the administration or management of prescription drug benefits provided by a carrier for the benefit of covered individuals. "Pharmacy benefits management" does not include any service provided by a nonprofit health maintenance organization that operates as a group model provided that the service is furnished through the internal pharmacy operation exclusively serves the members or patients of the nonprofit health maintenance organization.

"Pharmacy benefits manager" or "PBM" means an entity that performs pharmacy benefits management. "Pharmacy benefits manager" includes an entity acting for a PBM in a contractual relationship in the performance of pharmacy benefits management for a carrier, nonprofit hospital, or third-party payor under a health program administered by the Commonwealth.

"Pharmacy benefits manager affiliate" means a business, pharmacy, or pharmacist that directly or indirectly, through one or more intermediaries, owns or controls, is owned or controlled by, or is under common ownership interest or control with a pharmacy benefits manager.

"Rebate" means a discount or other price concession, including without limitation incentives, disbursements, and reasonable estimates of a volume-based discount, or a payment that is (i) based on utilization of a prescription drug and (ii) paid by a manufacturer or third party, directly or indirectly, to a pharmacy benefits manager, pharmacy services administrative organization, or pharmacy after a claim has been processed and paid at a pharmacy.

"Retail community pharmacy" means a pharmacy that is open to the public, serves walk-in customers, and makes available face-to-face consultations between licensed pharmacists and persons to whom medications are dispensed.

"Spread pricing" means the model of prescription drug pricing in which the pharmacy benefits manager charges a health benefit plan a contracted price for prescription drugs, and the contracted price for the prescription drugs differs from the amount the pharmacy benefits manager directly or indirectly pays the pharmacist or pharmacy for pharmacist services.

2020, cc. 219, 1288; 2022, c. 319.

§ 38.2-3466. (Effective October 1, 2020) License required to provide pharmacy benefits management services; requirements for a license, renewal, and revocation or suspension.

A. Unless otherwise covered by a license as a carrier, no person shall provide pharmacy benefits management services or otherwise act as a pharmacy benefits manager in the Commonwealth without first obtaining a license in a manner and in a form prescribed by the Commission.

B. Each applicant for a license as a pharmacy benefits manager shall make application to the Commission, in the form and containing the information listed in subsection C and any other information the Commission prescribes. The Commission may require any documents reasonably necessary to verify the information contained in an application. Each applicant shall, at the time of applying for a license, pay a nonrefundable application processing fee in an amount and in a manner prescribed by the Commission. The fee shall be collected by the Commission and paid directly into the state treasury and credited to the "Bureau of Insurance Special Fund – State Corporation Commission" for the maintenance of the Bureau of Insurance as provided in subsection B of § 38.2-400.

C. An applicant for a license as a pharmacy benefits manager shall provide the Commission the following information:

1. The name, address, and telephone contact number of the pharmacy benefits manager;

2. The name and address of each person with management or control over the pharmacy benefits manager;

3. The name and address of each person with a beneficial ownership interest in the pharmacy benefits manager; and

4. If the pharmacy benefits manager registrant (i) is a partnership or other unincorporated association, a limited liability company, or a corporation and (ii) has five or more partners, members, or stockholders, the registrant shall specify its legal structure and the total number of its partners, members, or stockholders who, directly or indirectly, own, control, hold with the power to vote, or hold proxies representing 10 percent or more of the voting securities of any other person.

D. An applicant shall provide the Commissioner with a signed statement indicating that, to the best of its knowledge, no officer with management or control of the pharmacy benefits manager has been convicted of a felony or has violated any of the requirements of state law applicable to pharmacy benefits

managers, or, if the applicant cannot provide such a statement, a signed statement describing the relevant conviction or violation.

E. Except where prohibited by state or federal law, by submitting an application for a license, the applicant shall be deemed to have appointed the clerk of the Commission as the agent for service of process on the applicant in any action or proceeding arising in the Commonwealth out of or in connection with the exercise of the license. Such appointment of the clerk of the Commission as agent for service of process shall be irrevocable during the period within which a cause of action against the applicant may arise out of transactions with respect to subjects of pharmacy benefits management in the Commonwealth. Service of process on the clerk of the Commission shall conform to the provisions of Chapter 8 (§ 38.2-800 et seq.).

F. Each applicant that has complied with the provisions of this article and Commission regulations is entitled to and shall receive a license in the form the Commission prescribes.

G. Each pharmacy benefits manager shall renew its license annually and shall, at the time of renewal, pay a renewal fee in an amount and in a manner prescribed by the Commission. The fee shall be collected by the Commission and paid directly into the state treasury and credited to the "Bureau of Insurance Special Fund – State Corporation Commission" for the maintenance of the Bureau of Insurance as provided in subsection B of § 38.2-400.

H. The Commission may refuse to issue or renew a license or may revoke or suspend a license if it finds that the applicant or license holder has not complied with the provisions of this article or Commission regulations.

2020, cc. 219, 1288.

§ 38.2-3467. Prohibited conduct by carriers and pharmacy benefits managers.

A. No carrier on its own or through its contracted pharmacy benefits manager or representative of a pharmacy benefits manager shall:

1. Cause or knowingly permit the use of any advertisement, promotion, solicitation, representation, proposal, or offer that is untrue;

2. Charge a pharmacist or pharmacy a fee related to the adjudication of a claim other than a reasonable fee for an initial claim submission;

3. Reimburse a pharmacy or pharmacist an amount less than the amount that the pharmacy benefits manager reimburses a pharmacy benefits manager affiliate for providing the same pharmacist services, calculated on a per-unit basis using the same generic product identifier or generic code number and reflecting all drug manufacturer's rebates, direct and indirect administrative fees, and costs and any remuneration;

4. Penalize or retaliate against a pharmacist or pharmacy for exercising rights provided pursuant to the provisions of this article;

5. Impose requirements, exclusions, reimbursement terms, or other conditions on a covered entity or contract pharmacy that differ from those applied to entities or pharmacies that are not covered entities or contract pharmacies on the basis that the entity or pharmacy is a covered entity or contract pharmacy or that the entity or pharmacy dispenses 340B-covered drugs. Nothing in this subdivision shall (i) apply to drugs with an annual estimated per-patient cost exceeding $250,000 or (ii) prohibit the identification of a 340B reimbursement request; or

6. Interfere with a covered individual's right to choose a pharmacy or provider, based on the pharmacy or provider's status as a covered entity or contract pharmacy.

B. No carrier, on its own or through its contracted pharmacy benefits manager or representative of a pharmacy benefits manager, shall restrict participation of a pharmacy in a pharmacy network for provider accreditation standards or certification requirements if a pharmacist meets such accreditation standards or certification standards.

C. No carrier, on its own or through its contracted pharmacy benefits manager or representative of a pharmacy benefits manager, shall include any mail order pharmacy or pharmacy benefits manager affiliate in calculating or determining network adequacy under any law or contract in the Commonwealth.

D. No carrier, on its own or through its contracted pharmacy benefits manager or representative of a pharmacy benefits manager, shall conduct spread pricing in the Commonwealth.

E. Each carrier on its own or through its contracted pharmacy benefits manager or representative of a pharmacy benefits manager shall comply with the provisions of this section in addition to complying with the provisions of § 38.2-3407.15:1.

2020, cc. 219, 1288; 2022, c. 319.

§ 38.2-3468. Examination of books and records; reports; access to records.

A. Each carrier, on its own or through its contract for pharmacy benefits, shall ensure that the Commissioner may examine or audit the books and records of a pharmacy benefits manager providing claims processing services or other prescription drug or device services for a carrier that are relevant to determining if the pharmacy benefits manager is in compliance with this article. The carrier shall be responsible for the charges incurred in the examination, including the expenses of the Commissioner or his designee and the expenses and compensation of his examiners and assistants.

B. Each carrier, on its own or through its contract for pharmacy benefits, shall report the following information to the Commissioner for each health benefit plan:

1. The aggregate amount of rebates received by the pharmacy benefits manager;

2. The aggregate amount of rebates distributed to the appropriate health benefit plan;

3. The aggregate amount of rebates passed on to the enrollees of each health benefit plan at the point of sale that reduced the enrollees' applicable deductible, copayment, coinsurance, or other cost-sharing amount;

4. Upon the request of the Commission, the individual and aggregate amount paid by the health benefit plan to the pharmacy benefits manager for services itemized by pharmacy, by product, and by goods and services; and

5. Upon the request of the Commission, the individual and aggregate amount a pharmacy benefits manager paid for services itemized by pharmacy, by product, and by goods and services.

The report required by this subsection shall be filed on a quarterly basis through March 31, 2023. The final quarterly report shall include information for the period ending December 31, 2022. Thereafter, by March 31 of each year, the report shall be filed on a calendar year basis. The 2023 calendar year report shall be filed by March 31, 2024.

C. All working papers, documents, reports, and copies thereof, produced by, obtained by or disclosed to the Commission or any other person in the course of an examination made under this article and any analysis of such information or documents shall be given confidential treatment, are not subject to subpoena, and may not be made public by the Commission or any other person. Access may also be granted to (i) a regulatory official of any state or country; (ii) the National Association of Insurance Commissioners (NAIC), its affiliate, or its subsidiary; or (iii) a law-enforcement authority of any state or country, provided that those officials are required under their law to maintain its confidentiality. Any such disclosure by the Commission shall not constitute a waiver of confidentiality of such papers, documents, reports or copies thereof. Any parties receiving such papers must agree in writing prior to receiving the information to provide to it the same confidential treatment as required by this section.

2020, cc. 219, 1288; 2022, c. 283.

§ 38.2-3469. (Effective October 1, 2020) Enforcement; regulations.

A. The Commission shall enforce this article.

B. Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such rules and regulations as it may deem necessary to implement this article.

2020, cc. 219, 1288.

§ 38.2-3470. (Effective October 1, 2020) Scope of article.

This article shall not apply with respect to claims under (i) an employee welfare benefit plan as defined in section 3 (1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002(1), that is self-insured or self-funded; (ii) coverages issued pursuant to Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid); or (iii) prescription drug coverages issued pursuant to Part D of Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare Part D).

2020, cc. 219, 1288.

Chapter 35 - ACCIDENT AND SICKNESS INSURANCE POLICIES

Article 1 - INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE POLICIES

§ 38.2-3500. Form of policy.

A. No individual accident and sickness insurance policy shall be delivered or issued for delivery to any person in this Commonwealth unless:

1. The entire consideration for the policy is expressed in the policy;

2. The time at which the insurance takes effect and terminates is expressed in the policy;

3. The policy insures only one person, except that it may insure eligible family members, originally or by subsequent amendment, upon the application of an adult member of a family who shall be deemed the policyowner;

4. The exceptions and reductions are set forth in the policy and, except those that are set forth in §§ 38.2-3503 through 38.2-3508, are printed with the benefit provisions to which they apply, or under an appropriate caption, but if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of the exception or reduction shall be included with that benefit provision;

5. Each form, including riders and endorsements, is identified by a form number in the lower left-hand corner of the first page of the form;

6. It contains no provision making any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless that portion is set forth 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 Commission; and

7. It contains a statement about the provisions of subsections A and B of § 32.1-325.2 regarding the status of the Department of Medical Assistance Services as the payor of last resort.

B. If any policy is issued by an insurer domiciled in this Commonwealth for delivery to a person residing in another state, and if the insurance supervisory official of the other state advises the Commission that any such policy is not subject to approval or disapproval by such official, the Commission may by ruling require that such policy meet the standards set forth in this chapter.

C. "Eligible family member" means the (i) spouse, (ii) dependent children, without regard to whether such children reside in the same household as the policyowner, (iii) children under a specified age not greater than 19 years, and (iv) any person dependent on the policyowner.

D. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

1952, c. 317, § 38.1-348; 1986, cc. 550, 562; 1993, c. 306; 1994, c. 316; 2011, c. 882.

§ 38.2-3501. Policy forms; powers of Commission.

A. Individual accident and sickness insurance policy forms and the rate manuals showing rules and classification of risks applicable to individual accident and sickness insurance policy forms shall be subject to the provisions of § 38.2-316. The Commission, subject to § 38.2-316, may disapprove or withdraw approval of any such policy form if it finds that the benefits provided in the policy form are or are likely to be unreasonable in relation to the premium charged. If the Commission disapproves a policy form or withdraws approval of a form, an insurer may proceed as indicated in § 38.2-1926.

B. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

1979, c. 726, § 38.1-362.8; 1986, c. 562; 2013, c. 751.

§ 38.2-3502. Notice to be printed on policy; return of policy to insurer.

A. Any individual accident and sickness insurance policy delivered or issued for delivery in this Commonwealth shall have printed on it a notice stating substantially:

"THIS POLICY MAY NOT APPLY WHEN YOU HAVE A CLAIM! PLEASE READ! This policy was issued based on the information entered in your application, a copy of which is attached to the policy. If you know of any misstatement in your application, or if any information concerning the medical history of any insured person has been omitted, you should advise the Company immediately regarding the incorrect or omitted information; otherwise, your policy may not be a valid contract.

RIGHT TO RETURN POLICY WITHIN 10 DAYS. If for any reason you are not satisfied with your policy, you may return this policy to the Company within ten days of the date you received it and the premium you paid will be promptly refunded."

B. If a policyowner returns the policy within ten days from the date of receipt, coverage under that policy shall become void from its inception upon the mailing or delivery of the policy to the insurer or its agent.

C. If the first paragraph of the notice required in subsection A of this section is inapplicable or partially inapplicable to a particular form of policy, the insurer may modify or omit the notice with the Commission's approval.

D. Nothing in this section shall prohibit an insurer from extending the right to examine period to more than ten days if the period is stated in the policy.

1966, c. 342, § 38.1-348.4; 1986, c. 562.

§ 38.2-3503. Required accident and sickness policy provisions.

A. Except as provided in § 38.2-3505, each individual accident and sickness insurance policy delivered or issued for delivery in this Commonwealth shall contain the provisions specified in this section using the same words which appear in this section. Provisions 1 through 12 shall apply to all such policies. In addition, provision 13 shall apply to all such policies that are delivered, issued for delivery, renewed, or extended in this Commonwealth on or after January 1, 2001. An insurer may substitute corresponding provisions of different wording approved by the Commission that are in each instance

not less favorable in any respect to the insured or the beneficiary. These provisions shall be preceded individually by the caption "REQUIRED PROVISIONS" or by such appropriate individual or group captions or subcaptions as the Commission may approve.

1. Provision 1:

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 Company and unless such approval is endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

2. Provision 2:

TIME LIMIT ON CERTAIN DEFENSES: (a) Misstatements in the application: After two years from the date of this policy, only fraudulent misstatements in the application may be used to void the policy or deny any claim for loss incurred or disability (as defined in the policy) that starts after the two-year period.

Provision 2 shall not be construed 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 1, 2, 3, 4, and 5 of § 38.2-3504 in the event of misstatement with respect to age, occupation or other insurance.

Instead of Provision 2, 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 50 or, (ii) for a policy issued after age 44, for at least five years from its date of issue, may contain the following provision, from which the clause in parentheses may be omitted at the insurer's option:

INCONTESTABLE:

(a) Misstatements in the application: After this policy has been in force for two years during the Insured's lifetime (excluding any period during which the Insured is disabled), the Company cannot contest the statements in the application.

PREEXISTING CONDITIONS:

(b) No claim for loss incurred or disability (as defined in the policy) that starts after one year from the date of issue of this policy will be reduced or denied because a sickness or physical condition, not excluded by name or specific description before the date of loss, had existed before the effective date of coverage.

3. Provision 3:

GRACE PERIOD: This policy has a _____ day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following _____ days. During the grace period the policy shall continue in force.

In Provision 3 a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies shall be inserted between the words "a" and "day," and between

"following" and "days." However, if provisions of federal law require a policy to have a grace period in excess of one month, the period of time that the policy shall continue in force during the grace period shall not be required to exceed one month from the beginning of the grace period.

A policy that contains a cancellation provision may add, at the end of Provision 3: "subject to the right of the Company to cancel in accordance with the cancellation provision."

A policy in which the insurer reserves the right to refuse any renewal shall have, in Provision 3, the following sentence:

The grace period will not apply if, at least _____ days before the premium due date, the Company has delivered or has mailed to the Insured's last address shown in the Company's records written notice of the Company's intent not to renew this policy.

In the above sentence a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies shall be inserted between the words "least" and "days."

4. Provision 4:

REINSTATEMENT: If the renewal premium is not paid before the grace period ends, the policy will lapse. Later acceptance of the premium by the Company or by an agent authorized to accept payment, without requiring an application for reinstatement, will reinstate the policy. If the Company or its agent requires an application for reinstatement, the Insured will be given a conditional receipt for the premium. If the application is approved the policy will be reinstated as of the approval date. Lacking such approval, the policy will be reinstated on the forty-fifth day after the date of the conditional receipt unless the Company has previously written the Insured of its disapproval. The reinstated policy will cover only loss that results from an injury sustained after the date of reinstatement and sickness that starts more than 10 days after such date. In all other respects the rights of the Insured and the Company will remain the same, subject to any provisions noted or attached to the reinstated policy. Any premiums the Company accepts for a reinstatement will be applied to a period for which premiums have not been paid. No premiums will be applied to any period more than 60 days prior to the date of reinstatement.

The last sentence of Provision 4 may be omitted from any policy that the Insured has the right to continue in force subject to its terms by the timely payment of premiums (i) until at least age 50, or (ii) for a policy issued after age 44, for at least five years from its effective date.

5. Provision 5:

NOTICE OF CLAIM: Written notice of claim must be given within 20 days after a covered loss starts or as soon as reasonably possible. The notice can be given to the Company at _____ (insert the location of such office as the insurer may designate for the purpose), or to the Company's agent. Notice should include the name of the Insured, and Claimant if other than the Insured, and the policy number.

Optional paragraph: If the Insured has a disability for which benefits may be payable for at least two years, at least once in every six months after the Insured has given notice of claim, the Insured must give the Company notice that the disability has continued. The Insured need not do this if legally incapacitated. The first six months after any filing of proof by the Insured or any payment or denial of a claim by the Company will not be counted in applying this provision. If the Insured delays in giving this notice, the Insured's right to any benefits for the six months before the date the Insured gives notice will not be impaired.

6. Provision 6:

CLAIM FORMS: When the Company receives the notice of claim, it will send the Claimant forms for filing proof of loss. If these forms are not given to the Claimant within 15 days after the giving of such notice, the Claimant shall meet the proof of loss requirements by giving the Company a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss Section.

7. Provision 7:

PROOFS OF LOSS: If the policy provides for periodic payment for a continuing loss, written proof of loss must be given the Company within 90 days after the end of each period for which the Company is liable. For any other loss, written proof must be given within 90 days after such loss. If it was not reasonably possible to give written proof in the time required, the Company shall not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, except in the absence of legal capacity, the proof required must be given no later than one year from the time specified.

8. Provision 8:

TIME OF PAYMENT OF CLAIMS: After receiving written proof of loss, the Company will pay _____ ___ (Insert period for payment which must not be less frequently than monthly) all benefits then due for _____ (Insert type of loss). Benefits for any other loss covered by this policy will be paid as soon as the Company receives proper written proof.

9. Provision 9:

PAYMENT OF CLAIMS: Benefits will be paid to the Insured. Loss of life benefits are payable in accordance with the beneficiary designation in effect at the time of payment. If none is then in effect, the benefits will be paid to the Insured's estate. Any other benefits unpaid at death may be paid, at the Company's option, either to the Insured's beneficiary or the Insured's estate.

Optional paragraph: If benefits are payable to the Insured's estate or a beneficiary who cannot execute a valid release, the Company can pay benefits up to $ _____ (insert an amount which shall not exceed $2,000), to someone related to the Insured or beneficiary by blood or by marriage whom the Company considers to be entitled to the benefits. The Company will be discharged to the extent of any payment made in good faith.

Optional paragraph: The Company may pay all or a portion of any indemnities provided for health care services to the health care services provider, unless the Insured directs otherwise in writing by the time proofs of loss are filed. The Company cannot require that the services be rendered by a particular health care services provider.

10. Provision 10:

PHYSICAL EXAMINATIONS AND AUTOPSY: The Company at its own expense has the right to have the Insured examined as often as reasonably necessary while a claim is pending. It may also have an autopsy made unless prohibited by law.

11. Provision 11:

LEGAL ACTIONS: No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required by this policy. No legal action may be brought after three years from the time written proof of loss is required to be given.

12. Provision 12:

CHANGE OF BENEFICIARY: The Insured can change the beneficiary at any time by giving the Company written notice. The beneficiary's consent is not required for this or any other change in the policy, unless the designation of the beneficiary is irrevocable.

13. Provision 13:

CANCELLATION BY INSURED: The Insured may cancel this policy at any time by written notice delivered or mailed to the Company effective upon receipt or on such later date as may be specified in the notice. In the event of cancellation, the Company shall return promptly the unearned portion of any premium paid. The earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

B. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

1952, c. 317, § 38.1-349; 1958, c. 452; 1966, c. 101; 1986, c. 562; 1987, c. 520; 1995, c. 522; 2000, c. 540; 2003, c. 377; 2013, c. 751.

§ 38.2-3504. Other provisions.

Except as provided in § 38.2-3505, no individual accident and sickness insurance policy delivered or issued for delivery in this Commonwealth shall contain provisions respecting the matters set forth below unless such provisions use the same words which appear in this section. Provisions 1 through 7, 8 a, and 9 through 11 shall apply to all such policies that are issued for delivery or delivered in this Commonwealth prior to January 1, 2001. Provisions 1 through 7, 8 b, and 9 through 11 shall apply to all such policies that are issued for delivery, delivered, renewed, or extended in this Commonwealth on or after January 1, 2001. The insurer may use a corresponding provision of different wording approved by the Commission that is not less favorable in any respect to the Insured or the beneficiary.

Any such provision shall be preceded individually by the appropriate caption OTHER PROVISIONS or by such appropriate individual or group captions or subcaptions as the Commission may approve.

1. Provision 1:

CHANGE OF OCCUPATION: If the Insured is injured or contracts sickness after having changed his occupation to one classified by the Company as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the Company will pay only the 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 Company for the more hazardous occupation. If the Insured changes his occupation to one classified by the Company as less hazardous than that stated in this policy, the Company, upon receipt of proof of the 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 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 Company prior to the occurrence of the loss for which the Company is liable or prior to the date of proof of change in occupation with the state insurance supervisory official in the state where the Insured resided at the time this policy was issued; but if the filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the Company in the state prior to the occurrence of the loss or prior to the date of proof of change in occupation.

2. Provision 2:

MISSTATEMENT OF AGE: If the Insured's age has been misstated, the benefits will be those the premium paid would have purchased at the correct age.

3. Provision 3:

OTHER INSURANCE IN THIS COMPANY: If an accident or sickness or accident and sickness policy or policies previously issued by the Company to the Insured is 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 insurance shall be void and all premiums paid for such excess shall be returned to the Insured or to his estate.

Instead of Provision 3, the following provision may be used:

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

4. Provision 4:

INSURANCE WITH OTHER COMPANIES: If there is other valid coverage, not with this Company, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this Company has not been given written notice prior to the occurrence or

commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable under this policy plus the total of the like amounts under all such other valid coverages for the same loss of which this Company had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

If Provision 4 is included in a policy that also contains Provision 5, the phrase "EXPENSE INCURRED BENEFITS" shall be added to the caption of Provision 4. The insurer may include in this provision a definition of "other valid coverage," approved by the Commission. The definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this Commonwealth or any other jurisdiction of the United States or Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the Commission. In the absence of such definition the term shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations, by union welfare plans, or employer or employee benefit organizations.

For the purpose of applying Provision 4, 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 company has had notice. In applying Provision 4 no third party liability coverage shall be included as "other valid coverage."

5. Provision 5:

INSURANCE WITH OTHER COMPANIES: If there is other valid coverage, not with this Company, providing benefits for the same loss on other than an expense incurred basis and of which this Company 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 under this policy for such loss as the like indemnities of which the Company 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.

If Provision 5 is included in a policy that also contains Provision 4, the phrase "OTHER BENEFITS" shall be added to the caption of Provision 5. The insurer may include in this provision a definition of "other valid coverage," approved by the Commission. The definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this Commonwealth or any other jurisdiction of the United States or Canada, and to any other

coverage approved by the Commission. In the absence of such definition the 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 Provision 5, any amount of benefit provided for the 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 Company has had notice. In applying Provision 5 no third party liability coverage shall be included as "other valid coverage."

6. Provision 6:

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 a claim is made, whichever is greater, the Company will be liable only for the proportionate amount of the benefits under this policy as the amount of the monthly earnings or the average monthly earnings of the Insured bears to the total amount of monthly benefits for the same loss under all the coverage upon the insured at the time the disability commences and for the return of the part of the premiums paid during such two years that exceeds 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 the coverage upon the Insured below the sum of $200 or the sum of the monthly benefits specified in the coverages, whichever is less, nor shall it operate to reduce benefits other than those payable for loss of time.

Provision 6 may be inserted only in a policy that the insured has the right to continue in force subject to its terms by the timely payment of premiums (i) until at least age 50 or (ii) for a policy issued after age 44, for at least five years from its date of issue. The insurer may include in this provision a definition of "valid loss of time coverage" approved by the Commission. The 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 Commonwealth or any other jurisdiction of the United States or Canada, or to any other coverage the inclusion of which may be approved by the Commission or any combination of coverages. In the absence of such definition the term shall not include any coverage provided for the 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.

7. Provision 7:

UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

8. Provision 8 a:

CANCELLATION BY COMPANY: The Company may cancel this policy at any time by written notice delivered to the Insured, or mailed to his last address as shown by the records of the Company, stating when, no less than _____ days thereafter, the cancellation shall be effective; and after the policy has been continued beyond its original term the Insured may cancel this policy at any time by written notice delivered or mailed to the Company effective upon receipt or on such later date as may be specified in the notice. In the event of cancellation, the Company will return promptly the unearned portion of any premium paid. If the Insured cancels, the earned premium shall be computed by the use of the short-rate table last filed with the state insurance supervisory official in the state where the Insured resided when the policy was issued. If the Company cancels, the earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

Provision 8 b:

CANCELLATION BY COMPANY: The Company may cancel this policy at any time by written notice delivered to the Insured, or mailed to his last address as shown by the records of the Company, stating when, no less than days thereafter, the cancellation shall be effective. In the event of cancellation, the Company will return promptly the unearned portion of any premium paid. The earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

In Provisions 8 a and 8 b, a number no less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies shall be inserted between the words "than" and "days."

9. Provision 9:

CONFORMITY WITH STATE STATUTES: Any provision of this policy that on its effective date is in conflict with the laws of the state in which the Insured resides on that date is hereby amended to conform to the minimum requirements of the laws.

10. Provision 10:

ILLEGAL OCCUPATION: The Company will not be liable for any loss that results from the Insured's committing or attempting to commit a felony or from the Insured's engaging in an illegal occupation.

11. Provision 11:

INTOXICANTS AND NARCOTICS: The Company will not be liable for any loss resulting from the Insured's being drunk, or under the influence of any narcotic unless taken on the advice of a physician.

1952, c. 317, § 38.1-350; 1986, c. 562; 2000, c. 540; 2003, c. 377.

§ 38.2-3505. Inapplicable or inconsistent provisions.

If any provision of this article is inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the Commission's approval, shall omit or modify the inapplicable or inconsistent provision to make that provision consistent with the coverage provided by the policy.

1952, c. 317, § 38.1-351; 1986, c. 562.

§ 38.2-3506. Order of certain policy provisions.

The provisions that are the subject of §§ 38.2-3503 and 38.2-3504, or any corresponding provisions that are used instead of them in accordance with these sections, shall be printed in the consecutive order of the provisions in such sections. However, any such provision 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.

1952, c. 317, § 38.1-352; 1986, c. 562.

§ 38.2-3507. Third-party ownership.

The word "insured," as used in this article, shall not be construed to prevent a person with a proper insurable interest from applying for and owning a policy covering another person or from being entitled to any indemnities, benefits and rights provided under the policy.

1952, c. 317, § 38.1-353; 1986, c. 562.

§ 38.2-3508. Requirements of other jurisdictions.

A. Any individual accident and sickness insurance policy delivered or issued for delivery to any person in this Commonwealth by a foreign or alien insurer may contain any provision that is prescribed or required by the insurer's domiciliary jurisdiction and that is not less favorable than the provisions of this article to the insured or the beneficiary.

B. Any individual accident and sickness insurance policy delivered or issued for delivery by a domestic insurer in any other jurisdiction may contain any provision permitted or required by the laws of the other jurisdiction.

Code 1950, § 38-224; 1952, c. 317, § 38.1-354; 1986, c. 562.

§ 38.2-3509. Denial or reduction of benefits because of existence of other like insurance.

A. No individual accident and sickness insurance policy, nor any subscription contract as provided for in Chapter 42 (§ 38.2-4200 et seq.) of this title, delivered or issued for delivery in this Commonwealth shall contain any provision for the denial or reduction of benefits because of the existence of other like insurance except to the extent that the aggregate benefits, with respect to the covered medical expenses incurred under the policy or plan and all other like insurance with other insurers, exceed all covered medical expenses incurred.

B. The term "other like insurance" may include group insurance or coverage provided by hospital or medical service organizations, union welfare plans, employer or employee benefit organizations, or workers' compensation insurance.

1970, c. 378, § 38.1-355; 1986, c. 562.

§ 38.2-3510. Conforming to statute.

No individual accident and sickness insurance policy provision that is not subject to this article shall make an individual accident and sickness insurance policy, or any portion of the policy, less favorable in any respect to the insured or the beneficiary than the provisions that are subject to this article.

Code 1950, § 38-223; 1952, c. 317, § 38.1-356; 1986, c. 562.

§ 38.2-3511. Application.

A. The insured shall not be bound by any statement made in an application for an individual accident and sickness policy unless a copy of the application is attached to or endorsed on the policy when issued as a part of the policy. If any such policy delivered or issued for delivery in this Commonwealth is reinstated or renewed, and the insured, beneficiary or assignee of the policy makes a written request to the insurer for a copy of the reinstatement or renewal application, if any, the insurer shall within fifteen days after the receipt of the request, deliver or mail to the person making the request, a copy of the application. If a copy is not so delivered or mailed, the insurer shall be precluded from introducing the application as evidence in any action or proceeding based upon or involving the policy or its reinstatement or renewal.

B. No alteration of any written application for any such policy shall be made by any person other than the applicant without his written consent, except that insertions may be made by the insurer, for administrative purposes only, in a manner indicating clearly that such insertions are not to be ascribed to the applicant.

C. The falsity of any statement in the application for any policy covered by this article may not bar the right to recovery under the policy unless the false statement materially affected either the acceptance of the risk or the hazard assumed by the insurer.

1952, c. 317, § 38.1-357; 1986, c. 562.

§ 38.2-3512. Notice; waiver.

The acknowledgment by any insurer of the receipt of notice given under any individual accident and sickness insurance policy, the furnishing of forms for filing proofs of loss, the acceptance of such proofs, or the investigation of any claim thereunder shall not operate as a waiver of any of the rights of the insurer in defense of any claim arising under the policy.

1952, c. 317, § 38.1-358; 1986, c. 562.

§ 38.2-3513. Age limit.

A. If any individual accident and sickness insurance 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 the date falls within a period for which a premium is accepted by the insurer or if the insurer accepts a premium after the date, the coverage provided by the policy will continue in force subject to any right of cancellation until the end of the period for which the premium has been accepted.

B. If 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 the premium, 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.

1952, c. 317, § 38.1-359; 1986, c. 562.

§ 38.2-3514. When liability not to be denied because of preexisting disease, physical impairment or defect.

No insurer that has delivered or issued for delivery in this Commonwealth an accident and sickness insurance policy pursuant to the provisions of this article shall deny liability on any claim otherwise covered under such policy because of the existence of a disease or physical impairment or defect, congenital or otherwise, at the time of the making of the application for such policy, unless it is shown that the applicant knew or might reasonably have been expected to know of such disease, impairment or defect.

1966, c. 184, § 38.1-361.1; 1986, c. 562.

§ 38.2-3514.1. Preexisting conditions provisions.

A. In determining whether a preexisting conditions provision applies to an insured, all coverage shall credit the time the person was covered under previous individual or group policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis if the previous coverage was continuous to a date not more than thirty days prior to the effective date of the new coverage, exclusive of any applicable waiting period under such coverage.

B. As used herein, a "preexisting conditions provision" means a policy provision that limits, denies, or excludes coverage for charges or expenses incurred during a twelve-month period following the insured's effective date of coverage, for a condition that, during a twelve-month period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek diagnosis, care, or treatment, or for which medical advice, diagnosis, care, or treatment was recommended or received within twelve months immediately preceding the effective date of coverage or as to pregnancy existing on the effective date of coverage.

C. This section shall not apply to the following insurance policies or contracts:

1. Short-term travel;

2. Accident-only;

3. Limited or specified disease contracts;

4. Long-term care insurance;

5. Short-term nonrenewable policies or contracts of not more than six months' duration which are subject to no medical underwriting or minimal underwriting;

6. Policies subject to Article 4.1 (§ 38.2-3430.1 et seq.) of Chapter 34 of this title;

7. Policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal government plans; and

8. Disability income.

1995, c. 522; 1997, c. 291; 1999, c. 1004.

§ 38.2-3514.2. Renewability of coverage.

A. Every individual policy, subscription contract or plan delivered, issued for delivery or renewal in this Commonwealth providing benefits to or on behalf of an individual shall provide for the renewability of such coverage at the sole option of the insured, policyholder, subscriber, or enrollee. The insurer, health services plan or health maintenance organization issuing such policy, subscription contract or plan shall be permitted to refuse to renew the policy, subscription contract or plan only for one or more of the following reasons:

1. Nonpayment of the required premiums by the insured, policyholder, subscriber, or enrollee, or such individual's representative;

2. In the event that the policy, subscription contract or plan contains a provision requiring the use of network providers, a documented pattern of abuse or misuse of such provision by the insured, policyholder, subscriber, or enrollee, continuing for a period of no less than two years;

3. Subject to the time limits contained in subdivision 2 of § 38.2-3503 or in regulations adopted by the Commission governing the practices of health maintenance organizations, for fraud or material misrepresentation by the individual, with respect to his application for coverage;

4. Eligibility of an individual insured for Medicare, provided that such coverage may not terminate with respect to other individuals insured under the same policy, subscription contract or plan and who are not eligible for Medicare; and

5. The insured, subscriber, or enrollee has not maintained a legal residence in the service area of the insurer, health services plan or health maintenance organization for a period of at least six months.

B. This section shall not apply to the following insurance policies, subscription contracts or plans:

1. Short-term travel;

2. Accident-only;

3. Disability income;

4. Limited or specified disease contracts;

5. Long-term care insurance;

6. Short-term nonrenewable policies or contracts of not more than six months' duration which are subject to no medical underwriting or minimal underwriting; and

7. Individual health insurance coverage as defined in subsection B of § 38.2-3431.

1996, c. 550; 1998, c. 24.

§ 38.2-3515. Repealed.

Repealed by Acts 2022, c. 180, cl. 2.

Article 2 - Accident and Sickness Insurance Minimum Standards

§ 38.2-3516. Purpose.

The purpose of this article is to authorize the Commission, pursuant to the authority granted in § 38.2-223, to issue rules and regulations to:

1. Establish the minimum standards for filing of policy forms for individual and small group health benefit plans as defined in § 38.2-3438;

2. Establish the minimum standards, terms, and coverages for individual and group accident and sickness policies known as excepted benefits, as defined in § 38.2-3431; and

3. Establish the minimum standards for short-term limited-duration insurance.

The Commission shall ensure that policy standards are simple and understandable and are not misleading or unreasonably confusing and that the sale of such policies provides for full disclosure.

1980, c. 204, § 38.1-362.11; 1986, c. 562; 2022, c. 531.

§ 38.2-3517. Definitions.

As used in this article:

"Form" means a policy, rider, endorsement, amendment, application, enrollment form, certificate of insurance, evidence of coverage, group agreement, supplemental agreement, or any other form required to be filed with or approved by the Commission.

"Policy" means an insurance policy, contract, certificate, evidence of coverage, or other agreement of insurance, including any attached rider, endorsement, or application.

1980, c. 204, § 38.1-362.12; 1986, c. 562; 2022, c. 531.

§ 38.2-3518. Standards for policy provisions.

A. Pursuant to the authority granted in § 38.2-223, the Commission may issue rules and regulations to establish standards for the sale of individual and group accident and sickness insurance policies. These rules and regulations shall be in addition to and in accordance with applicable laws of the Commonwealth, including Chapter 34 (§ 38.2-3400 et seq.), Article 1 (§ 38.2-3500 et seq.), this article, and Article 3 (§ 38.2-3521.1 et seq.).

B. Pursuant to the authority granted in § 38.2-223, the Commission may issue rules and regulations that specify prohibited policies or policy provisions not otherwise specifically authorized by statute that in the opinion of the Commission are unjust, unfair, or unfairly discriminatory to the policyowner, beneficiary, or any person insured under the policy.

1980, c. 204, § 38.1-362.13; 1981, c. 575; 1986, c. 562; 2022, c. 531.

§ 38.2-3519. Minimum standards for excepted benefits.

A. Pursuant to the authority granted in § 38.2-223, the Commission may issue rules and regulations establishing minimum standards for benefits under any of the categories of policies known as excepted benefits.

B. No excepted benefits policy shall be delivered or issued for delivery in the Commonwealth that does not meet the prescribed minimum standards established by the Commission or does not meet the requirements set forth in § 38.2-3501.

C. The Commission may prescribe the method of identification of policies based upon coverages provided.

1980, c. 204, § 38.1-362.14; 1986, c. 562; 2022, c. 531.

§ 38.2-3520. Coverage of preexisting conditions.

A. Notwithstanding the provisions of § 38.2-3503, if an insurer elects to use a simplified application form, with or without a specific question as to the applicant's health, but without any detailed questions concerning the insured's health history or medical treatment history, the policy shall cover any loss occurring after twelve months from the effective date of coverage from any preexisting condition not specifically excluded from coverage by terms of the policy. Except as so provided, the policy shall not include wording that would permit a defense based upon preexisting conditions.

B. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

1980, c. 204, § 38.1-362.15; 1981, c. 575; 1986, c. 562; 2013, c. 751.

Article 3 - GROUP ACCIDENT AND SICKNESS INSURANCE POLICIES

§ 38.2-3521. Repealed.

Repealed by Acts 1998, c. 154.

§ 38.2-3521.1. Group accident and sickness insurance definitions.

Except as provided in § 38.2-3522.1, no policy of group accident and sickness insurance shall be delivered in this Commonwealth unless it conforms to one of the following descriptions:

A. A policy issued to an employer, or to the trustees of a fund established by an employer, which employer or trustees shall be deemed the policyholder, to insure employees of the employer for the benefit of persons other than the employer, subject to the following requirements:

1. The employees eligible for insurance under the policy shall be all of the employees of the employer, or all of any class or classes thereof. The policy may provide that the term "employees" shall include the employees of one or more subsidiary corporations, and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the employer and of such affiliated corporations, proprietorships or partnerships is under common control. The policy may provide that the term "employees" shall include retired employees, former employees

and directors of a corporate employer. A policy issued to insure the employees of a public body may provide that the term "employees" shall include elected or appointed officials.

2. The premium for the policy shall be paid either from the employer's funds or from funds contributed by the insured employees, or from both. Except as provided in subdivision 3, a policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, except those who reject such coverage in writing.

3. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer, except as otherwise prohibited in this title.

B. A policy that is:

1. Not subject to Chapter 37.1 (§ 38.2-3727 et seq.): and

2. Issued to a creditor or its parent holding company or to a trustee or trustees or agent designated by two or more creditors, which creditor, holding company, affiliate, trustee, trustees or agent shall be deemed the policyholder, to insure debtors of the creditor or creditors with respect to their indebtedness, subject to the following requirements:

a. The debtors eligible for insurance under the policy shall be all of the debtors of the creditor or creditors, or all of any class or classes thereof. The policy may provide that the term "debtors" shall include:

(1) Borrowers of money or purchasers or lessees of goods, services, or property for which payment is arranged through a credit transaction;

(2) The debtors of one or more subsidiary corporations; and

(3) The debtors of one or more affiliated corporations, proprietorships or partnerships if the business of the policyholder and of such affiliated corporations, proprietorships or partnerships is under common control.

b. The premium for the policy shall be paid either from the creditor's funds, or from charges collected from the insured debtors, or from both. Except as provided in subdivision 3, a policy on which no part of the premium is to be derived from funds contributed by insured debtors specifically for their insurance must insure all eligible debtors.

3. An insurer may exclude any debtors as to whom evidence of individual insurability is not satisfactory to the insurer.

4. The total amount of insurance payable with respect to an indebtedness shall not exceed the greater of the scheduled or actual amount of unpaid indebtedness to the creditor. The insurer may exclude any payments that are delinquent on the date the debtor becomes disabled as defined in the policy.

5. The insurance may be payable to the creditor or any successor to the right, title, and interest of the creditor. Such payment or payments shall reduce or extinguish the unpaid indebtedness of the debtor

to the extent of each such payment and any excess of the insurance shall be payable to the insured or the estate of the insured.

6. Notwithstanding the preceding provisions of this section, insurance on agricultural credit transaction commitments may be written up to the amount of the loan commitment. Insurance on educational credit transaction commitments may be written up to the amount of the loan commitment less the amount of any repayments made on the loan.

C. A policy issued to a labor union, or similar employee organization, which labor union or organization shall be deemed to be the policyholder, to insure members of such union or organization for the benefit of persons other than the union or organization or any of its officials, representatives, or agents, subject to the following requirements:

1. The members eligible for insurance under the policy shall be all of the members of the union or organization, or all of any class or classes thereof.

2. The premium for the policy shall be paid from either funds of the union or organization, or from funds contributed by the insured members specifically for their insurance, or from both. Except as provided in subdivision 3, a policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members, except those who reject such coverage in writing.

3. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer, except as otherwise prohibited in this title.

D. A policy issued (i) to or for a multiple employer welfare arrangement, a rural electric cooperative, or a rural electric telephone cooperative as these terms are defined in 29 U.S.C. § 1002, or (ii) to a trust, or to the trustees of a fund, established or adopted by or for two or more employers, or by one or more labor unions of similar employee organizations, or by one or more employers and one or more labor unions or similar employee organizations, which trust or trustees shall be deemed the policyholder, to insure employees of the employers or members of the unions or organizations for the benefit of persons other than the employers or the unions or organizations, subject to the following requirements:

1. The persons eligible for insurance shall be all of the employees of the employers or all of the members of the unions or organizations, or all of any class or classes thereof. The policy may provide that the term "employee" shall include the employees of one or more subsidiary corporations, and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the employer and of such affiliated corporations, proprietorships or partnerships is under common control. The policy may provide that the term "employees" shall include retired employees, former employees and directors of a corporate employer. The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship.

2. The premium for the policy shall be paid from funds contributed by the employer or employers of the insured persons, or by the union or unions or similar employee organizations, or by both, or from funds contributed by the insured persons or from both the insured persons and the employers or unions or similar employee organizations. Except as provided in subdivision 3, a policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance must insure all eligible persons, except those who reject such coverage in writing.

3. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer, except as otherwise prohibited in this title.

E. 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 which association or trust shall be deemed the policyholder.

1. The association or associations shall:

a. Have at the outset a minimum of 100 persons;

b. Have been organized and maintained in good faith for purposes other than that of obtaining insurance;

c. Have been in active existence for at least five years;

d. Have a constitution and bylaws which provide that (i) the association or associations hold regular meetings not less than annually to further purposes of the members, (ii) except for credit unions, the association or associations collect dues or solicit contributions from members, and (iii) the members have voting privileges and representation on the governing board and committees;

e. Does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee);

f. Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member);

g. Does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

h. Meets such additional requirements as may be imposed under the laws of this Commonwealth.

2. The policy shall be subject to the following requirements:

a. The policy may insure members of such association or associations, employees thereof or employees of members, or one or more of the preceding or all of any class or classes thereof for the benefit of persons other than the employee's employer.

b. The premium for the policy shall be paid from funds contributed by the association or associations, or by employer members, or by both, or from funds contributed by the covered persons or from both the covered persons and the association, associations, or employer members.

3. Except as provided in subdivision 4, 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 such coverage in writing.

4. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer, except as otherwise prohibited in this title.

5. For a policy issued in the large group market and notwithstanding the provisions of § 38.2-3449, an insurer may (i) establish base rates formed on an actuarially sound, modified community rating methodology that considers the pooling of all participant claims and (ii) utilize each employer member's specific risk profile to determine contribution rates for each individual employer member's share of the premium by actuarially adjusting above or below established base rates.

F. A policy issued to a credit union or to a trustee or trustees or agent designated by two or more credit unions, which credit union, trustee, trustees, or agent shall be deemed the policyholder, to insure members of such credit union or credit unions for the benefit of persons other than the credit union or credit unions, trustee or trustees, or agent or any of their officials, subject to the following requirements:

1. The members eligible for insurance shall be all of the members of the credit union or credit unions, or all of any class or classes thereof.

2. The premium for the policy shall be paid by the policyholder from the credit union's funds and, except as provided in subdivision 3, must insure all eligible members.

3. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

G. Notwithstanding the provisions of subsection J, a policy issued to an association of real estate salespersons, as defined in § 54.1-2101, which association shall be deemed the policyholder, to insure members of such association, subject to the following requirements:

1. All of the members of such association shall be eligible for coverage. Members shall include (i) an employer member with at least one employee that is domiciled in the Commonwealth or (ii) a self-employed individual who (a) has an ownership right in a "trade or business," regardless of whether the trade or business is incorporated or unincorporated, (b) earns wages or self-employment income from the trade or business, and (c) works at least 20 hours a week or 80 hours a month providing personal services to the trade or business or earns income from the trade or business that at least equals the self-employed individual's cost of the health coverage.

2. The association shall (i) have at the outset a minimum of 25,000 members, (ii) have been organized and maintained in good faith for purposes other than that of obtaining insurance, (iii) have been in active existence for at least five years, and (iv) have a constitution and bylaws that provide that (a) the

association hold regular meetings not less than annually to further purposes of the members, (b) the association collects dues or solicits contributions from members, and (c) the members have voting privileges and representation on the governing board and committees.

3. In no case shall membership in the association be conditioned on any health status-related factor relating to an individual, including an employee of an employer or a dependent of an employee.

4. The health insurance coverage offered through the association shall be available to all members regardless of any health status-related factor relating to such members or individuals eligible for coverage through a member.

5. The association shall not make health insurance coverage offered through the association available other than in connection with a member of the association.

6. The premium for the policy shall be paid from funds contributed by the association or by employer members, or by both, or from funds contributed by the covered persons or from both the covered persons and the association or employer members.

7. The policy issued to such an association shall (i) be considered a large group market plan subject to all coverage mandates applicable to a large group market plan offered in the Commonwealth and the large group market insurance regulations under the federal Public Health Service Act, P.L. 78-410, as amended; (ii) be subject to the group health plan coverage requirements under the federal Patient Protection and Affordable Care Act, P.L. 111-148, as amended; (iii) be prohibited from denying coverage under the policy on the basis of a preexisting condition as set forth in § 38.2-3444; (iv) be guaranteed issue and guaranteed renewable; (v) notwithstanding the provisions of subsection A of § 38.2-3451 providing that a large group market plan is not required to provide coverage for essential health benefits in a manner that exceeds the requirements of the federal Patient Protection and Affordable Care Act, P.L. 111-148, as amended, as of January 1, 2019, be subject to the requirements to provide essential health benefits and cost-sharing requirements as set forth in § 38.2-3451; and (vi) offer a minimum level of coverage designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan.

8. The insurer issuing such a policy shall (i) treat all of the members and employees of employer members who are enrolled in coverage under the policy as a single risk pool; (ii) set premiums on the basis of all of the collective group experience of the members and employees of employer members who are enrolled in coverage under the policy; (iii) be permitted to vary premiums by age, but such rate shall not vary by more than four to one for adults; (iv) be prohibited from varying premiums on the basis of gender; (v) be prohibited from varying premiums on the basis of the health status of an individual employee of an employer member or a self-employed individual member; and (vi) not establish discriminatory rules based on the health status of an employer member, an individual employee of an employer member, or a self-employed individual for eligibility or contribution.

9. A policy that meets the requirements of subdivisions 7 and 8 shall be considered to be compliant with the large group market insurance regulations under the federal Public Health Service Act, P.L.

78-410, as amended, and, as such, the Commonwealth, through the regulation of such policy by the Commission, shall be considered to be substantially enforcing the federal Patient Protection and Affordable Care Act, P.L. 111-148, as amended, with regard to such policy. The Commission shall regulate the policy in a manner that is consistent with this subdivision. In any case in which a federal agency renders a decision that is contrary to the provisions of this subdivision, notwithstanding any other provision of law, the Attorney General may resolve any difference between federal law and the laws of the Commonwealth.

H. A policy issued to a health maintenance organization as provided in subsection B of § 38.2-4314.

I. A policy of blanket insurance issued in accordance with § 38.2-3521.2.

J. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

1998, c. 154; 2013, c. 751; 2014, c. 350; 2022, cc. 349, 350; 2023, cc. 514, 515.

§ 38.2-3521.2. Blanket accident and sickness insurance.

A. As used in this section, "blanket insurance" means that form of limited accident and sickness insurance defined as an "excepted benefit" under § 38.2-3431, providing coverage for specified circumstances and specific classes of persons defined in a policy issued to a master policyholder and not by specifically naming the persons covered, by certificate or otherwise, although a statement of the coverage provided may be given, or required by the policy to be given, to eligible persons.

B. An individual application need not be required from a person covered under a blanket insurance policy.

C. No insurer issuing a blanket insurance policy shall be required to furnish a certificate to each person covered by the policy.

D. A blanket insurance policy may be issued or issued for delivery in the Commonwealth if it conforms to one of the following descriptions:

1. A policy or contract issued to any common carrier or to any operator, owner, lessor or lessee of a means of transportation, which shall be deemed the policyholder, which policy or contract covers a group defined as all persons who may become passengers, renters, lessors, lessees, or operators defined by their travel status on such common carrier or means of transportation.

2. A policy issued to an employer, who shall be deemed the policyholder, covering any group of workers, dependents or guests defined by reference to hazards incident to any activity or activities or operations of the policyholder.

3. A policy issued to a school, an institution of higher education, a school district, school districts, or a school jurisdictional unit, or to the head, principal, or governing board thereof, who or which shall be deemed the policyholder, covering students, parents, teachers, employees, or volunteers.

4. A policy issued in the name of any volunteer or governmental fire department, first aid, civil defense, or other such volunteer group, which shall be deemed the policyholder, covering any group of the members, participants, or volunteers incident to any activity or activities or operations sponsored or supervised by such department or group.

5. A policy or contract issued to a sports team, camp, or sponsor thereof, which shall be deemed the policyholder, covering participants, members, campers, employees, officials, supervisors, or volunteers.

6. A policy or contract issued to a religious, charitable, recreational, educational, or civic organization or branch thereof, which shall be deemed the policyholder, covering any group of members, participants, or volunteers defined by reference to specified hazards incident to any activity or activities or operations sponsored or supervised by or on the premises of such policyholder.

7. A policy or contract issued to a restaurant, hotel, motel, resort, innkeeper, or other group with a high degree of potential customer liability, which shall be deemed the policyholder, covering patrons, guests, or volunteers.

8. A policy or contract issued to an entertainment production company, who shall be deemed the policyholder, covering any group of participants, volunteers, audience members, contestants, or workers.

9. A policy or contract issued to a health maintenance organization, a health care provider or other arranger of health services, which shall be deemed the policyholder, covering subscribers, patients, donors, and surrogates provided that the coverage is not made a condition of receiving care.

10. A policy or contract issued to a bank, association, financial or other institution, vendor, or to a parent holding company, or to the trustee, trustees, or agent designated by one or more banks, associations, financial or other institutions, or vendors under which accountholders, credit card holders, debtors, guarantors, or purchasers are insured.

11. A policy or contract issued to an incorporated or unincorporated association of persons having a common interest or calling, which association shall be deemed the policyholder, formed for purposes other than obtaining insurance, covering members or participants of such association.

12. A policy or contract issued to a travel agency, or other organization that provides travel related services, which organization shall be deemed the policyholder, to cover all persons for which travel related services are provided.

13. A policy issued to any other risk or class of risks which, in the discretion of the Commission, may be subject to the issuance of a blanket accident and sickness policy. The discretion of the Commission may be exercised on an individual risk basis or class of risks, or both.

E. Notwithstanding any other provision of this title, any benefits that are payable under a blanket insurance policy shall be paid directly to the person covered under such policy.

2014, c. 350.

§ 38.2-3522. Repealed.

Repealed by Acts 1998, c. 154.

§ 38.2-3522.1. Limits of group accident and sickness insurance.

Group accident and sickness insurance offered to a resident of this Commonwealth under a group accident and sickness insurance policy issued to a group other than one described in § 38.2-3521.1 shall be subject to the following requirements:

A. No such group accident and sickness insurance policy shall be delivered in this Commonwealth unless the Commission finds that:

1. The issuance of such group policy is not contrary to Virginia's public policy and is in the best interest of the citizens of this Commonwealth;

2. The issuance of the group policy would result in economies of acquisition or administration; and

3. The benefits are reasonable in relation to the premiums charged.

Insurers filing policy forms seeking approval under the provisions of this subsection shall accompany the forms with a certification, signed by the officer of the company with the responsibility for forms compliance, in which the company certifies that each such policy form will be issued only where the requirements set forth in subdivisions 1 through 3 of this subsection have been met.

B. No such group accident and sickness insurance coverage may be offered in this Commonwealth by an insurer under a policy issued in another state unless this Commonwealth or another state having requirements substantially similar to those contained in subdivisions 1, 2, and 3 of subsection A has made a determination that such requirements have been met.

1. An insurer offering group accident and sickness insurance coverage in this Commonwealth under this subsection shall file a certification, signed by the officer of the company having responsibility for forms compliance, in which the company certifies that all group insurance coverage marketed to residents of this Commonwealth under policies which have not been approved by this Commonwealth will comply with the provisions of § 38.2-3521.1 or have met the requirements set forth in subdivisions A 1 through A 3 of this section, and which clearly demonstrates that the substantially similar requirements of the state in which the contract will be issued have been met. The certification shall be accompanied by documentation from such state, evidencing the determination that such requirements have been met.

2. An insurer offering group accident and sickness insurance in this Commonwealth under this subsection that is unable to provide the documentation required in subdivision 1 of this subsection shall be required to file policy forms consistent with requirements in § 38.2-316 which are imposed on policies issued in Virginia. The policy shall be required to be approved as meeting all requirements of this title prior to its being offered to residents of this Commonwealth.

C. The premium for the policy shall be paid either from the policyholder's funds or from funds contributed by the covered persons, or from both.

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, except as otherwise prohibited in this title.

E. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

1998, c. 154; 2013, c. 751.

§ 38.2-3523. Repealed.

Repealed by Acts 1998, c. 154.

§ 38.2-3523.1. Review of records.

The Commission may review the records of any insurer to determine that the insurer's policies have been issued in compliance with the requirements set forth in this article. Insurers issuing coverage not complying with the provisions of § 38.2-3521.1 and not complying with the provisions of § 38.2-3522.1 shall be deemed to have committed a knowing and willful violation of this article, and shall be punished as set forth in subsection A of § 38.2-218.

1998, c. 154.

§ 38.2-3523.2. Policies issued outside of the Commonwealth of Virginia.

A group accident and sickness insurance policy issued outside of this Commonwealth, providing coverage to residents of this Commonwealth, that does not qualify under § 38.2-3521.1 or § 38.2-3522.1 shall be subject to the statutory requirements of this title and may subject the insurer issuing such policy to the penalties available under this title for violation of such requirements.

1998, c. 154.

§ 38.2-3523.3. Requirements for those marketing group accident and sickness insurance.

Insurance marketed to certificate holders of a group which does not qualify under § 38.2-3521.1 or § 38.2-3522.1 must be marketed by a person holding a valid life and health insurance agent license as required by Chapter 18 (§ 38.2-1800 et seq.) of this title.

1998, c. 154; 1999, c. 86.

§ 38.2-3523.4. Minimum number of persons covered.

A. A group accident and sickness insurance policy shall on the issue date and at each policy anniversary date, cover at least two persons, other than spouses or minor children, unless such spouse or minor child is determined to be an eligible employee as defined in § 38.2-3431.

B. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

1998, c. 154; 2013, c. 751.

§ 38.2-3524. Repealed.

Repealed by Acts 1998, c. 154.

§ 38.2-3525. Group accident and sickness insurance coverages of spouses, dependent children or other persons.

A. Coverage under a group accident and sickness insurance policy, except a policy issued pursuant to subsection B of § 38.2-3521.1, may be extended to insure:

1. The spouse and any child who is (i) under the age of 19 years, (ii) who is a dependent and under the age of 25 years, or (iii) who is a dependent and a full-time student under 25 years of age, without regard to whether such child resides in the same household as the insured group member, or any class of spouse and dependent children, of each insured group member who so elects; and

2. Any other class of persons as may mutually be agreed upon by the insurer and the group policyholder.

B. The amount of accident and sickness insurance for the spouse, dependent child or other person shall not exceed the amount of accident and sickness insurance for the insured group member.

C. At the insurer's option and subject to the policyholder's election, the coverage for children of the insured group member may be extended beyond the ages established in subsection A. Any such extension of coverage shall be as mutually agreed upon by the insurer and the group policyholder.

D. Notwithstanding the provisions of § 38.2-3538, one certificate may be issued for each insured group member if a statement concerning any spouse's, dependent child's, or other person's coverage is included in the certificate.

E. When a policy provides coverage for a dependent child who is enrolled based upon the child's status as a full-time student and such child is unable due to a medical condition to continue as a full-time student, coverage under the policy for such child nevertheless shall continue in force provided the child's treating physician certifies to the insurer at the time the child withdraws as a full-time student that the child's absence is medically necessary. Coverage for such child shall continue in force until the earlier of (i) the date that is 12 months from the date the child ceases to be a full-time student or (ii) the date the child no longer qualifies as a dependent child under the terms of the group policy. A child's status as a full-time student shall be determined in accordance with the criteria specified by the institution in which the child is enrolled.

F. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

1986, c. 562; 1993, c. 306; 1998, c. 154; 2004, c. 771; 2005, c. 871; 2007, c. 428; 2008, c. 209; 2011, c. 882.

§ 38.2-3526. Standard provisions required; exceptions.

A. No group accident and sickness insurance policy shall be delivered or issued for delivery in this Commonwealth unless it contains the standard provisions prescribed in this article.

B. The provisions of § 38.2-3531, subsection A of §§ 38.2-3533 and 38.2-3538 shall not apply to policies issued pursuant to subsection B of § 38.2-3522.1.

1986, c. 562; 1998, c. 154.

§ 38.2-3527. Grace period.

Each group accident and sickness insurance policy shall contain a provision that the policyowner is entitled to a grace period of not less than thirty-one days for the payment of any premium due except the first premium. The provision shall also state that during the grace period the accident and sickness coverage shall continue in force unless the policyowner has given the insurer written notice of discontinuance in accordance with the terms of the policy and in advance of the date of discontinuance. The policy may provide that the policyowner shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during the grace period.

1986, c. 562.

§ 38.2-3528. Incontestability.

A. Each group accident and sickness insurance policy shall contain a provision that the validity of the policy shall not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue.

B. The provision shall also state that no statement made by any person insured under the policy relating to his insurability or the insurability of his insured dependents shall be used in contesting the validity of the insurance with respect to which such statement was made:

1. After the insurance has been in force prior to the contest for a period of two years during the lifetime of the person about whom the statement was made; and

2. Unless the statement is contained in a written instrument signed by him.

C. This provision shall not preclude the assertion at any time of defenses based on the person's ineligibility for coverage under the policy or upon other provisions in the policy.

1986, c. 562.

§ 38.2-3529. Entire contract; statements deemed representations.

A. Each group accident and sickness insurance policy shall contain a provision that the policy, and any application of the policyowner, and any individual applications of the persons insured shall constitute the entire contract between the parties.

B. The provision shall also state that:

1. A copy of any application of the policyowner shall be attached to the policy when issued;

2. All statements made by the policyowner or by the persons insured shall be deemed representations and not warranties; and

3. No written statement made by any person insured shall be used in any contest unless a copy of the statement is furnished to the person or to his beneficiary or personal representative.

1986, c. 562.

§ 38.2-3530. Evidence of individual insurability.

Each group accident and sickness insurance policy shall contain a provision setting forth any conditions under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of his coverage.

1986, c. 562.

§ 38.2-3531. Additional exclusions and limitations.

A. Each group accident and sickness insurance policy shall contain a provision specifying all additional exclusions or limitations applicable under the policy for any disease or physical condition of a person, not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss, which existed prior to the effective date of the person's coverage under the policy.

B. Any such exclusion or limitation may only apply to a disease or physical condition for which medical advice or treatment was received by the person during the twelve months prior to the effective date of the person's coverage. The exclusion or limitation shall not apply to loss incurred or disability commencing after the earlier of (i) the end of a continuous period of twelve months commencing on or after the effective date of the person's coverage during which the person receives no medical advice or treatment in connection with the disease or physical condition, or (ii) the end of the two-year period commencing on the effective date of the person's coverage.

C. This section shall not apply to group accident and sickness policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis to an employer's employees and their dependents.

1986, c. 562; 1998, c. 24.

§ 38.2-3532. Misstatement of age.

Each group accident and sickness insurance policy where the premiums or benefits vary by age shall contain a provision that an equitable adjustment of premiums, benefits or both shall be made if the age of a person insured has been misstated. The provision shall contain a clear statement of the method of adjustment to be used.

1986, c. 562.

§ 38.2-3533. Individual certificates.

A. Each group accident and sickness insurance policy shall contain a provision that the insurer will issue to the policyholder for delivery to each person insured a certificate setting forth:

1. The insured person's insurance protection, including any limitations, reductions, and exclusions applicable to the coverage provided;

2. To whom the insurance benefits are payable;

3. Any family member's or dependent's coverage; and

4. The rights and conditions set forth in § 38.2-3541.

B. Each group policy issued pursuant to § 38.2-3522.1 B, where any part of the premium is paid by debtors from identifiable charges collected from the insured debtors not required of an uninsured debtor, shall contain a provision that the insurer will furnish to the policyholder for each debtor insured under the policy a form that will contain a statement describing the debtor's coverage and that the benefits payable shall be applied to reduce or extinguish the indebtedness.

1986, c. 562; 1998, c. 154.

§ 38.2-3534. Notice of claim.

Each group accident and sickness insurance policy shall contain a provision that written notice of a claim shall be given to the insurer within twenty days after the occurrence or commencement of any loss covered by the policy. Failure to give notice within that time shall not invalidate or reduce any claim if it can be shown that notice was given as soon as reasonably possible.

1986, c. 562.

§ 38.2-3535. Claim forms.

Each group accident and sickness insurance policy shall contain a provision that the insurer will furnish forms for filing proof of loss to the person making a claim or to the policyholder for delivery to that person. If the forms are not furnished within fifteen days after the insurer received notice of any claim under the policy, the person making the claim shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting within the time fixed in the policy of filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which a claim is made.

1986, c. 562.

§ 38.2-3536. Proofs of loss.

A. Each group accident and sickness insurance policy shall contain a provision that written proof of the loss shall be furnished to the insurer within ninety days after the date of the loss. In the case of a claim for loss of time for disability, each group accident and sickness insurance policy shall contain a provision that written proof of the loss shall be furnished to the insurer within ninety days after the commencement of the period for which the insurer is liable. Subsequent written proof of the continuance of the disability shall be furnished to the insurer at reasonable intervals required by the insurer.

B. Failure to furnish such proof within the prescribed time shall not invalidate or reduce any claim if it was not reasonably possible to furnish the proof within that time and the proof is furnished as soon as reasonably possible. In no event, except in the absence of legal capacity of the claimant, shall such proof be furnished later than one year from the time proof is otherwise required.

1986, c. 562.

§ 38.2-3537. Time of payment of claims.

Each group accident and sickness insurance policy shall contain a provision that all benefits payable under the policy other than benefits for loss of time shall be payable within sixty days after receipt of

proof of loss. The provision shall also state that, subject to proof of loss, all accrued benefits payable under the policy for loss of time shall be paid at least monthly during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of such period will be paid as soon as possible.

1986, c. 562.

§ 38.2-3538. Payment of benefits.

Each group accident and sickness insurance policy shall contain a provision that benefits for loss of life of the person insured shall be payable to the beneficiary designated by the person insured. However, if the policy contains conditions pertaining to family status, the beneficiary may be the family member specified by the policy terms. In either case, payment of those benefits is subject to the provisions of the policy in the event no such designated or specified beneficiary is living at the death of the person insured. The policy may also provide that if any benefit is payable to the estate of a person, or to a person who is a minor or otherwise not competent to give a valid release, the insurer may pay the benefit, up to an amount not exceeding $5,000, to any relative by blood or connection by marriage of the person who is deemed by the insurer to be equitably entitled to the benefit. The policy may also provide that all or any portion of any benefits provided for health care services may be paid to the health care services provider. All other benefits of the policy shall be payable to the person insured.

1986, c. 562; 1991, c. 87.

§ 38.2-3539. Physical examinations and autopsy.

Each group accident and sickness insurance policy shall contain a provision that the insurer shall have the right (i) to examine the person for whom a claim is made when and as often as it may reasonably require during the pendency of claim under the policy and (ii) to make an autopsy where it is not prohibited by law.

1986, c. 562.

§ 38.2-3540. Legal actions.

Each group accident and sickness insurance policy shall contain a provision that no action at law or in equity shall be brought to recover on the policy within sixty days after proof of loss has been filed in accordance with the policy requirements and that no such action shall be brought after the expiration of three years from the time that proof of loss was required to be filed.

1986, c. 562.

§ 38.2-3540.1. Claims experience.

A. Each group accident and sickness insurance policy and health care plan shall contain a provision which provides that the insurer, upon request, shall provide a policyholder that employed an average of at least 100 individuals who were insureds, subscribers, or enrollees on business days during the preceding 12-month period with a complete record of the policyholder's medical claims experience or medical costs incurred under the group policy, contract or plan. This record shall include all claims incurred for the lesser of (i) the period of time since the policy, contract or plan was issued or issued

for delivery or (ii) the period of time since the policy, contract, or plan was last renewed, reissued or extended, if already issued. This record shall be made available promptly to the policyholder upon request made not less than 30 days prior to the date upon which the premiums or contractual terms of the policy, contract or plan may be amended. Nothing in this section shall require the disclosure of personal or privileged information about an individual that is protected from disclosure under Chapter 6 (§ 38.2-600 et seq.) of this title, or under any other applicable federal or state law or regulation. No policyholder shall be required to pay for information requested pursuant to this section.

B. A policyholder that employed an average of at least 100 individuals who were insureds, subscribers or enrollees on business days during the preceding 12-month period shall receive from its insurer, upon request, at the time that the insurer provides a record of medical claims experience or medical costs under subsection A of this section (i) a summary of medical claims charges or medical costs incurred and the amount paid with respect to those claims for the most recently available 24-month period; (ii) a listing of the number of insured, subscribers or enrollees for whom combined medical claims payments or medical costs exceed $100,000 for the most recently available 12-month period, and for the preceding 12 months if not previously provided, with information as to whether these enrollees from the most recently available 12-month period remain enrolled under the policy, and provided that a policyholder and insurer may agree by contract to provide the listing for amounts less than $100,000; and (iii) total enrollment in each membership type as of the end of the most recently available 12-month period. This record shall be made available to the policyholder within 20 business days upon written request made not less than 45 days prior to the date upon which the premiums or contractual terms of the policy may be amended. Nothing in this section shall require the disclosure of personal or privileged information about an individual that is protected from disclosure under Chapter 6 (§ 38.2-600 et seq.) of this title, or under any other applicable federal or state law or regulation. No policyholder shall be required to pay for information requested pursuant to this section.

C. With respect to group accident and sickness insurance policies, the requirements of this section shall apply to all policies, contracts, and plans delivered, issued for delivery, reissued or extended on and after July 1, 2003, or at any time after the effective date hereof when any term of any such policy, contract or plan is changed or any premium adjustment is made. With respect to health care plans, the requirements of this section shall apply to all contracts delivered, issued for delivery, reissued or extended on and after January 1, 2005, or at any time after the effective date hereof when any term of any such contract or plan is changed or any premium adjustment is made.

1992, c. 800; 1999, c. 116; 2003, c. 654; 2004, c. 772.

§ 38.2-3540.2. Employee wellness program.

A. Each group accident and sickness insurance policy and health care plan may provide a premium discount to every employer instituting and maintaining an employee wellness program satisfying such criteria as each insurer may establish. An employer instituting and maintaining an employee wellness program in accordance with the insurer's criteria may require that any employee wishing to enroll in such program undergo a health assessment as a condition of enrollment.

B. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

2010, c. 272; 2013, c. 751.

§ 38.2-3541. Continuation on termination of eligibility.

A. Each group hospital policy, group medical and surgical policy, or group major medical policy delivered or issued for delivery in the Commonwealth or renewed, reissued, or extended if already issued, shall contain a provision for continuation of coverage under the group policy if the insurance on a person covered under such a policy ceases because of the termination of the person's eligibility for coverage, prior to that person becoming eligible for Medicare or Medicaid benefits. This provision shall not be applicable if the group policyholder is required by federal law to provide for continuation of coverage under its group health plan pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

B. The insured's present coverage shall continue under the policy for a period of 12 months immediately following the date of the termination of the person's eligibility, without evidence of insurability, subject to the following requirements:

1. The application and payment for the extended coverage is made to the group policyholder within 31 days after issuance of the written notice required in subsection C, but in no event beyond the 60-day period following the date of the termination of the person's eligibility;

2. Each premium for such extended coverage is timely paid to the group policyholder on a monthly basis during the 12-month period;

3. The premium for continuing the group coverage shall be at the insurer's current rate applicable to the group policy plus any applicable administrative fee not to exceed two percent of the current rate;

4. Continuation shall only be available to an employee or member who has been continuously insured under the group policy during the entire three-month period immediately preceding termination of eligibility; and

5. Continuation shall not be available to an individual whose eligibility for coverage under the group policy ceased because the individual was discharged from employment by the group policyholder for gross misconduct. As used in this subdivision, "gross misconduct" means any conduct connected with the individual's work that would constitute misconduct under § 60.2-618, including deliberately and willfully engaging in conduct evincing a complete disregard for the employer's workplace standards and policies.

C. The group policyholder shall provide each employee or other person covered under such a policy written notice of the availability of continuation of coverage and the procedures and timeframes for obtaining continuation of the group policy. Such notice shall be provided within 14 days of the policyholder's knowledge of the employee's or other covered person's loss of eligibility under the policy.

1979, c. 97, § 38.1-348.11; 1982, c. 625; 1984, c. 300; 1986, c. 562; 1988, c. 551; 2010, c. 503; 2014, c. 814; 2018, c. 471.

§ 38.2-3541.1. Repealed.

Repealed by Acts 2014, c. 814, cl. 2

§ 38.2-3541.2. Enrollment following change in eligibility status under assistance programs.

A. As used in this section, "assistance program" means the Commonwealth's medical assistance services program, established pursuant to § 32.1-325, or the Family Access to Medical Insurance Security Plan, established pursuant to § 32.1-351, including under any waiver or demonstration project conducted under or in relation thereto.

B. Any employer providing health insurance coverage for his employees under a group accident and sickness insurance policy, or subscription contract, or other evidence of coverage shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the policy, contract or plan, or a dependent of such an employee, if the dependent is eligible but not enrolled, for coverage under such terms, to enroll for coverage under the terms of the policy, contract or plan, if either of the following conditions is met:

1. The employee or dependent has received health insurance coverage under an assistance program, coverage of the employee or dependent under the assistance program is terminated as a result of loss of eligibility for such coverage, and the employee requests coverage under the group policy, contract or plan not later than 60 days after the date of termination of coverage under the assistance program; or

2. The employee or dependent becomes eligible under an assistance program for premium assistance for the purchase of coverage under the group policy, contract or plan, including contributions to the cost of employer-sponsored health insurance pursuant to subsection C of § 32.1-351.1, and the employee requests coverage under the group policy, contract or plan not later than 60 days after the date the employee or dependent is determined to be eligible for such premium assistance.

C. Any employer providing health insurance coverage for his employees under a group accident and sickness insurance policy, or subscription contract, or other evidence of coverage within the Commonwealth, shall provide to each employee a written notice informing the employee of premium assistance opportunities currently available for the employee or the employee's dependents through the Commonwealth's assistance programs. For purposes of compliance with this subsection, for employees residing within the Commonwealth, the employer may use a Virginia-specific model notice developed in accordance with section 701(f)(3)(B)(i)(II) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1181 (f)(3)(B)(i)(II)). An employer may provide the Virginia-specific model notice concurrent with (i) the furnishing of materials notifying the employee of health plan eligibility; (ii) materials provided to the employee in connection with an open season or election process conducted under the plan; or (iii) the furnishing of the summary plan description as provided in section 104(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1024).

D. If an employee or the employee's dependents are covered under an assistance program and potentially eligible for premium assistance for the purchase of coverage under the employer's group health plan, the plan administrator of the group health plan shall disclose to the Department of Medical Assistance Services, upon request, information about the benefits available under the group health plan in sufficient specificity, as determined under regulations of the Secretary of Health and Human Services in consultation with the Secretary, that require use of the model coverage coordination disclosure form developed under § 311(b)(1)(C) of the Children's Health Insurance Program Reauthorization Act of 2009, so as to permit the Department of Medical Assistance Services to make a determination concerning the cost-effectiveness of the provision by the Commonwealth of contributions to the cost of employer-sponsored health insurance, through premium assistance for the purchase of coverage under such group health plan, and in order for the Department of Medical Assistance Services to provide any required supplemental benefits under an assistance program.

2010, c. 504.

§ 38.2-3542. Notice to employees upon termination of coverage; penalty for failure to remit funds.

A. Any employer who (i) assumes part or all of the cost of providing group accident and sickness insurance or a group health services plan or group health care plan for his employees under a group insurance policy or subscription contract or other evidence of coverage; (ii) provides a facility for deducting the full amount of the premium from employees' salaries and remitting such premium to the insurer, health services plan, or health maintenance organization; or (iii) provides for health and medical care or reimbursement of medical expenses for his employees as a self-insurer, shall give written notice to participating employees in the event of termination or upon the receipt of notice of termination of any such policy, contract, coverage, or self-insurance not later than fifteen days after the termination of a self-insured plan or receipt of the notice of termination required by subsection C of this section.

B. Any employer who collects from his employees or covers any part of the cost of any of the policies, contracts, or coverages specified in subsection A of this section and who knowingly fails to remit to the insurer or plan such funds required to maintain coverage in accordance with the policy or contract provisions under which the employees are covered shall be guilty of a Class 1 misdemeanor and shall be subject to civil suit for any medical expenses the employee may become liable for as a result of the employer letting such coverage be terminated.

C. In the event the coverages specified in subsection A of this section are terminated due to nonpayment of premium by the employer, no such coverages shall be terminated by an insurer, health services plan, health maintenance organization or health insurance issuer as defined in § 38.2-3431 with respect to a covered individual unless and until the employer has been provided with a written or printed notice of termination, including a specific date, not less than fifteen days from the date of such notice, by which coverage will terminate if overdue premium is not paid. Coverage shall not be permitted to terminate for at least fifteen days after such notice has been mailed. Each insurer, health services plan, or health maintenance organization shall make reimbursement on all valid claims for services incurred prior to the date coverage is terminated.

1982, c. 586, § 38.1-356.01; 1986, cc. 251, 562; 1990, c. 301; 1999, c. 276.

§ 38.2-3543. Provisions required by other jurisdictions.

A. Group accident and sickness insurance policies of a foreign or alien insurer, delivered or issued for delivery in this Commonwealth, may contain any provision that is not less favorable to the insured or the beneficiary than the provisions required by this article and that is prescribed by the laws of its domiciliary jurisdiction.

B. Any group accident and sickness insurance policy of a domestic insurer may, when delivered or issued for delivery in any other jurisdiction, contain any provision permitted or required by the laws of that jurisdiction.

1986, c. 562.

§ 38.2-3543.1. Regulations.

The Commission may establish rules and regulations for coordination of benefits, as well as to establish standards to be met in connection with the marketing and contracting for group accident and sickness insurance in this Commonwealth. Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such rules and regulations as it may deem necessary to establish standards with regard to coordination of benefits provisions.

1994, c. 316; 1998, c. 154.

§ 38.2-3543.2. Applicability of laws.

In the event of conflict between the provisions of this article and other provisions of this title, the provisions of this article shall be controlling.

1998, c. 154.

Article 4 - INDUSTRIAL SICK BENEFIT INSURANCE

§ 38.2-3544. Definition of industrial sick benefit insurance.

Industrial sick benefit insurance means life insurance combined with accident and sickness insurance under which:

1. Premiums, dues or assessments are payable weekly;

2. A ten dollar maximum weekly indemnity is paid to members or policyowners in the event of sickness or accident;

3. A $250 maximum death benefit is provided, and the named beneficiary is confined to the spouse of the insured, a relative of the insured by blood, marriage or adoption, a person bound in a pledge of marriage to the insured, or any person dependent on the insured; and

4. The issuing insurer is not required by its charter, bylaws, or by statute to maintain the legal reserve for death benefits.

Code 1950, §§ 38-350, 38-351, 38-352; 1952, c. 317, § 38.1-483; 1986, c. 562.

§ 38.2-3545. Further restrictions as to beneficiaries.

Within the permitted classes of beneficiaries prescribed in § 38.2-3544, the issuing insurer may designate the classes of beneficiaries. No change of beneficiary shall be made by assignment, will, or otherwise to any person outside the designated classes without the consent of the insurer. If no person within the classes of beneficiaries prescribed in § 38.2-3544 survives the insured, the insurer may discharge its liability by payment of the proceeds of the policy to any person appearing to the insurer to be equitably entitled to the proceeds because of having incurred expense for the maintenance, medical attention or burial of the insured.

Code 1950, § 38-352; 1952, c. 317, § 38.1-484; 1986, c. 562.

§ 38.2-3546. Cancellation of sick benefit portion of policy.

Every policy of industrial sick benefit insurance issued in this Commonwealth after June 18, 1922, shall contain a provision that:

1. The sick benefit portion of the policy may be cancelled by either the insurer or the insured and the life portion continued by a payment of twenty percent of the original premium;

2. If the cancellation is by the insurer, it shall be without prejudice to any claim arising on account of disability commencing prior to the date on which the cancellation takes effect; and

3. Written notice of the cancellation and payment for the unearned portion of the premium shall be delivered to the insured or mailed to him at his last known address.

Code 1950, § 38-359; 1952, c. 317, § 38.1-485; 1986, c. 562.

§ 38.2-3547. Excessive insurance; remedy.

A. Any person holding industrial sick benefit insurance policies of several insurers, that, in the aggregate, provide sick benefits in excess of 150 percent of his weekly salary, wages or earnings, shall not be permitted to recover the excess, nor shall the insurer be compelled to pay the excess, unless the existence of all previous policies was admitted by the insured in all applications for insurance in excess of such sum. If by misstatements, or by the failure to admit the existence of previous policies, the insured has obtained such excess additional policies, and has received benefits under such policies in excess of the amount specified above the excess paid may be deducted from the death benefit provided for in the policies.

B. This section shall not apply in any case where the application for the excess policy did not contain any question in regard to the amount of insurance already carried by the applicant, nor where the application blank was printed in less than ten-point type.

Code 1950, § 38-360; 1952, c. 317, § 38.1-486; 1986, c. 562.

§ 38.2-3548. Agents subject to other insurance laws.

Each person representing any insurer in the sale of industrial sick benefit insurance shall be subject to the laws governing agents of insurers.

Code 1950, § 38-361; 1952, c. 317, § 38.1-487; 1986, c. 562.

§ 38.2-3549. Benefits not subject to legal process.

The payments in weekly or monthly installments to the holder of any policy of industrial sick benefit insurance shall not be subject to the lien of any attachment, garnishment proceeding, writ of fieri facias, or to levy or distress in any manner, for any debt due by the holder of the policy.

Code 1950, § 38-227; 1952, c. 317, § 38.1-488; 1986, c. 562.

§ 38.2-3550. Effective date.

No industrial sick benefit insurance policy as defined in § 38.2-3544 shall be delivered or issued for delivery in this Commonwealth after June 30, 1987.

1986, c. 562.

Article 5 - SMALL EMPLOYER HEALTH INSURANCE POOLING

§ 38.2-3551. Definitions.

A. As used in this article:

"Eligible dependent" means an individual who may be covered as a dependent under a group health policy or policies and who is eligible, as determined by a small employer health group cooperative, for coverage as a dependent of an eligible employee under a group health policy or policies issued to or through such small employer health group cooperative.

"Eligible employee" means an employee who works for a small employer on a full-time basis, has a normal work week of 30 or more hours, has satisfied applicable waiting period requirements, and is not a part-time, temporary, or substitute employee.

"Employer-member" means a small employer participating in a small employer health group cooperative.

"Group health policy" or "policy" means a group insurance policy providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, a group accident and sickness insurance policy or subscription contract, and a group health care plan for health care services or limited health care services provided by a health maintenance organization. For the purposes of this article, a group health policy or policy shall also mean a policy or plan provided by a dental or optometric services plan, dental plan organization, and a health maintenance organization offering limited health care services as defined in § 38.2-4300.

"Health insurance issuer" or "issuer" means a company authorized to issue coverage under Article 3 (§ 38.2-3521.1 et seq.) of Chapter 35, Chapter 42 (§ 38.2-4200 et seq.), Chapter 43 (§ 38.2-4300 et seq.), Chapter 45 (§ 38.2-4500 et seq.), or Chapter 61 (§ 38.2-6100 et seq.) of this title.

"Health status-related factor" means the following in relation to the individual or a dependent eligible for coverage under a group health plan or health insurance coverage offered by a health insurance issuer:

1. Health status;

2. Medical condition, including both physical and mental illnesses;

3. Claims experience;

4. Receipt of health care;

5. Medical history;

6. Genetic information;

7. Evidence of insurability, including conditions arising out of acts of domestic violence; or

8. Disability.

"Service area" means the geographic area within which a health insurance issuer is authorized to sell a group health policy or policies.

"Small employer" means, in connection with a group health policy with respect to a calendar year and a plan year, an employer who employed an average of at least one but not more than 50 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year.

"Small employer health group cooperative" or "cooperative" means an entity authorized by its employer-members to negotiate with health insurance issuers on their behalf as to the terms, including premium rates, under which a group health policy or policies may be issued, providing coverage for the eligible employees of such employer-members and their eligible dependents.

B. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

2006, c. 427; 2013, c. 751; 2016, c. 1.

§ 38.2-3552. Small employer health group cooperatives.

A. 1. Any person or persons may organize and maintain a small employer health group cooperative for the purpose of offering, providing, or facilitating the provision of coverage for health care services to its employer-members.

2. The membership of the small employer health group cooperative shall consist only of small employers. To participate as an employer-member of a small employer health group cooperative, an employer shall be a small employer.

3. A person or persons organizing a small employer health group cooperative and the small employers who propose to become employer-members of such cooperative shall jointly execute a small employer health group cooperative agreement. Such agreement shall identify the duties, rights and obligations of the parties, and may include terms addressing (i) the length of time an employer-member shall be enrolled through the cooperative and (ii) the conditions under which an employer-member may withdraw from the cooperative. If a small employer health group cooperative opts to be deemed the policyholder under subdivision 1 a of subsection B of this section, the small employer health group

cooperative agreement shall include provisions addressing the collection of funds from employer-members for the payment of all premiums due under the group health policy. Such provisions shall specifically address all rights and obligations of each employer-member within the cooperative when one or more employer-members fails to remit its respective share of any premium due. Such provisions shall also describe the circumstances under which the group health policy will lapse for nonpayment of premiums and shall identify the grace period requirements applicable to group accident and sickness insurance, pursuant to § 38.2-3527. Nothing in this subsection nor in the small employer health group cooperative agreement shall preclude or operate to prevent enforcement by the issuer of the provisions of the group health policy addressing the payment of premiums and termination of the policy due to nonpayment of premium.

B. A small employer health group cooperative shall be treated as, and given the same consideration and privileges as, a single entity for purposes of negotiating the terms, including premium rates, under which coverage may be issued or provided to the employer-members of the cooperative by a health insurance issuer proposing to issue a group health policy or policies for such purpose covering employer-members of the cooperative within the service area of the issuer, as follows:

1. At the option of the small employer health group cooperative, the cooperative shall either:

a. Be deemed the policyholder of such group health policy or policies covering its employer-members within the service area of the issuer; or

b. Be deemed only a sponsoring entity facilitating the acquisition of separate group health policies for its employer-members within the service area of the issuer, which may be made available through the cooperative by the issuer at terms mutually agreed upon by the cooperative and the issuer; and

2. A small employer health group cooperative opting to be deemed the policyholder under subdivision 1 a of this subsection shall obtain authorization acceptable to the health insurance issuer from each of its employer-members to act on behalf of the employer-members in this capacity. Such authorization:

a. Shall be included in the terms of the agreement referenced in subdivision 3 of subsection A;

b. Shall identify the specific representatives of the cooperative who shall be permitted to enter into insurance contracts on behalf of the employer-members; and

c. Shall specify the extent and limits of such authority.

C. To the extent that the activities of the cooperative or its representatives constitute selling, soliciting, or negotiating contracts of insurance, as those terms are defined in § 38.2-1800, the provisions of Chapter 18 (§ 38.2-1800 et seq.) of this title shall apply.

D. To the extent a small employer health group cooperative is a multiple employer welfare arrangement as that term is defined in regulations promulgated pursuant to § 38.2-3420, it shall be subject to all provisions of this title to the extent that such provisions are applicable to multiple employer welfare arrangements.

2006, c. 427.

§ 38.2-3553. Membership in a small employer health group cooperative.

A. A small employer health group cooperative:

1. Shall not limit, restrict, or condition a small employer's membership in the small employer health group cooperative on any health status-related factor relating to an individual, including an employee of a small employer or a dependent of an employee; and

2. Shall make group health policies offered through the small employer health group cooperative available to all eligible employees of its employer-members and their eligible dependents, regardless of any health status-related factor relating to individuals eligible for coverage through a member.

B. Notwithstanding subdivision 2 of subsection A, nothing in this article shall be construed as requiring (i) an issuer to provide coverage outside its service area or (ii) a small employer health group cooperative to make such coverage available to employer-members located outside the service area of the issuer.

C. A small employer health group cooperative shall not make group health policies offered through the cooperative available other than to the eligible employees of its employer-members and their eligible dependents.

2006, c. 427.

§ 38.2-3554. Provisions relating to health insurance issuers.

A. No group health policy shall be offered to a small employer group health cooperative that will cover a resident of the Commonwealth unless the Commission finds that:

1. The issuance of such group health policy is not contrary to Virginia's public policy and is in the best interest of the citizens of the Commonwealth;

2. The issuance of the group health policy would result in economies of acquisition or administration; and

3. The benefits are reasonable in relation to the premiums charged.

B. Issuers filing policy forms seeking approval under the provisions of this subsection shall provide with the forms a certification, signed by the officer of the company with the responsibility for forms compliance, in which the company certifies that each such policy form will be issued only when the requirements set forth in subdivisions 1 through 3 of subsection A have been satisfied.

C. If a small employer health group cooperative has elected, under subdivision B 1 a of § 38.2-3552, to be deemed the policyholder of a group health policy covering the eligible employees and eligible dependents of its employer-members within the service area of an issuer and has furnished the authorization required under subdivision B 2 of § 38.2-3552, the issuer of such policy shall deem the small employer health group cooperative to be the policyholder in all respects permissible under applicable state and federal laws and regulations.

D. If a small employer health group cooperative has elected, under subdivision B 1 b of § 38.2-3552, to be deemed only a sponsoring entity facilitating the acquisition of separate group health policies for its employer-members within the service area of an issuer, the issuer shall issue a separate policy to each such employer-member of the cooperative. Each such policy shall conform to the benefit and premium specifications and other policy terms mutually agreed upon by the issuer and the small employer health group cooperative in accordance with subsection B of § 38.2-3552.

E. An issuer providing a group health policy or policies to or through a small employer health group cooperative shall make such policy or policies available to every eligible employee of an employer-member within its service area who applies for such policy or policies, and their eligible dependents, subject to an individual employee's right to reject coverage in writing. No coverage may be offered only to certain eligible employees or their eligible dependents, and no eligible employees or their eligible dependents may be excluded or charged additional premiums, because of health status-related factors.

F. The premiums for the policy or policies issued to or through a small employer health group cooperative shall be paid from funds contributed by the small employer health group cooperative, its employer-members, or both; or from funds contributed by the covered persons, or from both the covered persons and the employer-members or small employer health group cooperative.

2006, c. 427.

§ 38.2-3555. Authority of the Commission.

Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such rules and regulations as it may deem necessary to implement this article.

2006, c. 427.

Chapter 35.1 - Health Carrier Internal Appeal Process and External Review

§ 38.2-3556. Definitions.

As used in this chapter, unless the context requires a different meaning:

"Adverse determination" means a determination by a health carrier or its designee utilization review entity that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated.

"Ambulatory review" means utilization review of health care services performed or provided in an outpatient setting.

"Authorized representative" means (i) a person to whom a covered person has given express written consent to represent the covered person in an external review, (ii) a person authorized by law to provide substituted consent for a covered person, or (iii) a family member of the covered person or the

covered person's treating health care professional only when the covered person is unable to provide consent.

"Best evidence" means evidence based on (i) randomized clinical trials; if randomized clinical trials are not available, then (ii) cohort studies or case-control studies; if clauses (i) and (ii) are not available, then (iii) case-series; or if clauses (i), (ii), and (iii) are not available, then (iv) expert opinion.

"Case-control study" means a retrospective evaluation of two groups of patients with different outcomes to determine which specific interventions the patients received.

"Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.

"Case-series" means an evaluation of a series of patients with a particular outcome, without the use of a control group.

"Certification" means a determination by a health carrier or its designee utilization review entity that an admission, availability of care, continued stay, or other health care service has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, and effectiveness.

"Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by a health carrier to determine the necessity and appropriateness of health care services.

"Cohort study" means a prospective evaluation of two groups of patients with only one group of patients receiving a specific intervention.

"Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

"Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

"Covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan.

"Discharge planning" means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility.

"Emergency medical condition" means the sudden and, at the time, unexpected onset of a health condition or illness that requires immediate medical attention, where failure to provide medical attention would result in a serious impairment to bodily functions or a serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

"Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

"Evidence-based standard" means the conscientious, explicit, and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients.

"Expert opinion" means a belief or an interpretation by specialists with experience in a specific area about the scientific evidence pertaining to a particular service, intervention, or therapy.

"Facility" means an institution providing health care services or a health care setting, including hospitals and other licensed inpatient centers; ambulatory surgical or treatment centers; skilled nursing centers; residential treatment centers; diagnostic, laboratory, and imaging centers; and rehabilitation and other therapeutic health settings.

"Final adverse determination" means an adverse determination involving a covered benefit that has been upheld by a health carrier, or its designee utilization review entity, at the completion of the health carrier's internal appeal process.

"Health benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

"Health care professional" means a physician or other health care practitioner licensed, accredited, or certified to perform specified health care services consistent with the laws of the Commonwealth.

"Health care provider" or "provider" means a health care professional or a facility.

"Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

"Health carrier" means an entity, subject to the insurance laws and regulations of the Commonwealth or subject to the jurisdiction of the Commission, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an accident and sickness insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or a nonstock corporation offering or administering a health services plan, a hospital services plan, or a medical or surgical services plan, or any other entity providing a plan of health insurance, health benefits, or health care services except as excluded under § 38.2-3557.

"Independent review organization" means an entity that conducts independent external reviews of adverse determinations and final adverse determinations.

"Medical or scientific evidence" means evidence found in (i) peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; (ii) peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medica (EMBASE); (iii) medical journals recognized by the Secretary of Health and Human Services under §

1861(t)(2) of the federal Social Security Act; (iv) the following standard reference compendia: the American Hospital Formulary Service Drug Information; Drug Facts and Comparisons; the American Dental Association Accepted Dental Therapeutics; the United States Pharmacopeia -- Drug Information; National Comprehensive Cancer Network's Drugs & Biologics Compendium; and Elsevier Gold Standard's Clinical Pharmacology; (v) findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the federal Agency for Healthcare Research and Quality, the National Institutes of Health, the National Cancer Institute, the National Academy of Sciences, the Centers for Medicare and Medicaid Services, the federal Food and Drug Administration, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services; or (vi) any other medical or scientific evidence that is comparable to the sources listed in clauses (i) through (v).

"NAIC" means the National Association of Insurance Commissioners.

"Prospective review" means utilization review conducted prior to an admission or a course of treatment.

"Randomized clinical trial" means a controlled, prospective study of patients that have been randomized into an experimental group and a control group at the beginning of the study with only the experimental group of patients receiving a specific intervention and includes study of the groups for variables and anticipated outcomes over time.

"Retrospective review" means a review of medical necessity conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.

"Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the clinical necessity and appropriateness of the initial proposed health care service.

"Utilization review" means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

"Utilization review entity" means an individual or entity that conducts utilization review.

2011, c. 788.

§ 38.2-3557. Scope of chapter.

A. This chapter shall apply to all health carriers, except that the provisions of this chapter shall not apply to a policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, disability income, hospital indemnity, long-term care, dental, vision care, or any other limited supplemental benefit or to a Medicare supplement policy of insurance, coverage under a plan through Medicare, Medicaid, or the federal employees health benefits program,

self-insured plans, any coverage issued under Chapter 55 of Title 10 of the U.S. Code, and any coverage issued as supplemental to that coverage, any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis.

B. Notwithstanding the provisions of this section, self-insured employee welfare benefit plans may request a standard external review from the Commission. "Employee welfare benefit plan" has the meaning set forth in the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002 (1).

2011, c. 788.

§ 38.2-3558. Health carrier's internal appeal process.

Each health carrier shall establish an internal appeal process, including a process for urgent care appeals, to consider a utilization review adverse determination or other adverse benefit determination or decision that is appealed by a covered person, his authorized representative, or his provider. The Commission shall promulgate regulations effectuating the purpose of this section, including timeframes for filing appeals, types of claims that may be appealed including rescissions, notice requirements, rights of the covered person, and reviewer requirements.

2011, c. 788.

§ 38.2-3559. Notice of right to external review.

A. A health carrier shall notify the covered person in writing of an adverse determination or final adverse determination and the covered person's right to request an external review. The notice of the right to request an external review shall include the following, or substantially similar, language: "We have denied your request for the provision of or payment for a health care service or course of treatment. You may have the right to have our decision reviewed by health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment you requested by submitting a request for external review to the Commission."

B. The notice of the right to request an external review of an adverse determination shall include the following statements informing the covered person that:

1. If the covered person's adverse determination involves (i) cancer or (ii) a medical condition where the time frame for completion of an expedited internal appeal of an adverse determination would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or his authorized representative may file a request for an expedited external review pursuant to § 38.2-3562;

2. If the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated, the covered person or

his authorized representative may file a request for an expedited external review pursuant to § 38.2-3563;

3. If the covered person or his authorized representative files a request for an expedited internal appeal with the health carrier, he may file at the same time a request for an expedited external review of an adverse determination pursuant to § 38.2-3562 or 38.2-3563. The independent review organization assigned to conduct the expedited external review will determine whether the covered person shall be required to complete the expedited internal appeal prior to conducting the expedited external review; and

4. If the covered person or his authorized representative files a standard appeal with the health carrier's internal appeal process, and the health carrier does not issue a written decision within 30 days following the date the appeal requesting a review is filed and the covered person or his authorized representative did not request or agree to a delay, the covered person or his authorized representative may file a request for external review and shall be considered to have exhausted the health carrier's internal appeal process.

C. The notice of the right to request an external review of a final adverse determination shall include the following statements informing the covered person that:

1. If the covered person has a medical condition where the time frame for completion of a standard external review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or his authorized representative may file a request for an expedited external review pursuant to § 38.2-3562;

2. If the final adverse determination involves an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not been discharged from a facility, the covered person or his authorized representative may request an expedited external review pursuant to § 38.2-3562; and

3. If the final adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational, the covered person or his authorized representative may file a request for a standard external review pursuant to § 38.2-3563; or if the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated, the covered person or his authorized representative may request an expedited external review pursuant to subsection B of § 38.2-3563.

D. The health carrier shall include the standard and expedited external review procedures and any forms with the notice of the right to an external review.

2011, c. 788; 2019, cc. 826, 840.

§ 38.2-3560. Exhaustion of internal appeal process.

A. A request for an external review shall not be made until the covered person has exhausted the health carrier's internal appeal process, provided that a covered person's exhaustion of the health carrier's internal appeal process shall not be required if the adverse determination relates to the treatment of a cancer of the covered person.

B. A covered person shall be considered to have exhausted the health carrier's internal appeal process if the covered person or his authorized representative has filed an appeal requesting a review of an adverse determination, and, except to the extent the covered person or his authorized representative requested or agreed to a delay, has not received a written decision from the health carrier within 30 days following the date the appeal was filed with the health carrier.

C. If a covered person or his authorized representative files a request for an expedited internal appeal of an adverse determination with the health carrier, the covered person or his authorized representative is deemed to have exhausted the internal appeal process and may file a request for an expedited external review of the adverse determination at the same time. Upon receipt of a request for an expedited external review of an adverse determination, the independent review organization conducting the external review shall determine whether the covered person shall be required to complete the health carrier's expedited internal appeal process before it conducts the expedited external review. The independent review organization shall promptly notify the covered person and his authorized representative, if any, of this determination, and either proceed with the expedited external review or wait until completion of the internal expedited appeal process.

D. A request for an external review of an adverse determination may be made before the covered person has exhausted the health carrier's internal appeal process whenever the health carrier agrees to waive the exhaustion requirement. If the exhaustion requirement is waived, the covered person or his authorized representative may file a request in writing for a standard external review.

2011, c. 788; 2019, cc. 826, 840.

§ 38.2-3561. Standard external review.

A. Within 120 days after the date of receipt of a notice of the right to an external review of a final adverse determination or an adverse determination if the internal appeal process has been deemed to be exhausted or waived, a covered person or his authorized representative may file a request for an external review in writing with the Commission. Within one business day after the date of receipt of a request for external review, the Commission shall send a copy of the request to the health carrier.

B. Within five business days following the date of receipt of the external review request from the Commission, the health carrier shall complete a preliminary review of the request to determine whether:

1. The individual is or was a covered person at the time the health care service was requested or, in the case of a retrospective review, was a covered person at the time the health care service was provided;

2. The health care service is a covered service, except as excluded for not meeting the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness;

3. The covered person has exhausted or is deemed to have exhausted the health carrier's internal appeal process, provided that a covered person's exhaustion of the health carrier's internal appeal process shall not be required if the adverse determination relates to the treatment of a cancer of the covered person; and

4. All the information and forms required to process the external review are complete.

C. Within one business day after completion of the preliminary review, the health carrier shall notify in writing the Commission, the covered person, and his authorized representative, if any, whether the request is complete and eligible for external review and, if ineligible, the reasons for ineligibility. If the request is not complete, the notice shall include what information or materials are needed to make the request complete. Such notice shall include a statement informing the covered person and his authorized representative, if any, that the health carrier's determination of ineligibility may be appealed to the Commission. If the health carrier makes an ineligibility determination, the Commission may determine that a request is eligible for external review and require that it be referred for external review. In making this determination, the Commission's decision shall be made in accordance with the terms of the covered person's health benefit plan and the requirements of subsection B.

D. Within one business day after the date of receipt of the notice described in subsection C, the Commission shall assign an independent review organization to conduct the external review and notify in writing the health carrier, the covered person, and his authorized representative, if any, of the request's eligibility and acceptance for external review and the name of the assigned independent review organization. The Commission shall include in such notice a statement that the covered person or his authorized representative may submit in writing to the assigned independent review organization, within five business days following the date of receipt, additional information that the independent review organization shall consider when conducting the external review.

E. Within five business days after the date of receipt of the notice from the Commission, the health carrier or its designee utilization review entity shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or final adverse determination. Failure by the health carrier or its utilization review entity to provide the documents and information within the time specified shall not delay the conduct of the external review. If the health carrier or its utilization review entity fails to provide the documents and information within the time specified, the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination. Within one business day after making such decision, the independent review organization shall notify the covered person, his authorized representative, if any, the health carrier, and the Commission.

F. The assigned independent review organization shall review all of the information and documents timely received from the health carrier and any other information submitted in writing by the covered person or his authorized representative. The independent review organization is not required to, but may, accept and consider information submitted late from the covered person or his authorized representative, if any. Upon receipt of any information submitted by the covered person or his authorized representative, the assigned independent review organization shall within one business day forward the information to the health carrier.

G. Upon receipt of the information from the assigned independent review organization, the health carrier may reconsider its adverse determination or final adverse determination. Reconsideration by the health carrier of its adverse determination or final adverse determination shall not delay or terminate the external review. The external review may only be terminated if the health carrier decides to reverse its adverse determination or final adverse determination and provide coverage or payment for the health care service. Within one business day after making the decision to reverse its adverse determination or final adverse determination, the health carrier shall notify the covered person, his authorized representative, if any, the assigned independent review organization, and the Commission in writing of its decision. Upon receipt of the notice of the health carrier's decision to reverse its adverse determination or final adverse determination, the assigned independent review organization shall terminate the external review.

H. The assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall also consider the following in reaching a decision:

1. The covered person's medical records;

2. The attending health care professional's recommendation;

3. Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, his authorized representative, or the covered person's treating provider;

4. The terms of coverage under the covered person's health benefit plan;

5. The most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government or national or professional medical societies, boards, and associations;

6. Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review entity; and

7. The opinion of the independent review organization's clinical reviewer or reviewers after considering the information or documents described in subdivisions 1 through 6 to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

In reaching a decision, the assigned independent review organization shall not be bound by any decisions or conclusions reached during the health carrier's utilization review process or the internal appeal process.

I. Within 45 days after the date of receipt of the request for an external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to the covered person, his authorized representative, if any, the health carrier, and the Commission. The independent review organization shall include in such notice: a general description of the reason for the request for external review; the date the independent review organization received the assignment from the Commission to conduct the external review; the date the external review was conducted; the date of its decision; the principal reason or reasons for its decision, including what applicable, if any, evidence-based standards were a basis for its decision; the rationale for its decision; and references to the evidence or documentation, including evidence-based standards, considered in reaching its decision.

J. Upon receipt of a notice reversing the adverse determination or final adverse determination, the health carrier promptly shall approve the coverage.

2011, c. 788; 2019, cc. 826, 840.

§ 38.2-3562. Expedited external review.

A. A covered person or his authorized representative may make a request for an expedited external review with the Commission at the time the covered person receives:

1. An adverse determination if the adverse determination involves (i) cancer or (ii) a medical condition of the covered person for which the time frame for completion of an expedited internal appeal involving an adverse determination would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, and the covered person or his authorized representative has filed a request for an expedited internal appeal of the adverse determination; or

2. A final adverse determination if the covered person has (i) cancer or (ii) a medical condition where the time frame for completion of a standard external review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, or if the final adverse determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not been discharged from a facility.

B. Upon receipt of a request for an expedited external review, the Commission shall promptly send a copy of the request to the health carrier. Promptly upon receipt of such request, the health carrier shall determine whether the request meets the eligibility requirements in subsection B of § 38.2-3561. The health carrier shall promptly notify the Commission, the covered person, and his authorized representative, if any, of its eligibility determination. Such notice shall include a statement informing the covered person and his authorized representative, if any, that the health carrier's determination of

ineligibility may be appealed to the Commission. If the health carrier makes an ineligibility determination, the Commission may determine that a request is eligible for external review and require that it be referred for external review. In making such determination, the Commission decision shall be made in accordance with the terms of the covered person's health benefit plan and the requirements of subsection B of § 38.2-3561.

Upon receipt of the notice that the request meets the eligibility requirements, the Commission shall promptly assign an independent review organization to conduct the expedited external review. The Commission shall promptly notify the health carrier of the name of the assigned independent review organization.

C. Promptly upon receipt of the notice from the Commission of the name of the independent review organization assigned, the health carrier or its designee utilization review entity shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically, by telephone, facsimile, or any other available expeditious method.

D. The assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall also consider the following in reaching a decision:

1. The covered person's pertinent medical records;

2. The attending health care professional's recommendation;

3. Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, his authorized representative, or the covered person's treating provider;

4. The terms of coverage under the covered person's health benefit plan;

5. The most appropriate practice guidelines, which shall include evidence-based standards, and may include any other practice guidelines developed by the federal government or national or professional medical societies, boards, and associations;

6. Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review entity in making adverse determinations; and

7. The opinion of the independent review organization's clinical reviewer or reviewers after considering the information and documents described in clauses 1 through 6 to the extent the information and documents are available and the clinical reviewer or reviewers consider appropriate.

In reaching a decision, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process or internal appeal process.

E. As expeditiously as the covered person's medical condition or circumstances requires, but in no event more than 72 hours after the date of receipt of an eligible request for an expedited external review, the assigned independent review organization shall make a decision to uphold or reverse the adverse determination or final adverse determination and notify the covered person, his authorized representative, if any, the health carrier, and the Commission. If such decision was not in writing, within 48 hours after the date of providing such decision, the assigned independent review organization shall provide written confirmation of the decision to the covered person, his authorized representative, if any, the health carrier, and the Commission and include the information set forth in subsection I of § 38.2-3561.

F. Upon receipt of a decision reversing the adverse determination or final adverse determination, the health carrier shall promptly approve the coverage.

G. An expedited external review shall not be available for retrospective adverse determinations or retrospective final adverse determinations.

2011, c. 788; 2019, cc. 826, 840.

§ 38.2-3563. External review of experimental or investigational treatment adverse determinations.

A. Within 120 days after the date of receipt of a notice of the right to an external review of an adverse determination or final adverse determination that involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, a covered person or his authorized representative may file a request for external review with the Commission.

B. A covered person or his authorized representative may make an oral request for an expedited external review of the adverse determination or final adverse determination if the covered person's treating physician certifies, in writing, that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated. The following shall apply with regard to such requests for an expedited external review:

1. Upon receipt of a request for an expedited external review, the Commission shall promptly notify the health carrier;

2. Upon notice of the request for expedited external review, the health carrier shall promptly determine whether the request meets the eligibility requirements in subsection D. The health carrier shall promptly notify the Commission and the covered person and his authorized representative, if any, of its eligibility determination. Such notice shall include a statement informing the covered person and his authorized representative, if any, that a health carrier's ineligibility determination may be appealed to the Commission;

3. If the health carrier makes an ineligibility determination, the Commission may determine that a request is eligible for external review and require that it be referred for external review. The Com-

mission shall make such determination in accordance with the terms of the covered person's health benefit plan and the requirements of subsection D;

4. Upon receipt of the notice that the expedited external review request meets the eligibility requirements, the Commission shall promptly assign an independent review organization to review the expedited request and notify the health carrier of the name of the assigned independent review organization;

5. Promptly upon receipt of the notice of the assigned independent review organization, the health carrier or its designee utilization review entity shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically, by telephone, facsimile, or any other available expeditious method;

6. Upon receipt of the notice from the Commission, the assigned independent review organization shall promptly assign one or more clinical reviewers in accordance with the provisions of subdivision F 3 to conduct the external review;

7. In reaching an opinion, each clinical reviewer shall also consider the documents listed in subsection J. Each clinical reviewer shall provide an opinion orally or in writing to the assigned independent review organization as expeditiously as the covered person's medical condition or circumstances require, but in no event more than five calendar days after being selected. If the opinion provided was not in writing, within 48 hours following the date of the opinion the clinical reviewer shall provide a written opinion to the assigned independent review organization. The written opinion shall include the information described in subsection K. Recommendations from more than one clinical reviewer shall meet the provisions of subsection L; and

8. Within 48 hours after the date it receives an opinion from all clinical reviewers, the assigned independent review organization shall make a decision and provide notice of the decision orally or in writing to the covered person, his authorized representative, if any, the health carrier, and the Commission. If the notice was not in writing, within 48 hours after the date of the notice, the assigned independent review organization shall provide written confirmation of the decision to the covered person, his authorized representative, if any, the health carrier, and the Commission. The decision shall include the information described in subsection M.

C. Within one business day after the date of receipt of the request for a standard external review, the Commission shall notify the health carrier.

D. Within five business days following the date of receipt of such notice, the health carrier shall conduct and complete a preliminary review of the request to determine whether:

1. The individual is or was a covered person in the health benefit plan at the time the health care service or treatment was recommended or requested or, in the case of a retrospective review, was a

covered person in the health benefit plan at the time the health care service or treatment was provided;

2. The recommended or requested health care service or treatment is a covered service except for the health carrier's determination that the service or treatment is experimental or investigational for the particular medical condition and is not explicitly listed as an excluded benefit under the covered person's health benefit plan;

3. The covered person's treating physician has certified that one of the following situations is applicable:

a. Standard health care services or treatments have not been effective in improving the condition of the covered person;

b. Standard health care services or treatments are not medically appropriate for the covered person; or

c. There is no available standard health care service or treatment covered that is more beneficial than the recommended or requested health care service or treatment;

4. The covered person's treating physician:

a. Has recommended a health care service or treatment that the physician certifies, in writing, is likely to be more beneficial to the covered person, in the physician's opinion, than any available standard health care services or treatments; or

b. Who is a licensed, board certified, or board eligible physician qualified to practice in the area of medicine appropriate to treat the covered person's condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested is likely to be more beneficial to the covered person than any available standard health care services or treatments;

5. The covered person has exhausted or is deemed to have exhausted the health carrier's internal appeal process; and

6. The covered person has provided all the required information and forms that are necessary to process an external review.

E. Within one business day after completion of the preliminary review, the health carrier shall notify in writing the Commission and the covered person and his authorized representative, if any, whether the request is complete and eligible for external review. The following shall apply with regard to such requests:

1. If the request is not complete, the health carrier shall inform in writing the Commission, the covered person, and his authorized representative, if any, and include in the notice what information or materials are needed to make the request complete. If the request is not eligible for external review, the health carrier shall inform the covered person, his authorized representative, if any, and the Commission in writing and include in the notice the reasons for its ineligibility. Such notice shall include a

statement informing the covered person and his authorized representative, if any, that the health carrier's determination of ineligibility may be appealed to the Commission; and

2. If the health carrier makes an ineligibility determination, the Commission may determine that a request is eligible for external review and require that it be referred for external review. In making this determination, the Commission's decision shall be made in accordance with the terms of the covered person's health benefit plan and the requirements of subsection D.

F. Within one business day after the receipt of the notice from the health carrier, the Commission shall assign an independent review organization to conduct the external review and notify in writing the health carrier, the covered person, and his authorized representative, if any, of the request's eligibility and acceptance for external review, and the name of the assigned independent review organization. The following shall apply with regard to such an external review:

1. The Commission shall include in such notice a statement that the covered person or his authorized representative, if any, may submit in writing to the assigned independent review organization, within five business days following the date of receipt, additional information that the independent review organization shall consider when conducting the external review;

2. Within one business day after the receipt of such notice, the assigned independent review organization shall select one or more clinical reviewers, as it determines is appropriate, to conduct the external review; and

3. In selecting clinical reviewers, the assigned independent review organization shall select physicians or other health care professionals who meet the minimum qualifications of § 38.2-3565 and, through clinical experience in the past three years, are experts in the treatment of the covered person's condition and knowledgeable about the recommended or requested health care service or treatment. Neither the covered person, his authorized representative, if any, nor the health carrier shall choose or control the choice of the physicians or other health care professionals to be selected to conduct the external review.

G. Within five business days after the date of receipt of the notice from the Commission, the health carrier or its designee utilization review entity shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or the final adverse determination. Failure by the health carrier or its designee utilization review entity to provide the documents and information within the required time specified shall not delay the conduct of the external review. If the health carrier or its designee utilization review entity has failed to provide the documents and information within the required time specified, the assigned independent review entity may terminate the external review and make a decision to reverse the adverse determination or final adverse determination. Promptly upon making such decision, the independent review organization shall notify the covered person, his authorized representative, if any, the health carrier, and the Commission.

H. Each clinical reviewer selected shall review all of the information and documents timely received from the health carrier and any other information submitted in writing by the covered person or his authorized representative. The assigned independent review organization is not required to, but may, accept and consider information submitted late from the covered person or his authorized representative, if any. Upon receipt of any information submitted by the covered person or his authorized representative, within one business day after the receipt of the information, the assigned independent review organization shall forward the information to the health carrier.

I. Upon receipt of the information from the assigned independent review organization, the health carrier may reconsider its adverse determination or final adverse determination. Reconsideration by the health carrier of its adverse determination or final adverse determination shall not delay or terminate the external review. The external review may be terminated only if the health carrier decides to reverse its adverse determination or final adverse determination and provide coverage or payment for the recommended or requested health care service or treatment. Promptly upon making the decision to reverse its adverse determination or final adverse determination, the health carrier shall notify the covered person, his authorized representative, if any, the assigned independent review organization, and the Commission in writing of its decision. Upon receipt of notice of the health carrier's decision to reverse its adverse determination or final adverse determination, the assigned independent review organization shall terminate the external review.

J. To the extent the information or documents are available and the reviewer considers appropriate, each clinical reviewer shall also consider the following in reaching an opinion:

1. The covered person's pertinent medical records;

2. The attending physician's or health care professional's recommendation;

3. Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, his authorized representative, or the covered person's treating physician or health care professional;

4. Whether the recommended or requested health care service or treatment is a covered service except for the health carrier's determination that the service or treatment is experimental or investigational; and

5. Whether the recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration, if applicable, for the condition, or medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person than any available standard health care service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments.

K. Within 20 days after being selected to conduct a standard external review, each clinical reviewer shall provide an opinion to the assigned independent review organization on whether the recommended or requested health care service or treatment should be covered. Each clinical reviewer's opinion shall be in writing and include the following information: a description of the covered person's medical condition; a description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested health care service or treatment is more likely than not to be more beneficial to the covered person than any available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments; a description and analysis of any medical or scientific evidence considered in reaching the opinion; a description and analysis of any evidence-based standard; and information on the extent, if any, to which the reviewer's rationale for the opinion regarding the recommended or requested health care service or treatment is based on (i) whether the health care service or treatment has been approved by the federal Food and Drug Administration for the condition or (ii) medical or scientific evidence or evidence-based standards that demonstrate the recommended or requested health care service or treatment is more likely than not to be more beneficial to the covered person than any available standard health care service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments.

L. Within 20 days after the date it receives an opinion from all clinical reviewers, the assigned independent review organization shall make a decision and provide written notice to the covered person, his authorized representative, if any, the health carrier, and the Commission. If:

1. A majority of the clinical reviewers recommend that the recommended or requested health care service or treatment should be covered, the independent review organization shall make a decision to reverse the health carrier's adverse determination or final adverse determination;

2. A majority of the clinical reviewers recommend that the recommended or requested health care service or treatment should not be covered, the independent review organization shall make a decision to uphold the health carrier's adverse determination or final adverse determination; or

3. The clinical reviewers are evenly split as to whether the recommended or requested health care service or treatment should be covered, the independent review organization shall obtain the opinion of an additional clinical reviewer. The additional clinical reviewer selected shall use the same information as the original clinical reviewers. The selection of the additional clinical reviewer shall not extend the time within which the assigned independent review organization is required to make a decision.

M. The independent review organization shall include in the notice required pursuant to subsection L a general description of the reason for the request for external review; the written opinion of each clinical reviewer, including the recommendation of each clinical reviewer as to whether the recommended

or requested health care service or treatment should be covered and the rationale for the reviewer's recommendation; the date the independent review organization was assigned by the Commission to conduct the external review; the date the external review was conducted; the date of its decision; the principal reason or reasons for its decision; and the rationale for its decision.

N. Upon receipt of a notice of a decision reversing the adverse determination or final adverse determination, the health carrier shall promptly approve coverage of the recommended or requested health care service or treatment.

2011, c. 788.

§ 38.2-3564. Binding nature of external review decision.

A. An external review decision is binding on the health carrier. Failure to comply with the assigned independent review organization's external review decision shall be a knowing and willful violation of this section and subject to one or more of the following: (i) punishment as provided in § 38.2-218, (ii) the suspension or revocation of any license issued by the Commission, or (iii) any order that may be issued by the Commission pursuant to § 38.2-219.

B. An external review decision is binding on the covered person except to the extent the covered person has other remedies available under applicable federal or state law.

C. A covered person or his authorized representative may not file a subsequent request for external review involving the same adverse determination or final adverse determination for which the covered person has already received an external review decision.

2011, c. 788.

§ 38.2-3565. Minimum qualifications for independent review organizations.

A. An independent review organization shall have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process and that include, at a minimum:

1. A quality assurance mechanism in place that: ensures that external reviews are conducted within the specified time frames and required notices are provided in a timely manner, ensures the selection of qualified and impartial clinical reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases and that the independent review organization employs or contracts with an adequate number of clinical reviewers to meet this objective, ensures the confidentiality of medical and treatment records and clinical review criteria, and ensures that any person employed by or under contract with the independent review organization adheres to the requirements of this chapter;

2. A toll-free telephone service to receive information on a 24-hour-a-day, seven-day-a-week basis that is capable of accepting, recording, or providing appropriate instruction to incoming telephone callers; and

3. Provisions for maintaining records and providing reports to the Commission in accordance with the requirements set out in § 38.2-3568.

B. All clinical reviewers assigned by an independent review organization to conduct external reviews shall be physicians or other appropriate health care providers who shall meet the following minimum qualifications:

1. Be an expert in the treatment of the covered person's medical condition that is the subject of the external review;

2. Be knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition of the covered person;

3. Hold a nonrestricted license in their health care field in a state and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review; and

4. Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical reviewer's physical, mental, or professional competence or moral character.

C. An independent review organization may not own or control, be a subsidiary of, or in any way be owned or controlled by, or exercise control with, a health benefit plan, a national, state, or local trade association of health benefit plans, or a national, state, or local trade association of health care providers.

D. Neither the assigned independent review organization nor any clinical reviewer assigned by the independent organization may have a material professional, familial, or financial conflict of interest with any of the following that is the subject of the external review:

1. The health carrier;

2. The covered person or his authorized representative;

3. Any officer, director, or management employee of the health carrier;

4. The health care provider, the health care provider's medical group, or the independent practice association recommending the health care service or treatment;

5. The facility at which the recommended health care service or treatment would be provided; or

6. The developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended.

E. An independent review organization shall be accredited by a nationally recognized private accrediting entity that has standards that the Commission has determined are equivalent to or exceed the minimum qualifications of this section. The following shall apply with regard to accrediting entities:

1. Upon request, a nationally recognized private accrediting entity shall make its current accreditation standards available to the Commission or the NAIC. The Commission shall initially and periodically review the accreditation standards of the nationally recognized private accrediting entity to determine whether the entity's standards are, and continue to be, equivalent to or exceed the minimum qualifications established under this section;

2. The Commission may accept a review conducted by the NAIC for the purpose of this determination. The Commission may exclude any private accrediting entity that is not reviewed by the NAIC; and

3. The Commission may approve independent review organizations that are not accredited by a nationally recognized private accrediting entity only if there are no acceptable nationally recognized private accrediting entities providing independent review organization accreditation.

F. An independent review organization shall be unbiased. An independent review organization shall establish and maintain written procedures to ensure that it is unbiased.

2011, c. 788.

§ 38.2-3566. Approval of independent review organizations.

A. Each independent review organization that wishes to be eligible to conduct external reviews shall submit an application to the Commission for approval or reapproval. The Commission may charge a reasonable fee for initial approval and each reapproval.

B. The Commission shall approve independent review organizations that meet the minimum qualifications to conduct external reviews. Such approval is not subject to the Virginia Public Procurement Act (§ 2.2-4300 et seq.).

C. An independent review organization is eligible for approval if it is accredited by a nationally recognized private accrediting entity that the Commission has determined has standards that are equivalent to or at least meet the minimum qualifications for independent review organizations.

D. An approval or reapproval is effective for two years, unless the Commission determines before its expiration that the independent review organization is not satisfying the minimum qualifications or its decisions have been consistently unclear or incomplete. Whenever the Commission determines that an independent review organization has lost its accreditation or does not meet the requirements of this subsection, the Commission shall terminate the approval of the independent review organization and remove it from the list of independent review organizations approved to conduct external reviews.

E. The Commission shall maintain and periodically update a list of approved independent review organizations.

F. The assignment by the Commission of an approved independent review organization shall be done on a random basis, taking into consideration the nature of the health care service or treatment.

2011, c. 788.

§ 38.2-3567. Independent review organizations to be held harmless.

No independent review organization or clinical reviewer working on behalf of an independent review organization or an employee, agent, or contractor of an independent review organization shall be liable in damages to any person for any opinions rendered or acts or omissions performed within the scope of the organization's or person's duties under the law during or upon completion of an external review, unless the opinion was rendered or act or omission performed in bad faith or involved gross negligence.

2011, c. 788.

§ 38.2-3568. External review reporting requirements.

A. An independent review organization shall maintain written records, in the aggregate by state and by health carrier, on all external review requests and external reviews conducted during each calendar year. Each independent review organization shall submit a report to the Commission. The report shall be submitted to the Commission by April 1 of the following calendar year. The report shall include in the aggregate by state, and for each health carrier: the total number of requests for external review; the number of requests for external review resolved and, of those resolved, the number upholding the adverse determination or final adverse determination, and the number reversing the adverse determination or final adverse determination; the average length of time for resolution; a summary of the types of coverages or cases for which an external review was sought; the number of external reviews that were terminated as the result of a reconsideration by the health carrier; and any other information the Commission may request or require. The independent review organization shall retain required written records for at least three years.

B. Each health carrier shall maintain written records, in the aggregate by state and for each type of health benefit plan offered, on all requests for external review. Each health carrier shall submit a report to the Commission. The report shall be submitted to the Commission by April 1 of the following calendar year. The report shall include in the aggregate by state, and by type of health benefit plan: the total number of requests for external review, the number of requests determined eligible for external review, the number of external reviews completed, and any other information the Commission may request or require. The health carrier shall retain required written record for at least three years.

2011, c. 788.

§ 38.2-3569. Funding of external review.

The health carrier against which a request for an external review is filed shall pay the cost incurred by the independent review organization in conducting the external review.

2011, c. 788.

§ 38.2-3570. Disclosure requirements.

Each health carrier shall include a description of the external review procedures in or attached to the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage it provides to covered persons. The description shall include a statement that informs the covered person of his right to file a request for an external review of an adverse determination or final adverse determination with the Commission. The statement shall explain that external review is available when the adverse determination or final adverse determination involves an issue of medical necessity, appropriateness, health care setting, level of care, or effectiveness. The statement shall include the telephone number and address of the Commission. The statement shall inform the covered person that, when filing a request for an external review, the covered person will be required to authorize the release of any medical records of the covered person that may be required to be reviewed for the purpose of reaching a decision on the external review.

2011, c. 788.

§ 38.2-3571. Regulations.

Pursuant to the authority granted by § 38.2-223, the Commission may adopt such rules and regulations as it may deem necessary to implement this chapter.

2011, c. 788.

Chapter 36 - MEDICARE SUPPLEMENT POLICIES

§ 38.2-3600. Medicare supplement policy; definition.

"Medicare supplement policy" means an individual or group accident and sickness insurance policy or certificate, or a health maintenance organization subscription contract or evidence of coverage, issued or issued for delivery in this Commonwealth which is (i) designed primarily to supplement Medicare by providing benefits for payment of hospital, medical or surgical expenses, or (ii) advertised, marketed or otherwise purported to be a supplement to Medicare.

For group policies, the term does not include a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or a combination of employees and labor organizations, for employees, former employees, or a combination of employees and labor organizations or for members or former members, or combination thereof, of the labor organizations.

1979, c. 726, § 38.1-362.7; 1986, c. 562; 1992, c. 225; 1996, c. 11.

§ 38.2-3601. Medicare supplement policies; minimum return for group policies generally.

Group Medicare supplement policies shall be expected to return to policyholders in the form of aggregate benefits at least seventy-five percent of the aggregate amount of premiums collected.

1981, c. 575, § 38.1-362.8:1; 1986, c. 562.

§ 38.2-3602. Repealed.

Repealed by Acts 1989, c. 151, § 2.

§ 38.2-3603. Same; minimum return for individual policies.

Medicare supplement policies sold on an individual basis shall be expected to return to policyowners in the form of aggregate benefits at least sixty-five percent of the aggregate amount of premiums collected.

1981, c. 575, § 38.1-362.8:3; 1986, c. 562; 1991, c. 120.

§ 38.2-3604. Free look notice required.

Notwithstanding the provisions of § 38.2-3502, Medicare supplement policies shall have printed on the policy a notice stating substantially: "RIGHT TO RETURN POLICY WITHIN THIRTY DAYS. If for any reason you are not satisfied with your policy you may return this policy to the company within thirty days of the date you received it and the premium paid will be promptly refunded."

A policy returned pursuant to the notice shall be void upon the mailing or delivery of the policy to the insurer.

Nothing in this section shall prohibit an insurer from extending the right to examine period to more than thirty days if the period is specified in the policy.

1980, c. 204, § 38.1-362.13; 1981, c. 575; 1986, c. 562; 1989, c. 151.

§ 38.2-3605. Coverage of preexisting conditions; Medicare supplement policies.

Notwithstanding subdivision 2 (b) of § 38.2-3503 or the provisions of § 38.2-3514.1, an insurer that issues a Medicare supplement policy shall not deny a claim for losses incurred more than six months from the effective date of coverage on the grounds that a condition existed prior to the effective date of coverage regardless of the application form used. Except as so provided, the policy or contract shall not include wording that would permit a defense based upon preexisting conditions.

1980, c. 204, § 38.1-362.15; 1981, c. 575; 1986, c. 562; 1995, c. 522.

§ 38.2-3606. Outline of coverage.

Pursuant to the authority granted in § 38.2-223, the Commission may issue rules and regulations that may (i) require that an outline of coverage for Medicare supplement policies be delivered to the insured at the time the application is made and (ii) prescribe the format and content of the outline of coverage.

1980, c. 204, § 38.1-362.16; 1986, c. 562; 1996, c. 11.

§ 38.2-3607. Group or individual Medicare supplement policies; minimum standards.

A. The provisions of §§ 38.2-3418.1, 38.2-3604, 38.2-3605, 38.2-3606 and 38.2-3516 through 38.2-3520 shall be applicable to group Medicare supplement policies. The term "policy" as used in this article shall include a certificate issued under a group Medicare supplement policy which has been delivered or issued for delivery in this Commonwealth.

B. The provisions of § 38.2-3418.1 shall be applicable to individual Medicare supplement policies.

C. No Medicare supplement policy or certificate in force in this Commonwealth shall contain benefits that duplicate benefits provided by Medicare.

1981, c. 575, § 38.1-362.17; 1986, c. 562; 1989, c. 646; 1996, c. 11.

§ 38.2-3608. Regulations establishing minimum standards.

A. The Commission may issue regulations to establish minimum standards for payment of claims under Medicare supplement policies and for marketing practices, compensation arrangements, requirements for loss ratio refunds or credits, Medicare select policies and certificates, and reporting practices of insurers providing such policies.

B. The Commission may revise or amend such regulations and may increase the scope of the regulations only to the extent necessary to maintain federal approval of the Commonwealth's program for regulation of Medicare supplement insurance pursuant to the requirements established by the United States Department of Health and Human Services.

C. The Commission shall annually advise the standing committees of the General Assembly having jurisdiction over insurance matters of revisions and amendments made pursuant to subsection B.

1989, c. 151; 1990, c. 268; 1992, c. 225; 1996, c. 11.

§ 38.2-3609. Insurer to file copy of advertisement with Commission.

Every insurer, health service plan or health maintenance organization providing Medicare supplement insurance or benefits in this Commonwealth shall file with the Commission a copy of any Medicare supplement advertisement intended for use in this Commonwealth whether through written, radio or television medium.

1989, c. 151.

§ 38.2-3610. Medicare supplement policies for persons eligible by reason of disability.

A. An insurer, health services plan, or health maintenance organization issuing Medicare supplement policies or certificates in the Commonwealth, including policies or certificates issued on an individual or group basis or through a group trust, shall offer the opportunity of enrolling in at least one of its issued Medicare supplement policies or certificates to any individual who resides in the Commonwealth, is under 65 years of age, is eligible for Medicare by reason of disability, as defined by 42 U.S.C. § 426(b) or 42 U.S.C. § 426-1, and is enrolled in Medicare Part A and B, or will be so enrolled by the effective date of coverage. Such Medicare supplement policies or certificates shall be issued on a guaranteed renewable basis under which the insurer shall be required to continue coverage as long as premiums are paid on the policy or certificate. Such Medicare supplement policies or certificates shall be offered:

1. Upon the request of the individual during the six-month period beginning with the first month in which the individual is eligible for Medicare by reason of a disability. For those persons who are retroactively enrolled in Medicare Part B due to a retroactive eligibility decision made by the Social Security Administration, the application must be submitted within a six-month period beginning with the month in which the person receives notification of the retroactive eligibility decision; or

2. Upon the request of the individual during the 63-day period following voluntary or involuntary termination of coverage under a group health plan.

B. The six-month period to enroll in a Medicare supplement policy or certificate for an individual who is under 65 years of age and is eligible for Medicare by reason of disability under 42 U.S.C. § 426(b) and otherwise eligible under subsection A and first enrolled in Medicare Part B before January 1, 2021, shall begin on January 1, 2021. The six-month period to enroll in a Medicare supplement policy or certificate for an individual who is under 65 years of age and is eligible for Medicare by reason of disability under 42 U.S.C. § 426-1 and otherwise eligible under subsection A and first enrolled in Medicare Part B before January 1, 2024, shall begin on January 1, 2024.

C. A Medicare supplement policy or certificate issued to an individual under subsection A shall not exclude benefits based on a preexisting condition if the individual has a continuous period of creditable coverage of at least six months as of the effective date of coverage.

D. Effective January 1, 2024, an insurer shall not charge individuals who become eligible for Medicare by reason of disability and who are under 65 years of age premium rates for any Medicare supplement policy or certificate offered by the issuer that exceed the premium rates charged for such plan to individuals who are 65 years of age.

E. For purposes of this section, "creditable coverage" and "group health plan" have the same meanings ascribed to the terms in § 38.2-3431.

2020, c. 1161; 2023, cc. 371, 372.

Chapter 37 - CREDIT LIFE INSURANCE AND CREDIT ACCIDENT AND SICKNESS INSURANCE [Repealed]

§§ 38.2-3700 through 38.2-3716. Repealed.

Repealed by Acts 1992, c. 586, effective January 1, 1993.

Chapter 37.1 - CREDIT LIFE INSURANCE AND CREDIT ACCIDENT AND SICKNESS INSURANCE

§ 38.2-3717. Scope.

All life insurance and all accident and sickness insurance issued or sold in connection with loans or other credit transactions shall be subject to the provisions of this chapter except:

1. Such insurance issued in connection with a loan or other credit transaction of more than ten years duration;

2. Such insurance written in connection with a credit transaction that is:

a. Secured by a first mortgage or deed of trust; and

b. Made to finance the purchase of real property or the construction of a dwelling thereon, or to refinance a prior credit transaction made for such a purpose;

3. Where the issuance of such insurance is an isolated transaction on the part of the insurer not related to an agreement or a plan for insuring debtors of the creditor.

1960, c. 67, § 38.1-482.1; 1972, c. 527, § 38.2-3700; 1982, c. 223; 1986, c. 562; 1990, c. 236; 1992, c. 586.

§ 38.2-3718. Definitions.

For the purposes of this chapter:

"Commission" means the State Corporation Commission.

"Creditor" means the lender of money or vendor or lessor of goods, services, or property, rights or privileges, for which payment is arranged through a credit transaction, or any successor to the right, title or interest of any such lender, vendor, or lessor and an affiliate, associate or subsidiary of any of them or any other person in any way associated with them.

"Credit transaction" means any transaction by the terms of which the repayment of money loaned or loan commitment made, or payment for goods, services or properties sold or leased is to be made at a future date or dates.

"Critical period coverage" means a death benefit or an accident and sickness insurance benefit in which the benefit is equal to a specified number of monthly payments or the remaining payments on the loan, whichever is less.

"Debtor" means a borrower of money or a purchaser or lessee of goods, services, property, rights or privileges for which payment is arranged through a credit transaction.

"Form" means any policy, contract, rider, endorsement, amendment, certificate, application, enrollment request, or notice of proposed insurance pertaining to credit life insurance or credit accident and sickness insurance. For the purpose of administering §§ 38.2-3726, 38.2-3727 and 38.2-3730, (i) the earned premiums and incurred claims of all credit accident and sickness insurance forms issued in this Commonwealth with the same waiting period will be combined to determine the loss ratio in this Commonwealth regardless of differences in the contractual terms of each form and, (ii) the earned premiums and incurred claims of all credit life insurance forms issued in this Commonwealth will be combined to determine the loss ratio in this Commonwealth regardless of differences in the contractual terms or coverage types.

"Indebtedness" means the total amount payable by a debtor to a creditor in connection with a loan or other credit transaction.

"Open-end credit" means credit extended under an agreement in which:

1. The creditor reasonably contemplates repeated transactions;

2. The creditor imposes a finance charge from time to time on an outstanding unpaid balance; and

3. The amount of credit that may be extended to the debtor during the term of the agreement (up to any limit set by the creditor) is generally made available to the extent that any outstanding balance is repaid.

"Truncated coverage" means a credit life insurance benefit or a credit accident and sickness insurance benefit with a term of insurance coverage that is less than the term of the loan.

1960, c. 67, § 38.1-482.2; 1982, c. 223, § 38.2-3701; 1986, c. 562; 1992, c. 586.

§ 38.2-3719. Forms of credit life insurance and credit accident and sickness insurance.

A. Credit life insurance and credit accident and sickness insurance shall be issued only in the following forms:

1. Individual policies of life insurance issued to debtors on the term plan;

2. Individual policies of accident and sickness insurance issued to debtors on a term plan or disability benefit provisions in individual policies of credit life insurance;

3. Group policies of life insurance issued to creditors providing insurance upon the lives of debtors on the term plan;

4. Group policies of accident and sickness insurance issued to creditors on a term plan insuring debtors or disability benefit provisions in group credit life insurance policies to provide such coverage.

B. A policy of group credit life insurance or group credit accident and sickness insurance may be issued to a creditor or its parent holding company or to a trustee, trustees or agent designated by two or more creditors, which creditor, holding company, affiliate, trustee, trustees or agent shall be deemed the policyholder, to insure debtors of the creditor or creditors, subject to the following requirements:

1. The debtors eligible for insurance under the policy shall be all of the debtors of the creditor or creditors, or all of any class or classes of the group. The policy may provide that the term "debtors" shall include (i) borrowers of money or purchasers of goods, services or property for which payment is arranged through a credit transaction; (ii) the debtors of one or more subsidiary corporations; and (iii) the debtors of one or more affiliated corporations, proprietors or partnerships if the business of the policyholder and of such affiliated corporations, proprietors or partnerships is under common control.

2. The premium for the policy shall be paid by the policyholder, either from the creditor's funds, or from charges collected from the insured debtors, or from both. Except as provided in subdivision 3 of this subsection, a policy on which no part of the premium is to be derived from the collection of such identifiable charges must insure all eligible debtors.

3. Credit life insurance and credit accident and sickness insurance must be offered to all eligible debtors of a creditor except those for whom evidence of individual insurability is not satisfactory to the insurer.

Code 1950, § 38-428(6); 1950, p. 1001; 1952, c. 317, § 38.1-480; 1960, c. 272, § 38.2-3702; 1962, c. 154; 1975, c. 69; 1982, c. 223, § 38.1-482.3:1; 1983, c. 182; 1986, c. 562; 1987, c. 520; 1992, c. 586.

§ 38.2-3720. Amount of credit life insurance and credit accident and sickness insurance.

A. Credit life insurance. 1. Where an indebtedness is repayable in substantially equal installments, the amount of credit life insurance shall at no time exceed the actual amount of unpaid indebtedness.

2. Notwithstanding the provisions of subdivision A 1, insurance on agricultural credit transaction commitments not exceeding one year in duration may be written up to the amount of the loan commitment, on a nondecreasing or level-term plan.

3. Notwithstanding the provisions of subdivision A 1 of this subsection, or any other subsection, insurance on educational credit transaction commitments may be written for the amount of the loan commitment.

B. Credit accident and sickness insurance. -- The total amount of periodic indemnity payable by credit accident and sickness insurance in the event of disability, as defined in the policy, shall not exceed the aggregate of the periodic scheduled unpaid installments of the indebtedness; and the amount of each periodic indemnity payment shall not exceed the original indebtedness divided by the number of periodic installments.

C. Maximum aggregate provisions. -- A provision in a credit life insurance or credit accident and sickness insurance policy or certificate issued thereunder that sets a maximum limit on total benefits payable thereunder shall apply only to that specific indebtedness for which such policy or certificate was issued.

D. The amount of credit life insurance on an indebtedness of any debtor shall not exceed $70,000 with any one insurance company.

1960, c. 67, § 38.1-482.4; 1972, c. 527, §§ 38.2-3703, 38.2-3704; 1982, c. 223; 1986, c. 562; 1992, c. 586.

§ 38.2-3721. Term of credit life insurance and credit accident and sickness insurance.

A. The term of any policy or certificate of credit life insurance or credit accident and sickness insurance shall, subject to acceptance by the insurer, commence on the date when the debtor becomes obligated to the creditor; except that where a group policy provides coverage with respect to existing obligations, the insurance on a debtor with respect to such indebtedness shall commence on the effective date of the policy. Where evidence of insurability is required and such evidence is furnished more than thirty days after the date when the debtor becomes obligated to the creditor, the term of the insurance may commence on the date the insurance company determines the evidence to be satisfactory, and in such event there shall be an appropriate refund or adjustment of any charge to the debtor for insurance. The term of such insurance shall not extend more than fifteen days beyond the scheduled maturity date of the indebtedness except when extended without additional cost to the debtor. In all cases of termination prior to scheduled maturity, a refund shall be paid or credited as provided in § 38.2-3729.

B. Renewal or refinancing of the indebtedness. -- If the indebtedness is discharged due to renewal or refinancing prior to the scheduled maturity date, the insurance in force shall be terminated before any

new insurance may be issued in connection with the renewed or refinanced indebtedness. In all cases of such termination prior to scheduled maturity, a refund shall be paid or credited to the debtor as provided in § 38.2-3729. In any renewal or refinancing of the indebtedness, the effective date of the coverage for purposes of application of any policy provision shall be deemed to be the first date on which the debtor became insured under the policy covering the indebtedness which was renewed or refinanced at least to the extent of the remaining amount and duration of coverage in force on the indebtedness that was renewed or refinanced.

C. Termination of group credit insurance policy. -- 1. If a debtor is covered by a group credit insurance policy providing for the payment of single premiums to the insurer, then provision shall be made by the insurer that in the event of termination of the policy for any reason, insurance coverage with respect to any debtor insured under such policy shall be continued for the entire period for which the single premium has been paid.

2. If a debtor is covered by a group credit insurance policy providing for the payment of premiums to the insurer on a monthly outstanding balance basis, then the policy shall provide that, in the event of termination of such policy for whatever reason, notice of termination thereof shall be given to the insured debtor at least thirty days prior to the effective date of termination except where replacement of the coverage by the same or another insurer in the same or greater amount takes place without lapse of coverage. The notice required in this subdivision shall be given by the insurer or, at the option of the insurer, by the creditor, in writing, mailed to the insured debtor at the insured debtor's address as shown in the records of the insurer or creditor.

D. Each credit life insurance or credit accident and sickness insurance policy or certificate shall contain a provision that the insurance may be terminated upon written request of the debtor except if the insurance was required as security for any indebtedness at the time of the credit transaction. If insurance is required, the debtor shall have the right to terminate the insurance by furnishing evidence of other insurance that is at least equal in coverage and protection to the creditor.

1960, c. 67, § 38.1-482.5; 1982, c. 223, § 38.2-3706; 1986, c. 562; 1992, c. 586.

§ 38.2-3722. Variable interest rate indebtedness; amount; disclosure; refunds.

A. Notwithstanding the terms of § 38.2-3720, if the credit transaction provides for a variable interest rate and the insurance premiums are calculated and charged on a single premium basis, the initial amount of insurance coverage shall not exceed the scheduled amounts of unpaid indebtedness based upon the initial contract interest rate; and the death benefit shall be equal to the scheduled amount of insurance at the date of death or the amount required to liquidate the indebtedness in accordance with the terms of the contract of indebtedness, whichever is greater. If the actual interest rate charged at any time exceeds the original contract interest rate, the term of the insurance shall continue without additional charge for a period not to exceed three months. No additional premiums shall be charged for any additional coverage provided beyond that included in the single premium charge.

B. Each individual policy or group certificate of credit insurance issued in connection with credit transactions involving variable interest rates shall include a disclosure (i) that the death benefit shall in no case be less than the insured scheduled amount of coverage or the amount required to liquidate the insured indebtedness in accordance with the terms of the contract of indebtedness, whichever is greater; and (ii) that the term of insurance shall continue for a period not to exceed three months if the actual interest rate charge at any time exceeds the original contract interest rate.

C. Each individual policy or group certificate of credit insurance issued in connection with credit transactions involving variable interest rates shall provide that in the event of termination of the insurance prior to the original scheduled maturity date of the indebtedness, a refund of any amount paid by the debtor for such insurance shall be made in accordance with § 38.2-3729. Such refund shall be based on the terms of the original loan and the actual elapsed time.

For a loan with a term of more than sixty-one months, computation of such refund using the actuarial method shall be deemed to comply with the requirements hereof. For a loan with a term of sixty-one months or less, computation of such refund using the Rule of 78 shall be deemed to comply with the requirement hereof.

1984, c. 664, § 38.1-482.4:2; 1985, c. 234, § 38.2-3705; 1986, c. 562; 1992, c. 586.

§ 38.2-3723. Reserves.

A. Each insurer licensed to write credit life insurance in the Commonwealth shall establish and maintain reserves on all its credit life insurance. The minimum standard for the valuation for such reserves:

1. For both male and female insureds shall be the 2001 Commissioners' Standard Ordinary (CSO) Male Composite Ultimate Mortality Table as adopted by the National Association of Insurance Commissioners;

2. Where the credit life policy or certificate insures two lives shall be twice the 2001 CSO Male Composite Ultimate Mortality Table based on the age of the older insured;

3. Shall use, for the interest rate calculation, the calendar year statutory valuation interest rates determined pursuant to § 38.2-1371; and

4. Shall use, as the method of valuation, the Commissioners reserve valuation method set forth in § 38.2-1372.

Reserves may be calculated on an annual or a monthly basis with a reasonable assumption, subject to statistical proof, as to average ages at issue or at expiration.

B. Each insurer licensed to write credit accident and sickness insurance in the Commonwealth shall establish and maintain reserves on all its credit accident and sickness insurance. For contracts other than single premium credit disability contracts, the minimum standard for the valuation of such reserves shall be the total gross unearned premiums calculated by the actuarial method, but not less than the aggregate amounts calculated as of the valuation date by the refund formulas approved for

the policies by the Commission pursuant to subsection C of § 38.2-3729. For single premium credit disability contracts, the minimum standard for valuation of such reserves:

1. For plans having less than a 15-day elimination period, the morbidity standard shall be the 1985 Commissioners' Individual Disability Table A as adopted by the NAIC (85CIDA) with claim incidence rates increased by 12 percent;

2. For plans having a greater than 14-day elimination period, the morbidity standard shall be the 85CIDA for a 14-day elimination period with claim incidence rates increased by 12 percent; and

3. The interest rate used shall be the calendar year statutory valuation interest rate for valuation of whole life insurance determined pursuant to § 38.2-1371.

It may be assumed that all business written in any calendar month was written as of the fifteenth of such month.

C. For all credit life and disability contracts in the aggregate, if the net premium refund liability exceeds the aggregate recorded contract reserve, the insurer shall establish an additional reserve liability that is equal to the excess of the net refund liability over the contract reserve recorded. The net refund liability may include consideration of commission, premium tax, and other expenses recoverable. In all cases, such amounts shall be evaluated for probability of recovery.

D. In no event shall the aggregate reserves for all policies, contracts and benefits be less than the aggregate reserves determined by a qualified actuary to be necessary to support fully the insurer's obligations under its policies, certificates and contracts.

1982, c. 223, § 38.1-482.12:1; 1986, c. 562, § 38.2-3715; 1992, c. 586; 2002, c. 72; 2009, c. 642; 2014, c. 571.

§ 38.2-3724. Policy provisions; disclosure to debtors; delivery of policy or certificate.

A. Credit life insurance and credit accident and sickness insurance shall be evidenced by an individual policy, or in the case of group insurance by a certificate of insurance. The policy or certificate of insurance shall: (i) be a document separate and apart from the loan or credit agreement, (ii) refer exclusively to the insurance coverage, and (iii) be delivered to the debtor.

B. Each policy or certificate of credit life insurance or credit accident and sickness insurance shall set forth:

1. The name and address of the insurer;

2. The name or names of the debtor or, in the case of a certificate, the identity by name or otherwise of the debtor;

3. The age or date of birth of the debtor(s);

4. The premium or amount payable by the debtor separately for credit life insurance and credit accident and sickness insurance;

5. A description of the coverage including the amount and term of the coverage, and any exceptions, limitations or restrictions;

6. A statement that the benefits shall be paid to the creditor to reduce or extinguish the unpaid indebtedness; and

7. A statement that if the amount of insurance exceeds the amount necessary to discharge the indebtedness, any such excess shall be payable to a beneficiary, other than the creditor, named by the debtor or to his estate.

C. A credit life or credit accident and sickness insurance policy or certificate, which provides truncated or critical period coverage or any other type of similar coverage that does not provide benefits or coverage for the entire term or amount of the indebtedness, shall be subject to the following requirements:

1. The credit life or credit accident and sickness insurance policy or certificate shall include a statement printed on the face of the policy or first page of the certificate which clearly describes the limited nature of the insurance. The statement shall be printed in capital letters and in bold twelve-point or larger type; and

2. The credit life or credit accident and sickness insurance policy or certificate shall not include any benefits or coverage other than truncated or critical period coverage or any other type of similar coverage that does not provide benefits or coverage for the entire term or amount of the indebtedness.

D. No individual or group credit life insurance or credit accident and sickness insurance policy shall be delivered or issued for delivery in this Commonwealth unless the policy complies with the following requirements:

1. Each policy shall contain a provision (i) that the policy, or the policy and any application endorsed upon or attached to the policy when issued, shall constitute the entire contract between the parties, and (ii) that all statements made by the creditor or by the individual debtors shall, in the absence of fraud, be deemed representations and not warranties;

2. Each policy shall contain a provision that the validity of the policy shall not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue; and that no statement made by any person insured under the policy relating to his insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after the insurance has been in force for a period of two years during such person's lifetime, and prior to the date on which the claim thereunder arose;

3. Each policy shall contain a provision that when a claim for the death or disability of the insured arises, settlement shall be made upon receipt of due proof of such death or disability;

4. On the face of each policy and certificate there shall be a title that briefly and accurately describes the nature and form of the policy;

5. Each policy and certificate, including any rider or endorsement, shall be identified by a form number in the lower lefthand corner of the first page of the form. The type size of the text of the policy form or certificate, including any rider and endorsement, shall not be less than ten-point type, one-point leaded;

6. Each individual policy or group certificate shall meet the readability standards established by the Commission;

7. Each individual policy and certificate shall have printed on it a notice stating in substance that if, during a period of at least ten days from the date the policy or certificate is delivered to the policyowner or certificateholder the policy or certificate is surrendered to the insurer or its agent with a written request for cancellation, the policy or certificate shall be void from the beginning and the insurer shall refund any premium paid for the policy or certificate; and

8. Each individual policy or group certificate paid in advance or by a single premium shall include a provision, separately and prominently captioned, stating in substance the following:

"REFUND OF PREMIUM IN THE EVENT OF EARLY TERMINATION"

"In the event this insurance policy or certificate is terminated prior to its originally scheduled maturity date, or the insured indebtedness is terminated or paid off earlier than scheduled, the insurer shall, within 30 days of receipt of notification from the debtor of such termination or early payoff, refund or credit any amount paid by the debtor for the insurance beyond the actual date of termination or payoff. Early termination of debt includes termination by renewal or refinancing. The debtor's notification to the insurer shall include proof of termination or early payoff of the insured indebtedness."

E. An individual credit life insurance or credit accident and sickness insurance policy or certificate of insurance shall be delivered or mailed to the insured debtor at the time the indebtedness is incurred or within ten business days thereafter except as provided in subsection F of this section. For open-end credit transactions, agricultural or educational loan commitments, or where no direct charge is made to the debtor for his insurance, the individual policy or group certificate of insurance may be delivered to the insured debtor at the time he first becomes eligible for the insurance and need not be delivered again each time new indebtedness is added.

F. If the individual policy or certificate of insurance is not delivered or mailed to the debtor at the time indebtedness is incurred, or within ten business days thereafter, a notice of proposed insurance, setting forth (i) the name and address of the insurer, (ii) the name or names of the debtor, (iii) the age of the debtor, (iv) the premium or amount of payment by the debtor, if any, separately for credit life insurance and credit accident and sickness insurance, and (v) the amount, term and a brief description of the coverage provided, shall be delivered to the debtor. The notice of proposed insurance shall refer exclusively to insurance coverage and shall be separate and apart from the loan or credit transaction. Upon acceptance of the insurance by the insurer and within thirty days of the date upon which the indebtedness is incurred, the insurer shall deliver or mail the individual policy or group certificate of

insurance to the debtor. The notice of proposed insurance shall state that upon acceptance by the insurer, the insurance shall become effective as provided in § 38.2-3721.

G. If the policy or certificate is issued by any insurer other than the insurer listed on the application, enrollment request, or notice of proposed insurance, the debtor shall receive a policy or certificate of insurance setting forth the name and address of the substituted insurer and the amount of the premium to be charged. If the amount of the premium is less than that set forth in the notice of proposed insurance, an appropriate refund shall be made.

1960, c. 67, § 38.1-482.6; 1982, c. 223, §§ 38.2-3707, 38.2-3709; 1986, c. 562; 1988, c. 551; 1992, c. 586; 2009, c. 643; 2010, c. 211.

§ 38.2-3725. Policy forms to be filed with Commission; approval or disapproval by Commission.

A. No form shall be delivered or issued for delivery in this Commonwealth until a copy of each form has been filed with and approved by the Commission.

B. If a group policy of credit life or credit accident and sickness insurance is delivered in another state, the insurer shall be required to file the group certificate, application or enrollment request, and notice of proposed insurance delivered or issued for delivery in this state for approval. These forms shall comply with § 38.2-3724, with the exception of subsection D and § 38.2-3737. The premium rates shall comply with those established in this chapter or it must be demonstrated to the satisfaction of the Commission that the rates are actuarially equivalent to those required by §§ 38.2-3726 and 38.2-3727 if the coverage differs from that required in Virginia. In no case shall the premiums exceed those set by the Commission in §§ 38.2-3726 and 38.2-3727, as amended by § 38.2-3730.

C. The Commission shall disapprove or withdraw approval previously given to any form if the Commission determines that:

1. It does not comply with the laws of this Commonwealth;

2. It contains any provision or has any title, heading, backing or other indication of the contents of any or all of its provisions which encourage misrepresentation or are unjust, unfair, misleading, deceptive or contrary to the public policy of this Commonwealth; or

3. The premium rates or charges are not reasonable in relation to the benefits provided.

D. The benefits provided by any credit life insurance form shall be considered reasonable in relation to the premium charged provided that the rate does not exceed the current prima facie rate set by the Commission. The prima facie rate that shall be effective January 1, 1993, shall be that set forth in § 38.2-3726. Thereafter, effective January 1, 1995, the Commission shall, on a triennial basis, set forth adjusted prima facie rates that will achieve a sixty percent loss ratio. The methodology used by the Commission in setting the prima facie rates shall be as set forth in § 38.2-3730. The prima facie rates shall be provided to insurers no later than September 1 prior to each triennium and shall be effective as to all forms issued on or after January 1 of the following triennium.

E. The benefits provided by any credit accident and sickness insurance form shall be considered reasonable in relation to the premium charged provided that the rate does not exceed the current prima facie rates set by the Commission. The Commission shall set forth adjusted prima facie rates that will achieve a fifty percent loss ratio as of January 1, 1993, and adjusted prima facie rates that will achieve a sixty percent loss ratio as of January 1, 1995. Thereafter, the Commission shall, on a triennial basis, set forth adjusted prima facie rates that will achieve a sixty percent loss ratio. The methodology used by the Commission in setting the prima facie rates shall be as set forth in § 38.2-3730. The prima facie rates shall be provided to insurers no later than September 1, 1992, for the rates to be effective January 1, 1993; September 1, 1994, for the rates to be effective January 1, 1995; and September 1 prior to each triennium thereafter, and shall be effective as to all forms issued on or after such January 1.

F. If necessary to assure availability of credit insurance, the Commission may consider other factors in order to provide a fair return to insurers. These other factors may include, but are not limited to, the following: (i) actual and expected loss experience; (ii) general and administrative expenses; (iii) loss settlement and adjustment expenses; (iv) reasonable creditor compensation; (v) investment income; (vi) the manner in which premiums are charged; (vii) other acquisition costs, reserves, taxes, regulatory license fees and fund assessments; and (viii) other relevant data consistent with generally accepted actuarial standards.

G. The Commission shall, within thirty days after the filing of any form requiring approval, notify the insurer filing the form of the form's approval or disapproval. If a form is disapproved, the Commission shall also notify the insurer of its reasons for disapproval. The Commission may extend the period within which it shall indicate its approval or disapproval of a form by thirty days. Any form received but not approved or disapproved by the Commission shall be deemed approved at the expiration of the thirty days, or sixty days if the period is extended. No insurer shall use a form deemed approved under the provisions of this section until the insurer has filed with the Commission a written notice of its intent to use the form together with a copy of the form and the original transmittal letter thereof. The notice shall be filed in the offices of the Commission at least ten days prior to the insurer's use of the form.

H. If the Commission proposes to withdraw approval previously given to any form, it shall notify the insurer in writing not less than thirty days prior to the proposed effective date of withdrawal and give its reasons for withdrawal. No insurer shall issue such forms or use them after the effective date of withdrawal, except as provided in subsection I of this section.

I. Any insurer aggrieved by the disapproval or withdrawal of approval of any form may proceed as indicated in § 38.2-1926.

1982, c. 223, § 38.1-482.7:1; 1986, c. 562, § 38.2-3710; 1992, c. 586; 1999, c. 586.

§ 38.2-3726. Credit life insurance rates.

A. The benefits provided by any credit life insurance form shall be deemed reasonable in relation to the premium charged or to be charged if the rates do not exceed the rates set forth below, except as such rates are modified pursuant to the requirements of § 38.2-3730:

1. $.7519 per month per $1,000 of outstanding insured indebtedness if premiums are payable on a monthly outstanding balance basis.

2. $.48 per $100 of initial indebtedness repayable in twelve equal monthly installments. If premiums are payable on a single premium basis and the amount of the insurance decreases in equal monthly amounts, the following formula shall be used to develop single premium rates from the outstanding balance rate:

$$Sp = \frac{(n+1)}{20\left(1 + \frac{.0363}{24}n\right)} Op$$

where Sp is the single term premium per $100 of initial insured indebtedness, n is the credit term in months, and Op is the monthly outstanding balance rate per $1,000 of outstanding insured indebtedness.

3. If premiums are payable on a single premium basis when the benefit provided is level term, the following formula shall be used to develop single premium rates from the outstanding balance rate:

$$Sp = \frac{n}{10\left(1 + \frac{.055}{24}n\right)} Op$$

where Sp is the single term premium per $100 of initial insured indebtedness, n is the credit term in months, and Op is the monthly outstanding balance rate per $1,000 of outstanding insured indebtedness.

4. If the benefits provided are other than those described in the introduction to this subsection, premium rates for such benefits shall be actuarially consistent with the rates provided in the above subdivisions.

5. Joint coverage on any of the bases in this subsection shall not exceed 165 percent of the specific rate for that type of coverage.

B. The premium rates in subsection A shall apply to policies providing credit life insurance to be issued with or without evidence of insurability, to be offered to all debtors, and, except as set forth below, containing: (i) no exclusions other than suicide within six months of the incurred indebtedness; and (ii) age restrictions making ineligible for coverage debtors age seventy or over at the time the

indebtedness is incurred or debtors having attained age seventy or over on the maturity date of the indebtedness.

1. Insurance written in connection with an open-end credit plan may provide for the cessation of insurance or a reduction in the amount of insurance upon attainment of an age not less than seventy.

2. On insurance written in connection with closed-end credit plans and open-end credit plans where the amount of insurance is based on or limited to the outstanding unpaid balance, no provision excluding or denying a claim for death resulting from a preexisting condition except for those conditions for which the insured debtor received medical diagnosis or treatment within six months preceding the effective date of coverage and which caused the death of the insured debtor within six months following the effective date of coverage. The effective date of coverage for each part of the insurance attributable to a different advance or charge to the plan account is the date on which the advance or charge is posted to the plan account.

3. At the option of the insurer and in lieu of a preexisting condition exclusion on insurance written in connection with open-end credit where the amount of insurance is based on or limited to the outstanding unpaid balance, a provision limiting the amount of insurance payable on death due to natural causes to the balance as it existed six months prior to the date of death if there have been one or more increases in the outstanding balance during such six-month period and if evidence of insurability has not been required in the six-month period prior to date of death.

1992, c. 586.

§ 38.2-3727. Credit accident and sickness insurance rates.

A. The Commission shall, based on a morbidity study, promulgate seven-, fourteen- and thirty-day retroactive and nonretroactive credit accident and sickness insurance premium rates which will reasonably be expected to produce the loss ratio as required by subsection E of § 38.2-3725. These prima facie rates will be published by the Commission no later than September 1, 1992, and will be effective on or after January 1, 1993. After this date, the premium charged in connection with any credit accident and sickness insurance policy or certificate issued in this Commonwealth may not exceed the then-published prima facie rate as set forth in this section and as may be adjusted pursuant to § 38.2-3730.

The morbidity study shall be based on policies and certificates issued in this Commonwealth for the past three years, the premiums charged for those contracts and the experience produced by those contracts. The Commission may also take into consideration the reserves held on these contracts and the methods used to produce those reserves and any other information which the Commission in its discretion may consider necessary to produce a credible morbidity study.

B. The benefits provided by any credit accident and sickness insurance form shall be deemed reasonable in relation to the premium charged or to be charged if the rates do not exceed the rates initially published by the Commission pursuant to subsection A of this section, except as such rates are modified pursuant to the requirements of § 38.2-3730.

C. If premiums are paid on the basis of a premium rate per month per $1,000 of outstanding insured indebtedness, they shall be computed according to the following formula or according to a formula approved by the Commission which produces rates actuarially equivalent to the single premium rates:

$$Opn = \frac{20}{n+1} Spn$$

Where Spn = Single Premium Rate per $100 of initial insured indebtedness repayable in n equal monthly installments.

Op = Monthly Outstanding Balance Premium Rate per $1,000.

n = Original repayment period, in months.

D. A credit accident and sickness insurance form may not be issued with a waiting period, retroactive or nonretroactive, which differs from the waiting periods set forth in this section.

E. The premium rates in subsection B shall apply to policies providing credit accident and sickness insurance to be issued with or without evidence of insurability, to be offered to all eligible debtors, and containing:

1. No provision excluding or denying a claim for disability resulting from preexisting conditions except for those conditions for which the insured debtor received medical advice, diagnosis or treatment within six months preceding the effective date of the debtor's coverage and which caused loss within the six months following the effective date of coverage. The effective date of coverage for each part of the insurance attributable to a different advance or charge to an open-end credit account is the date on which the advance or charge is posted to the plan account.

2. No other provision which excludes or restricts liability in the event of disability caused in a specific manner except that it may contain provisions excluding or restricting coverage in the event of normal pregnancy and intentionally self-inflicted injuries.

3. No actively-at-work requirement more restrictive than one requiring that the debtor be actively at work at a full-time gainful occupation on the effective date of coverage. "Full-time" means a regular work week of not less than thirty hours. A debtor shall be deemed to be actively at work if absent from work due solely to regular day off, holiday or paid vacation.

4. No age restrictions, or only age restrictions making ineligible for coverage debtors sixty-five or over at the time the indebtedness is incurred or debtors who will have attained age sixty-six or over on the maturity date of the indebtedness.

5. A daily benefit equal in amount to one-thirtieth of the monthly benefit payable under the policy for the indebtedness.

6. A definition of "disability" which provides that during the first twelve months of disability the insured shall be unable to perform the duties of his occupation at the time the disability occurred, and

thereafter the duties of any occupation for which the insured is reasonably fitted by education, training or experience.

7. A provision written in connection with an open-end credit plan which may provide for the cessation of insurance or reduction in the amount of insurance upon attainment of an age not less than sixty-five.

F. Joint coverage on any of the bases in this section shall not exceed 165 percent of the rates applicable to that type of coverage.

1992, c. 586; 1995, c. 167.

§ 38.2-3728. Use of rates.

A. Use of prima facie rates. An insurer that files rates or has rates on file that are not in excess of the prima facie rates set forth in § 38.2-3726 or published as set forth in § 38.2-3727, to the extent adjusted pursuant to § 38.2-3730, may use those rates without further proof of their reasonableness.

B. Use of rates higher than prima facie rates. An insurer may file for approval of and use rates that are higher than the prima facie rates set forth in § 38.2-3726 or published as set forth in § 38.2-3727, to the extent adjusted by § 38.2-3730. In order to use these higher rates, it shall be demonstrated to the satisfaction of the Commission that the use of such higher rates will result in a ratio of claims incurred to premiums earned (assuming the use of such higher rates) that is not less than the loss ratios as required by § 38.2-3725 D and E for those accounts to which such higher rates apply and that such upward deviations will not result on a statewide basis for that insurer of a ratio of claims incurred to premiums earned of less than the expected loss ratio underlying the current prima facie rate developed or adjusted pursuant to § 38.2-3730. Deviations effective for 1993 and 1994 for credit life insurance shall be derived based upon a fifty percent loss ratio.

If rates higher than the prima facie rates provided for in §§ 38.2-3726 and 38.2-3727, to the extent adjusted pursuant to § 38.2-3730, are filed for approval, the filing shall specify the account or accounts to which such rates apply. Such rates may be applied on an equitable basis approved by the Commission to only one or more accounts specified by the insurer for which the experience has been less favorable than expected.

C. Approval period of deviated rates.

1. A deviated rate will be in effect for a period of time not longer than the experience period used to establish such rate. In no event will deviated rates remain in effect after the effective date that new prima facie rates are effective as set forth in § 38.2-3730.

2. Notwithstanding subsection A of this section, the prima facie rates shall be employed in the event that the account becomes insured by another insurer.

D. As used in this section:

1. "Experience" means "earned premiums" and "incurred claims" during the experience period.

2. "Experience period" means the most recent period of time for which experience is reported, but not for a period longer than three full years.

3. "Incurred claims" means total claims paid during the experience period, adjusted for the change in claim reserve.

1992, c. 586.

§ 38.2-3729. Refunds.

A. Each individual policy or group certificate shall provide that, in the event of termination of the insurance prior to the scheduled maturity date of the indebtedness, any refund of an amount paid by the debtor for insurance shall be paid or credited promptly to the debtor or person entitled thereto.

B. If a creditor requires a debtor to make any payment for credit life insurance or credit accident and sickness insurance and an individual policy or group certificate of insurance is not issued, the creditor shall immediately give written notice to such debtor and shall promptly make an appropriate credit to the account.

C. Refund formulas which any insurer desires to use for decreasing term credit life insurance with terms of more than sixty-one months must develop refunds which are at least as favorable to the debtor as refunds based on the actuarial method. Refund formulas for decreasing term credit life insurance with terms of sixty-one months or less must develop refunds which are at least as favorable to the debtor as refunds based on the Rule of 78 or the actuarial method, whichever method is consistent with the original method of premium calculation. Refund formulas for credit accident and sickness insurance shall develop refunds that are at least as favorable to the debtor as refunds based on the actuarial method. The actuarial method will result in refunds equal to the premium cost of scheduled benefits subsequent to the date of cancellation or termination, computed at the schedule of premium rates in effect on the date of issue. The refund of premiums for level term credit life insurance shall be no less than the pro rata unearned gross premium. Refund formulas must be filed with and approved by the Commission prior to use.

D. The requirements of subsection C of this section that refund formulas be filed with the Commission shall be considered fulfilled if the refund formulas are set forth in the individual policy or group certificate filed with the Commission.

E. Refunds may be computed:

1. On a daily basis; or

2. From the end of the loan month if sixteen days or more of a loan month have been earned, provided that, if fifteen days or less of a loan month have been earned, the refund is computed from the beginning of the loan month.

F. No refund of five dollars or less need be made.

G. Voluntary prepayment of indebtedness. If a debtor prepays the indebtedness other than as a result of death:

1. Any credit life insurance covering such indebtedness shall be terminated and an appropriate refund of the credit life insurance premium shall be paid or credited to the person entitled to the refund in accordance with this section; and

2. Any credit accident and sickness insurance covering such indebtedness shall be terminated and an appropriate refund of the credit accident and sickness insurance premium shall be paid or credited to the person entitled to the refund in accordance with this section. If a claim under such coverage is in progress at the time of prepayment, the amount of refund may be determined as if the prepayment did not occur until the payment of benefits terminates. No refund need be paid during any period of disability for which credit accident and sickness benefits are payable. A refund shall be computed as if prepayment occurred at the end of the disability period.

H. Involuntary prepayment of indebtedness. If an indebtedness is prepaid by the proceeds of a credit life insurance policy covering the debtor, then it shall be the responsibility of the insurer to see that the following are paid to the insured debtor, if living, or the beneficiary, other than the creditor, named by the debtor or to the debtor's estate:

1. An appropriate refund of the credit accident and sickness insurance premium in accordance with this section; and

2. The amount of benefits in excess of the amount required to repay the indebtedness after crediting any unearned interest or finance charges.

1960, c. 67, § 38.1-482.8; 1982, c. 223, § 38.2-3711; 1986, c. 562; 1992, c. 586; 2002, c. 72; 2009, c. 643.

§ 38.2-3730. Experience reports and adjustment of prima facie rates.

A. Each insurer doing insurance business in this Commonwealth shall annually file with the National Association of Insurance Commissioners a report of credit life and credit accident and sickness written on a calendar year basis. Such report shall utilize the Credit Insurance Supplement-Annual Statement Blank as then approved by the National Association of Insurance Commissioners. Such filing shall be made in accordance with and no later than the due date in the Instructions in the Annual Statement.

B. The Commission shall, on a triennial basis, recalculate rates to determine the actual loss ratio for each form of insurance and adjust the prima facie rates, as provided in §§ 38.2-3726 and 38.2-3727, by applying the ratio of the actual loss ratio to the loss ratio standard set forth in § 38.2-3725 to the prima facie rates. The Commission shall publish notice of the adjusted actual statewide prima facie rates to be used by insurers during the next triennium and provide an opportunity for a hearing. As set forth in this section, the following formula shall be used to adjust the prima facie rates:

$$a \quad b \quad \text{PFR} \quad X \quad \frac{\text{Actual Loss Ratio}}{\text{---------}}$$

c Loss Ratio Standard

Where PFR is the prima facie rate as provided in §§ 38.2-3726 and 38.2-3727, the Actual Loss Ratio is the ratio of the incurred claims to the earned premiums at prima facie rates for all companies for the preceding three years as reported in the Annual Statement Supplements and the Loss Ratio Standard is the loss ratio provided in § 38.2-3725.

1992, c. 586; 2015, c. 11; 2022, c. 412.

§ 38.2-3731. Claims.

A. All claims shall be promptly reported to the insurer or its designated claim representative. The insurer shall maintain adequate claim files. All claims shall be settled as soon as possible and in accordance with the terms of the insurance contract.

B. All claims shall be paid or credited by: (i) electronic means to the account of the claimant to whom payment of the claim is due pursuant to the policy provisions or to an account or person specified by such claimant; or (ii) draft drawn upon the insurer or by check of the insurer to the order of the claimant to whom payment of the claim is due pursuant to the policy provisions, or to a person specified by such claimant.

C. No plan or arrangement shall be used where any person other than the insurer or its designated claim representative shall be authorized to settle or adjust claims. The creditor shall not be designated as claim representative for the insurer in adjusting claims. A group policyholder may, by arrangement with the insurer, draw drafts or checks, or credit by electronic means in payment of claims due to the group policyholder subject to audit and review by the insurer. The insurer shall periodically review claims payments made on its behalf by claim representatives or group policyholders.

1960, c. 67, § 38.1-482.11; 1982, c. 223, § 38.2-3713; 1986, c. 562; 1992, c. 586.

§ 38.2-3732. Insurer delegation of duties.

Any insurer that delegates to a creditor any of its duties under the laws of this Commonwealth or the regulations of this Commission shall be responsible to see that such creditor discharges such duties in accordance with said laws and regulations. A finding by the Commission that either the insurer or its delegee has failed to comply with such requirements shall subject the insurer and creditor to any and all disciplinary actions authorized under this title. Such responsibility shall include but not be limited to a determination that:

1. Proper insurance rates are being charged by the creditor;

2. Proper refunds are being made;

3. Claims are being filed and properly handled;

4. Amounts of insurance payable on death in excess of the amounts necessary to discharge indebtedness are properly distributed; and

5. The creditor is promptly and fairly processing complaints concerning its credit insurance operations and is maintaining proper procedures for and records of complaints processed.

1992, c. 586.

§ 38.2-3733. Portion of premium may be allowed to creditor; insurance may be provided and serviced at creditor's place of business.

A. A portion of the premium for credit life insurance or credit accident and sickness insurance may be allowed by the insurer to a creditor for providing and servicing such insurance. Such portion of the premium so allowed shall not be deemed as a rebate of premium or as interest charges or consideration or an amount in excess of permitted charges in connection with the loan or other credit transaction.

B. All of the acts necessary to provide and service credit life insurance and credit accident and sickness insurance may be performed within the same place of business in which is transacted the business giving rise to the loan or other credit transaction.

1960, c. 67, § 38.1-482.9; 1982, c. 223, § 38.2-3712; 1986, c. 562; 1992, c. 586.

§ 38.2-3734. License requirements.

Any person who, in this Commonwealth, on behalf of an insurer licensed in this Commonwealth, sells, solicits, or negotiates individual or group policies of credit life insurance shall first apply for and obtain a license from the Commission as either a life and annuities insurance agent or as a limited lines credit insurance agent as defined in § 38.2-1800. Any person who, in this Commonwealth, on behalf of an insurer licensed in this Commonwealth, sells, solicits, or negotiates individual or group policies of credit accident and sickness insurance, shall first apply for and obtain a license from the Commission as either a health agent or as a limited lines credit insurance agent as defined in § 38.2-1800 of this title, and shall be required to be appointed to represent such insurer in this Commonwealth as set forth in § 38.2-1833.

1992, c. 586; 2001, c. 706.

§ 38.2-3735. Disclosure and readability.

A. If a creditor makes available to the debtors more than one plan of credit life insurance or more than one plan of credit accident and sickness insurance, all debtors must be informed of all such plans for which they are eligible. In the case of credit life insurance:

1. If a creditor offers a plan of insurance that insures the actual amount of unpaid indebtedness, the creditor shall also offer to the debtor a plan of insurance that insures only the actual amount of indebtedness less any unearned interest or finance charges; and

2. In the event that a plan of insurance that insures the actual amount of unpaid indebtedness is offered, the creditor shall provide to each debtor a disclosure form which shall clearly disclose the difference in premiums charged for a contract wherein the gross indebtedness is insured versus a contract wherein only the net indebtedness is insured. This disclosure shall include the differences

between the amount financed, the monthly payment and the total charge for each type of insurance. The form shall be signed and dated by the debtor and the agent, if any, soliciting the application or the creditor's representative, if any, soliciting the enrollment request. A copy of this disclosure shall be given to the debtor, and a copy shall be made a part of the creditor's loan file.

Nothing contained in this subsection shall be construed to prohibit the creditor from combining such disclosure, in order to avoid redundancy, with other forms of disclosure required under state or federal law.

B. When elective credit insurance is offered, the borrower must be given written disclosure that purchase of credit insurance is not required and is not a factor in granting credit. The disclosure shall also include notice that the borrower has the right to use alternative coverage or to buy insurance elsewhere.

C. If the debtor is given a contract which includes a single premium payment to be charged for elective credit insurance, the debtor must be given:

1. A contract which does not include the elective credit insurance premium; or

2. A disclosure form which shall clearly disclose the difference in premiums charged for a contract with credit insurance and one without credit insurance. This disclosure shall include the difference between the amount financed, the monthly payment and the charge for each kind of insurance. The form shall be signed and dated by the debtor and the agent, if any, soliciting the application or the creditor's representative, if any, soliciting the enrollment request. A copy of this disclosure shall be given to the debtor and a copy shall be made a part of the creditor's loan file.

Nothing contained in this subsection shall be construed to prohibit the creditor from combining such disclosure, in order to avoid redundancy, with other forms of disclosure required under state or federal law.

D. If credit life insurance or credit accident and sickness insurance is required as security for any indebtedness, the debtor shall have the option of (i) furnishing the required amount of insurance through existing policies of insurance owned or controlled by him or (ii) procuring and furnishing the required coverage through any insurer authorized to transact insurance in this Commonwealth. The creditor shall inform the debtor of this option in writing and shall obtain the debtor's signature acknowledging that he understands this option. Nothing contained in this subsection shall be construed to prohibit the creditor from combining such disclosure, in order to avoid redundancy, with other forms of disclosure required under state or federal law.

E. No contract of insurance upon a debtor paid in advance or by a single premium shall be made or effectuated unless, at the time of the contract, the debtor is provided with a notice prominently disclosing his rights to a refund of premium in the event the insurance is terminated prior to its scheduled maturity date or the insured indebtedness is terminated or paid off early, and of the obligation of the debtor to provide notification to the insurer under subdivision D 8 of § 38.2-3724. This notice shall be

signed and dated by the debtor and the agent, if any, soliciting the application or the creditor's representative, if any, soliciting the enrollment request. A copy of the signed notice shall be given to the debtor and a copy shall be made part of the insurer's file.

F. Readability. -- The Commission shall not approve any form unless the policy or certificate is written in nontechnical, readily understandable language, using words of common everyday usage.

A form shall be deemed acceptable under this section if the insurer certifies that the form achieves a Flesch Readability Score of forty or more, using the Flesch Readability Formula as set forth in Rudolf Flesch, The Art of Readable Writing (1949, as revised 1974), and certifies compliance with the guidelines set forth in this section.

1992, c. 586; 1999, c. 586; 2009, c. 643; 2010, c. 211.

§ 38.2-3736. Noncontributory coverage.

If no specific charge is made to the debtor for credit life or credit accident and sickness insurance, the Commission is granted discretion in applying the provisions of this chapter. Each company must comply with § 38.2-3725 and the filing letter must specifically request an exemption from Virginia law. For purposes of this section, it will be considered that the debtor is charged a specific amount for insurance if an identifiable charge for insurance is disclosed in the credit or other instrument furnished the debtor which sets out the financial elements of the credit transactions, or if there is a differential in finance, interest, service or other similar charges made to debtors who are in like circumstances, except for their insured or noninsured status.

1992, c. 586.

§ 38.2-3737. Application.

A. No contract of insurance upon a debtor shall be made or effectuated unless at the time of the contract, the debtor, being of lawful age and competent to contract for insurance, applies for the insurance in writing on a form approved by the Commission.

B. The application or enrollment request shall be required to:

1. Contain the name and signature of the agent or creditor's representative, if any, who solicited the application or enrollment request;

2. Contain the name and address of the insurer and creditor; the name and age of the debtor(s); the premium, rate or amount payable by the debtor separately for credit life insurance and credit accident and sickness insurance; the type of insurance coverage provided; the date of application; and separately, the amount and term, including the effective and cancellation dates, of the insurance and loan contracts; and

3. Include the disclosure requirements set forth in subsections A, B, C, D, and E of § 38.2-3735 unless such requirements have been separately disclosed in another form or forms approved by the Commission.

C. The application or enrollment request form shall be separate and apart from the loan or credit transaction papers and will refer exclusively to insurance coverage.

D. No individual or group credit life insurance or credit accident and sickness insurance application form shall contain a question of general good health unless the application form contains appropriate specific questions concerning the applicant's health history or medical treatment history.

E. Neither this section nor subsection B of § 38.2-3735 shall apply to credit life or credit accident and sickness insurance that will insure open-end monthly outstanding balance credit transactions if the following criteria are met:

1. The credit life insurance and credit accident and sickness insurance that will insure the open-end monthly outstanding balance credit transaction are offered to the debtor after the loan or credit transaction that it will insure has been approved by the creditor and has been effective at least seven days;

2. The solicitation for the insurance is by mail or telephone. The person making the solicitation shall not condition the future use or continuation of the open-end credit upon the purchase of credit life or credit accident and sickness insurance;

3. The creditor makes available only one plan of credit life insurance and one plan of credit accident and sickness insurance to the debtor;

4. The debtor is provided written confirmation of the insurance coverage within thirty days of the effective date of such coverage. The effective date of coverage shall begin on the date the solicitation is accepted; and

5. The individual policy or certificate has printed on it a notice stating that if, during a period of at least thirty days from the date that the policy or certificate is delivered to the policyowner or certificate holder, the policy or certificate is surrendered to the insurer or its agent with a written request for cancellation, the policy or certificate shall be void from the beginning and the insurer shall refund any premium paid for the policy or certificate. This statement shall be prominently included on the face page of the policy or certificate, and shall be printed in capital letters and in bold 12-point or larger type.

F. The following shall be applicable to open-end credit transactions by mail, telephone, or brochure solicitations, that are not excluded from the requirements of this section and of subsection B of § 38.2-3735 by subsection E, where the insurer is offering only one plan of credit life insurance or one plan of credit accident and sickness insurance:

1. Section 38.2-3735 shall not apply to such transactions, provided that the following disclosures are included in such solicitations, whether as part of the application or enrollment request or separately:

a. The name and address of the insurer(s) and creditor; and

b. A description of the coverage offered, including the amount of coverage, the premium rate for the insurance coverage offered, and a description of any exceptions, limitations, or restrictions applicable to such coverage.

2. Subsections B and D of this section shall not apply to such transactions, provided that the application or enrollment request utilized as part of such transaction:

a. Is printed in a type size of not less than eight-point type, one point leaded, notwithstanding the requirements set forth in subdivision D 5 of § 38.2-3724 regarding minimum type size for policies and certificates;

b. Contains a prominent statement that the insurance offered is optional, voluntary, or not required;

c. Contains no questions relating to insurability other than the debtor's age or date of birth and, if applicable, active employment status; and

d. If the disclosures required by subdivision 1 of this subsection are not included in the application or enrollment request, makes reference to such disclosures with sufficient information so as to assist the reader in locating such disclosures within the solicitation.

3. Each insurer proposing to utilize an application or enrollment request in such transactions shall file such form for approval by the Commission. If the insurer anticipates utilizing such application or enrollment form in more than one solicitation, the insurer shall submit, as part of its filing of such form, a certification signed by an officer of the insurer, stating that any such subsequent use of the application or enrollment form will utilize the same form number and will not vary in substance from the wording and format in which the form is submitted for approval. Upon approval of such application or enrollment form by the Commission, the insurer shall be permitted to utilize such form in various solicitation materials, provided that the application or enrollment form, when incorporated into such solicitation materials, has the same form number and wording substantially identical to that contained on the approved application or enrollment form.

G. Notwithstanding the provisions of subsection A, a contract of insurance may be made or effectuated in connection with a credit transaction between a creditor regulated pursuant to Chapter 13 (§ 6.2-1300 et seq.) of Title 6.2 or 12 U.S.C. § 1751 et seq. and a debtor who is of lawful age, competent to contract for the insurance and a member of the creditor if:

1. The credit transaction and the solicitation for such insurance is effected by mail, telephone or other electronic means;

2. The purchase of credit insurance is not required by the creditor and is not a factor in granting the credit;

3. The creditor or insurer, within three business days after the credit transaction is effected, transmits to the debtor, either separately or with the documents that pertain to the credit transaction, an application or enrollment request form approved by the Commission which includes or to which is attached a prominent notice that clearly advises the debtor that unless he mails the completed and signed

application or enrollment request to the creditor within forty-five days following the date of the credit transaction, all such coverage requested in connection with the credit transaction will be void from the beginning; and

4. In the event the debtor does not transmit the completed and signed application or enrollment request to the creditor within the time specified in subdivision 3, the full amount of the premium charged for the insurance is returned to or credited to the account of the debtor and written notice thereof is sent to the debtor within fifteen days of the date the policy or certificate is cancelled.

1992, c. 586; 1993, c. 627; 1994, c. 202; 1995, c. 167; 1999, c. 586; 2009, c. 643.

§ 38.2-3738. What laws applicable.

In the event of conflict between the provisions of this chapter and other provisions of this title, the provisions of this chapter shall be controlling. Subdivisions 1 and 2 of § 38.2-508 shall not apply to the insurance subject to the provisions of this chapter where application of these subdivisions would conflict with the requirements of any federal agency.

1960, c. 67, § 38.1-482.1; 1972, c. 527, § 38.2-3716; 1982, c. 223; 1986, c. 562; 1992, c. 586.

Chapter 38 - COOPERATIVE NONPROFIT LIFE BENEFIT COMPANIES

Article 1 - General Provisions

§ 38.2-3800. Scope of chapter.

This chapter applies to cooperative nonprofit life benefit companies as defined in § 38.2-3801 and to the classes of insurance and insurance benefits those companies are authorized to provide.

1952, c. 317, § 38.1-496; 1986, c. 562.

§ 38.2-3801. Cooperative nonprofit life benefit company defined.

A. Any company that (i) is organized without capital stock, (ii) has a representative form of government, (iii) conducts its business under the provisions of this chapter without profit and for the sole benefit of its members and their beneficiaries, (iv) issues benefit certificates or policies of life insurance, annuities, or accident and sickness insurance, or any combination of those classes of insurance, upon its members, and (v) maintains the reserves required in this chapter on all contracts issued by it to its members, shall be a cooperative nonprofit life benefit company.

B. As used in this chapter, "company" means a cooperative nonprofit life benefit company as defined in subsection A of this section.

Code 1950, § 38-467; 1952, c. 317, § 38.1-497; 1986, c. 562.

§ 38.2-3802. Continuation of existing companies.

Any company licensed and doing business in this Commonwealth on July 1, 1952, may continue to do business in accordance with the powers contained in its certificate of incorporation, subject to the provisions of this chapter, but no such company shall be permitted to extend its powers.

1952, c. 317, § 38.1-498; 1986, c. 562.

§ 38.2-3803. Licensing of additional companies prohibited.

Any company that was not licensed and doing business in this Commonwealth on July 1, 1952, shall not be issued a license to do the business of insurance in this Commonwealth. On or after July 1, 1952, only a renewal of a license held by the company for the preceding year will be issued.

1952, c. 317, § 38.1-499; 1986, c. 562.

§ 38.2-3804. What laws applicable.

All companies shall comply with all of the provisions of this title relating to insurance companies generally. In the event of conflict between the provisions of this chapter and other provisions of this title, the provisions of this chapter shall be controlling.

1952, c. 317, § 38.1-502; 1986, c. 562.

§ 38.2-3805. General powers of company; limitation on increase in rates.

Each company shall make a constitution, laws or bylaws for its government, the admission of its members, the management of its affairs and the fixing and readjustment of the rates of contribution of its members. It may change, add to, or amend the constitution, laws or bylaws and shall have the other powers necessary and incidental to effect the objects and purposes of the company. It may make refunds to its members from any surplus funds of the company, but it may only increase rates or make extra assessments against members whose contracts include provisions for rate increases and extra assessments.

Code 1950, § 38-478; 1952, c. 317, § 38.1-503; 1986, c. 562.

§ 38.2-3806. Constitution and bylaws.

Each company shall provide in its constitution, laws or bylaws for:

1. A representative form of government for the management of the company, to be carried on either with or without a lodge, or with membership in the lodge optional;

2. A legislative or governing body composed of its officers and representatives to be elected either by the adult members or by delegates elected directly or indirectly by the adult members; and

3. The manner of selecting representatives of the members for membership in its legislative body.

Code 1950, § 38-479; 1952, c. 317, § 38.1-504; 1986, c. 562.

§ 38.2-3807. Governing body; board of directors.

The governing body of each company shall meet at least once every four years. Meetings of the governing body may be held in any state where the company is authorized to do business. The members of the governing body shall not vote by proxy.

A board of directors to conduct the business of the company shall be elected by the governing body for a period of not more than four years or until the next quadrennial meeting of the body. The board of directors shall elect the officers to conduct the business of the company under its direction. No officer shall be elected for a period beyond that for which the board of directors has been elected.

Code 1950, § 38-480; 1952, c. 317, § 38.1-505; 1986, c. 562.

§ 38.2-3808. Filing copies of constitution and bylaws.

Each company shall file with the Commission a duly certified copy of its constitution, laws or bylaws and all amendments or additions. Printed copies of the constitution, laws or bylaws, certified by the secretary or corresponding officer of the company, shall be prima facie evidence of their legal adoption and filing.

Code 1950, § 38-481; 1952, c. 317, § 38.1-506; 1986, c. 562.

§ 38.2-3809. How a company may become legal reserve life insurer.

Any company filing with the Commission a resolution of its board of directors or similar body, or of its legislative body, making a request to become a legal reserve life insurer, upon submitting proof satisfactory to the Commission that the request is properly authorized and that the condition of its business qualifies it under the laws of this Commonwealth to be classed as a legal reserve life insurer, shall become a legal reserve life insurer under the name and the plan provided by proper amendment of its charter or certificate of incorporation.

Code 1950, § 38-477; 1952, c. 317, § 38.1-507; 1986, c. 562.

§ 38.2-3810. Institutions maintainable; company a charitable institution.

Any company may maintain homes for aged members, or children's homes, hospitals or recreational centers, or any other charitable institution, and may provide for the erection of monuments or memorials to deceased members. Such a company is hereby classified as a charitable institution.

Code 1950, § 38-482; 1952, c. 317, § 38.1-508; 1986, c. 562.

§ 38.2-3811. Benefits not subject to process.

Any money, other benefit, charity, relief or aid to be paid, provided or rendered by any company shall not be liable to attachment, garnishment or other process, or be seized, taken, appropriated or applied by any legal or equitable process or operation of law to pay any debt or liability of a member, his beneficiary, or any other person who may have a right thereunder, either before or after payment.

Code 1950, § 38-493; 1952, c. 317, § 38.1-510; 1986, c. 562.

§ 38.2-3812. Tax on gross premium receipts.

The officers of each company shall, at the time of making the annual statement, file with the Commission a sworn statement of its gross premium receipts collected from members residing in this Commonwealth for the preceding year ending December 31. Each company shall pay into the state treasury by March 1 of each year, a tax of one percent on its collected gross premiums. The tax shall be in lieu of all other taxes, state, county or municipal, based on such gross premium receipts. No city, town, municipality or other subdivision of the Commonwealth shall impose any license fee on the company or any of its agents for the privilege of conducting business in any portion of this Commonwealth. In determining such gross premium receipts, the company shall not take credit for any expenditures.

Code 1950, § 38-494; 1952, c. 317, § 38.1-511; 1986, c. 562; 1987, cc. 565, 655.

§ 38.2-3813. Suits against company.

A suit or an action at law may be instituted against any company in any county or city in this Commonwealth.

Code 1950, § 38-495; 1950, p. 242; 1952, c. 317, § 38.1-512; 1986, c. 562.

Article 2 - RESERVES, POLICIES AND BENEFITS

§ 38.2-3814. Contracts in writing; fees.

All contracts of any company for insurance or other benefits shall be in writing. No company or any of its officers or agents shall include in the sum charged a member, any fee, compensation, or other charge. However, a local medical examiner's fee and a policy fee on accident and sickness contracts may be charged.

Code 1950, § 38-484; 1952, c. 317, § 38.1-514; 1986, c. 562.

§ 38.2-3815. What benefits policies may provide.

Any company may provide for (i) stipulated premiums, (ii) death, annuity, endowment and disability benefits, and (iii) cash surrender and loan values to an amount not exceeding the reserve, or its equivalent, in paid-up or extended term insurance, based upon the mortality standards set forth in this chapter.

Code 1950, § 38-483; 1952, c. 317, § 38.1-515; 1986, c. 562.

§ 38.2-3816. Policies companies may issue; reserves required; provisions concerning increase of rates and extra assessments.

Any company may issue contracts of life, accident and sickness insurance or combinations of them. The reserves for such policies or contracts shall be based upon the American Experience Table of Mortality, with an interest assumption of no more than four percent, or some higher standard, or upon any minimum standard allowed by law in this Commonwealth for legal reserve life insurers. It may provide in its laws or bylaws and membership contracts that the rates shall not be increased or extra assessments made.

Code 1950, § 38-488; 1952, c. 317, § 38.1-516; 1986, c. 562.

§ 38.2-3817. Paid-up insurance or extended term insurance.

Any company shall provide for automatic paid-up or extended term insurance in the event of the default in premium payments of any contract that has been in force for at least two years from the date of issue. The amount of such insurance shall not exceed the amount which the reserve that is credited to the member will purchase. The company shall carry the liability on its books.

Code 1950, § 38-486; 1952, c. 317, § 38.1-517; 1986, c. 562.

§ 38.2-3818. Officers and members not individually liable for payment.

Officers and members of the supreme, grand or any subordinate body of any company shall not be individually liable for the payment of any disability or death or other benefits provided for in the laws,

bylaws and contracts of the company. Benefits shall be payable out of the funds of the company and in the manner provided by its laws and bylaws.

Code 1950, § 38-487; 1952, c. 317, § 38.1-519; 1986, c. 562.

Chapter 39 - MUTUAL ASSESSMENT LIFE, ACCIDENT AND SICKNESS INSURERS

Article 1 - General Provisions

§ 38.2-3900. Scope of chapter.

This chapter applies to mutual assessment life, accident and sickness insurers and to the classes of insurance written by these insurers.

1985, c. 400, § 38.1-549.1; 1986, c. 562.

§ 38.2-3901. Definitions.

As used in this chapter:

"Mutual assessment life, accident and sickness insurance" means life, accident and sickness insurance and annuities provided by an insurer which has a right to assess its members for contributions and which is licensed under this chapter.

"Mutual assessment life, accident and sickness insurer" means a nonstock corporation that provides life, accident or sickness insurance or annuity contracts for which the following provisions are applicable:

1. All benefits payable to beneficiaries are mainly provided for by (i) assessments upon members made when needed by the insurer, or (ii) advance premiums paid at fixed dates, with the right reserved by the insurer to make additional assessments; or

2. If definite periodic premiums are used without the right to make additional assessments, premiums must be sufficient to pay average claims in accordance with standards applicable to insurers licensed pursuant to Chapter 10 (§ 38.2-1000 et seq.) of this title.

1985, c. 400, § 38.1-549.2; 1986, c. 562.

§ 38.2-3902. Classes of insurance that may be written by mutual assessment life, accident and sickness insurers.

The following classes of insurance can be written by mutual assessment life, accident and sickness insurers:

Category A

1. Life insurance as defined in § 38.2-102;

2. Industrial life insurance as defined in § 38.2-104; and

3. Accident and sickness insurance as defined in § 38.2-109 except Medicare supplement insurance as defined in § 38.2-3600.

Category B

1. Credit life insurance as defined in § 38.2-103;

2. Variable life insurance as defined in § 38.2-105;

3. Credit accident and sickness insurance as defined in § 38.2-108; and

4. Medicare supplement insurance as defined in § 38.2-3600.

Category C

1. Annuities as defined in § 38.2-106; and

2. Variable annuities as defined in § 38.2-107.

1985, c. 400, § 38.1-549.3; 1986, c. 562.

§ 38.2-3903. What laws applicable.

Except as provided in this section, all mutual assessment life, accident and sickness insurers shall comply with all provisions of this title relating to insurers generally. Until July 1, 1990, those classes of insurance specified in Category A of § 38.2-3902 shall be exempt from this title, except this chapter and Chapters 5 and 6 of this title. In the event of conflict between the provisions of this chapter and other provisions of this title, the provisions of this chapter shall be controlling.

1985, c. 400, § 38.1-549.4; 1986, c. 562.

§ 38.2-3904. Conversion of mutual assessment life, accident and sickness insurers.

A. Any mutual assessment life, accident and sickness insurer which chooses to remove itself from the provisions of this chapter by becoming an insurer licensed pursuant to Chapter 10 (§ 38.2-1000 et seq.) of this title may do so by meeting the requirements of that chapter. When applying for a license pursuant to Chapter 10, an insurer shall submit an application to the Commission that shows that each requirement of Chapter 10 has been met. If the applicant does not meet these requirements, the applicant may submit for approval a plan that includes a schedule for meeting these requirements. The schedule must provide for compliance with these requirements within five years of the approval of the application. The Commission may grant an additional period in order to achieve compliance with the requirements of Chapter 10 after an informal hearing.

B. If the Commission approves the application, the insurer shall have all the rights, privileges and responsibilities of a licensed insurer not subject to the provisions of this chapter.

C. The Commission, upon failure of the applicant to comply with the terms of an approved schedule, may require the applicant to adhere to the requirements of this chapter.

1985, c. 400, § 38.1-549.5; 1986, c. 562.

Article 2 - ORGANIZATION AND LICENSING OF COMPANIES

§ 38.2-3905. Incorporation of companies.

Any insurer that was licensed and transacting in this Commonwealth the business of mutual assessment life, accident and sickness insurance on July 1, 1985, may continue to transact that business in accordance with its license.

1985, c. 400, § 38.1-549.6; 1986, c. 562.

§ 38.2-3906. Licensing of additional companies prohibited.

Any insurer that was not licensed and engaged in the business of mutual assessment life, accident and sickness insurance in this Commonwealth under the provisions of former Title 38.1 on July 1, 1952, shall not be issued a license pursuant to this chapter to transact the business of insurance in this Commonwealth. On or after that date a license shall not be issued except for renewal of a license held by the insurer for the preceding year.

1985, c. 400, § 38.1-549.7; 1986, c. 562.

§ 38.2-3907. Directors; terms; annual meetings; voting; executive committee.

A. As provided in its certificate of incorporation and as provided in its bylaws, the management of any mutual assessment life, accident and sickness insurer shall be vested in a board of at least five directors, each of whom shall be a member of the insurer. Each director shall hold office for one year or for a longer term if specified by the bylaws, and thereafter until his successor is elected and has qualified. Vacancies on the board may be filled for the unexpired term by the remaining directors.

B. The annual meeting of the members of the insurer shall be held as provided by the certificate of incorporation or the bylaws. A quorum shall consist of the larger of ten members or the number of members specified by either the certificate of incorporation or bylaws. In all meetings of members, each member of the insurer shall be entitled to one vote, or a number of votes based upon insurance in force, the number of policies held, or the amount of premiums paid as provided in the bylaws of the insurer. Votes by proxy may be received in accordance with the certificate of incorporation or the bylaws. The date of the annual meeting shall be stated in the policy, or notice of the date and location of the annual meeting shall be provided annually.

C. Notwithstanding the provisions of the charter of any insurer to the contrary, upon a resolution adopted by the board of directors of the insurer and approved by a majority of its members present in person or by proxy, the directors of the insurer may be divided into classes, and only a portion may be elected each year. Pursuant to the provisions of § 13.1-869 the directors may appoint an executive committee to exercise the powers and perform the duties set out in that section.

1985, c. 400, § 38.1-549.8; 1986, c. 562.

§ 38.2-3908. Officers.

Unless the certificate of incorporation provides otherwise, the directors shall elect from their number a president and may elect a chairman, and shall also elect a secretary and a treasurer and any

additional officers as they determine necessary, who may or may not be members of the insurer. The offices of secretary and treasurer may be held by one person. Unless otherwise provided in the certificate of incorporation, the term of these officers shall be not less than one year nor more than three years or until their successors are elected or qualified.

1985, c. 400, § 38.1-549.9; 1986, c. 562.

§ 38.2-3909. Inspection of books and papers.

The books and papers of the insurer shall be open for examination by members or their representatives at all reasonable times.

1985, c. 400, § 38.1-549.10; 1986, c. 562.

Article 3 - POLICY PROVISIONS AND BENEFITS

§ 38.2-3910. Policy forms to be filed.

Every mutual assessment life, accident and sickness insurer shall file with the Commission a copy of all policy forms and standard endorsements which the insurer intends to use. These companies shall be exempt from form approval requirements regarding those lines of insurance specified in Category A of § 38.2-3902 until July 1, 1990.

1985, c. 400, § 38.1-549.11; 1986, c. 562.

§ 38.2-3911. Time limit on certain defenses.

Every insurance policy or contract shall contain a provision that after two years from the effective date of the policy or contract, only fraudulent misstatements in the application may be used to void the policy or contract or deny any claim for a loss incurred or a disability that starts after the two-year period. This provision may be omitted if the incontestable clause referred to in § 38.2-3912 is included.

1985, c. 400, § 38.1-549.12; 1986, c. 562.

§ 38.2-3912. Incontestability of policies.

Every insurance policy or contract shall contain a provision that it shall be incontestable after it has been in force during the lifetime of the insured for two years from its date of issuance, except for nonpayment of the policy's assessments or premiums. In the case of life policies and at the option of the insurer, provisions relating to benefits in the event of disability and provisions which grant additional insurance specifically against death by accident or accidental means, may be excepted in the incontestability provision. This provision may be omitted if the time limit on the certain defense clause specified in § 38.2-3911 is included.

1985, c. 400, § 38.1-549.13; 1986, c. 562; 1987, c. 520.

§ 38.2-3913. Required grace periods.

Each insurance policy shall have a provision that the insured is entitled to a thirty-one-day period within which the payment of any premium or assessment after the first payment may be made. At the

option of the insurer this may be subject to a reasonable interest charge for the number of days of grace elapsing before the payment of the premium or assessment. The provision shall also state that during the grace period the policy shall continue in full force, but if a claim arises under the policy during the grace period before the overdue premium or assessment is paid, the amount of such premium or assessment, with applicable interest, may be deducted from any amount payable under the policy in settlement.

1985, c. 400, § 38.1-549.14; 1986, c. 562.

§ 38.2-3914. Policy to specify amount of payment and when to be paid.

Each policy shall specify the sum of money payable upon the occurrence of the insured risk. Each policy shall also state that payment shall be made within thirty days after showing proof of the occurrence of the insured risk.

1985, c. 400, § 38.1-549.15; 1986, c. 562.

Article 4 - INSURANCE TRANSACTIONS

§ 38.2-3915. Assessment contract.

Contracts issued by a mutual assessment life, accident and sickness insurer shall be on forms prescribed by the insurer and shall be substantially uniform among members of the respective classes of insurance written by the insurer. Each member shall pay his pro rata share of all losses or damages sustained, expenses of operations of the insurer, and the maintenance of an adequate surplus to policyowners as determined by the board of directors. Periodic assessments may be collected as advance premiums, or by past assessments, or by both methods. The amount of assessments shall be established by the board of directors of the insurer. When a contract is subject to assessment, the contingent liability of each member of an insurer shall be clearly stated in the contract. Contracts omitting the right of contingent assessment shall be deemed to be nonassessable.

1985, c. 400, § 38.1-549.16; 1986, c. 562.

§ 38.2-3916. Classification of risks; rates.

Any insurer writing mutual assessment life, accident and sickness insurance may classify the risks insured against, and fix the rate of assessment of premium for such insurance in accordance with the classifications.

1985, c. 400, § 38.1-549.17; 1986, c. 562.

§ 38.2-3917. Right to limit assessment liability; when contingent assessment liability waived.

Any mutual assessment life, accident and sickness insurer having a surplus to policyowners of at least $100,000 may limit the contingent assessment liability of members, or classes of members, to an amount not more than 1 additional current annual assessment. Any insurer having surplus to policyowners of at least $300,000 may issue contracts omitting the right to make contingent assessment against members if reserves for these contracts are established and maintained in the same manner

as would be required by an insurer licensed pursuant to Chapter 10 (§ 38.2-1000 et seq.) of this title. Contracts so issued shall be treated in all respects as nonassessment contracts.

1985, c. 400, § 38.1-549.18; 1986, c. 562.

§ 38.2-3918. Notice of assessment; how given.

After an assessment is made, the insurer shall give each member subject to the assessment written notice stating the amount of the assessment and the date when payment is due. Except where the provisions of the bylaws or the policy provide otherwise, the time of payment shall not be less than thirty days nor more than sixty days from the service of the notice. This notice may be served personally or mailed with the United States Postal Service. If sent by mail, notice shall be considered given at the time of mailing and shall be sent to the member at his address shown on the insurer's records.

1985, c. 400, § 38.1-549.19; 1986, c. 562.

§ 38.2-3919. Agents' licenses required.

A. Except as provided in subsection B, each individual who is a resident of this Commonwealth who desires to obtain a license to sell, solicit, or negotiate any of the classes of insurance specified in § 38.2-3902 shall obtain that license only when that individual has passed a written examination prescribed by the Commission.

B. Any individual who is licensed prior to July 1, 1990, and whose license is restricted to the classes of insurance specified in Category A of § 38.2-3902 shall be exempted from the written examination provision noted above.

C. Business entities, as defined in § 38.2-1800, whether resident or nonresident, as well as nonresident individuals who desire to obtain a license to sell, solicit, or negotiate any of the classes of insurance specified in § 38.2-3902 shall be eligible for licensing upon satisfaction of the requirements set forth in § 38.2-1836.

1985, c. 400, § 38.1-549.20; 1986, c. 562; 2001, c. 706.

Article 5 - FINANCIAL PROVISIONS

§ 38.2-3920. Surplus to policyowners.

A. A mutual assessment life, accident and sickness insurer shall have a minimum surplus to policyowners of $100,000.

B. In order to write the classes of insurance referred to in Category C of § 38.2-3902, minimum surplus to policyowners shall be $800,000.

1985, c. 400, § 38.1-549.21; 1986, c. 562.

§ 38.2-3921. Limitation on single risk to be assumed.

No single risk shall be assumed by a mutual assessment life, accident and sickness insurer if the risk exceeds fifteen percent of the company's total surplus to policyowners. Any risk or portion of any risk that has been reinsured in accordance with § 38.2-3922 shall be deducted in determining the

limitation of risk prescribed by this section. For the purposes of this section the amount of surplus to policyowners shall be determined on the basis of the last sworn statement of the insurer, or the last report of examination filed with the Commission, whichever is more recent at the time the risk is assumed. Mutual assessment life, accident and sickness insurers licensed on July 1, 1985, shall conform to this limitation by July 1, 1990. Until July 1, 1986, the single risk limit, after deducting for reinsurance, shall be twenty-five percent of surplus to policyowners. Between July 1, 1986, and July 1, 1988, single risk limits, after deducting for reinsurance, shall be twenty percent of surplus to policyowners. This section shall not apply to insurance coverages defined in §§ 38.2-108 and 38.2-109 and Medicare supplement insurance defined in § 38.2-3600.

1985, c. 400, § 38.1-549.22; 1986, c. 562.

§ 38.2-3922. Reinsurance.

Any mutual assessment life, accident and sickness insurer may reinsure the whole or any part of its risks with any solvent insurer licensed in this Commonwealth or licensed in any other state having standards of solvency, at least equal to those required in this Commonwealth. However, the reinsurance shall be ceded without contingent liability on the part of the reinsured insurer. Any mutual assessment life, accident and sickness insurer having a surplus in excess of $800,000 may accept or assume reinsurance from any licensed insurer.

1985, c. 400, § 38.1-549.23; 1986, c. 562.

§ 38.2-3923. Reserves required.

In addition to providing for claims incurred but not settled, mutual assessment life, accident and sickness insurers shall maintain the following reserve liabilities:

1. Life policies written with the right to make additional assessments shall have reserves established as a single group in the same manner as group annual renewable term insurance is reserved for insurers licensed pursuant to Chapter 10 (§ 38.2-1000 et seq.) of this title.

2. Life or annuity policies written without the right to make additional assessments shall have reserves established using the standard valuation provisions required of insurers licensed under Chapter 10 of this title issuing similar types of policies.

3. Accident and sickness policies shall have reserves established in accordance with regulations promulgated by the Commission for insurers licensed pursuant to Chapter 10 of this title.

4. The foregoing reserve computations for statutory accounting purposes shall be applicable to all policies hereafter in existence and shall supersede any separate reserve requirement or separate mortuary funds that have been previously used, pursuant to statute, custom or policy provision.

1985, c. 400, § 38.1-549.24; 1986, c. 562.

Chapter 40 - BURIAL SOCIETIES

§ 38.2-4000. Societies to which chapter applies.

The provisions of this chapter apply to every person designated as a "burial society." A "burial society" is any person engaged in the business of providing benefits for any payment of funeral, burial or other expenses of deceased members, by levying assessments or dues that are collected or are to be collected from the members of the society, or from the members of a class of the society.

Code 1950, § 38-143; 1952, c. 317, § 38.1-550; 1986, c. 562.

§ 38.2-4001. Society may be incorporated.

Any existing burial society licensed and operating in this Commonwealth that is an unincorporated association may be incorporated under the provisions of Article 3 (§ 13.1-818 et seq.) of Chapter 10 of Title 13.1 and, except as otherwise provided in this title, shall be subject to all the general restrictions and shall have all the general powers imposed and conferred upon such corporations by law. All burial societies shall be under the supervision and control of the Commission.

Code 1950, §§ 38-145, 38-146; 1952, c. 317, § 38.1-551; 1956, c. 431; 1986, c. 562.

§ 38.2-4002. Continuation of existing societies.

Any burial society that was licensed and operating as a burial society on July 1, 1952, in this Commonwealth may continue to operate as a burial society as long as it complies with the provisions of this chapter and all other applicable statutes.

1952, c. 317, § 38.1-552; 1986, c. 562.

§ 38.2-4003. Licensing of additional societies prohibited.

Any burial society that was not licensed and operating as a burial society in this Commonwealth on July 1, 1952, shall not be issued a license as a burial society in this Commonwealth. On or after July 1, 1952, only a renewal of a license held by a society for the preceding year will be issued.

1952, c. 317, § 38.1-553; 1986, c. 562.

§ 38.2-4004. What laws applicable.

All burial societies shall comply with all of the provisions of this title relating to insurance companies generally. In the event of conflict between the provisions of this chapter and other provisions of this title, the provisions of this chapter shall be controlling.

Code 1950, §§ 38-145, 38-146; 1952, c. 317, § 38.1-554; 1986, c. 562.

§ 38.2-4005. License may be renewed annually.

Each license to a burial society shall expire on the June 30 next occurring after its effective date and may be renewed by the Commission annually.

Code 1950, § 38-146; 1952, c. 317, § 38.1-556; 1978, c. 4; 1986, c. 562.

§ 38.2-4006. Annual meeting.

Each burial society shall hold, within the city or county in which the principal office is located in this Commonwealth, a stated annual meeting of its members, or representatives of local boards or sub-

ordinate bodies, subject to any regulations, restrictions and provisions the constitution or bylaws of the society may provide.

Code 1950, §§ 38-145, 38-455; 1952, c. 317, §§ 38.1-531, 38.1-555; 1986, c. 562.

§ 38.2-4007. Adoption of bylaws.

Each burial society now authorized to do business in this Commonwealth shall, before the adoption of any bylaw or amendment, mail the proposed bylaw or amendment to the members and directors of the society, together with a notice of the time and place when the proposed bylaw or amendment will be considered.

Code 1950, §§ 38-145, 38-456; 1952, c. 317, §§ 38.1-532, 38.1-555; 1986, c. 562.

§ 38.2-4008. Fidelity bond required.

As a condition of licensing, each burial society, on behalf of its officers who are charged with the duty of handling its funds, shall obtain, and thereafter for as long as the license remains in effect keep in force, a surety bond with corporate security approved by the Commission. The bond shall be in an amount, not less than $10,000 nor more than $100,000, to be fixed by the Commission. The bond shall secure to the society and its members the faithful performance of its officers' duties and a proper accounting of its funds. The Commission may require the society to provide certification of compliance with the requirements of this section.

Code 1950, § 38-148; 1952, c. 317, § 38.1-558; 1986, c. 562; 2001, c. 706; 2002, c. 147.

§ 38.2-4009. Inspection of books and papers.

The books and papers of the burial society shall be open for examination by members or their representatives at all reasonable times.

Code 1950, §§ 38-145, 38-457; 1952, c. 317, §§ 38.1-533, 38.1-555; 1986, c. 562.

§ 38.2-4010. Accumulation of reserve for an emergency fund.

A. In addition to provision for liability incurred on account of claims reported but not settled, claims incurred but not reported, and premiums, dues or assessments collected in advance, every company shall accumulate and maintain a reserve for an emergency fund, which in the preparation of financial statements shall be considered a liability of the corporation, of at least $10,000.

B. Each burial society shall, in each calendar year, add to that reserve for an emergency fund at least five percent of its net receipts from premiums, dues or assessments from policies of life insurance until the total accumulated reserve fund equals twenty percent of the total benefits provided in the outstanding certificates of life insurance. However, when the corporation has issued policies of life insurance on a legal reserve basis, the net receipts from those policies shall not be considered in the calculation of the reserve for an emergency fund, but the burial society shall be required to maintain only the reserve provided for in the certificates.

Code 1950, §§ 38-149, 38-461; 1952, c. 317, §§ 38.1-534, 38.1-559; 1986, c. 562.

§ 38.2-4011. Maintenance of reserve for an emergency fund.

When the reserve for an emergency fund accumulated in accordance with the provisions of § 38.2-4010 equals the maximum amount provided in subsection B of that section, it shall be maintained at not less than that amount. However, no burial society shall be required, in any one year, to set aside more than five percent of its net receipts from premiums, dues or assessments from certificates of life insurance, other than certificates issued on a legal reserve basis.

Code 1950, § 38-462; 1952, c. 317, § 38.1-535; 1986, c. 562.

§ 38.2-4012. Disposition of reserve for an emergency fund; discontinuance of business; receiver.
The reserve for an emergency fund required by § 38.2-4010, together with the income earned on that fund, shall be a trust fund for the payment of death claims. Whenever the reserve for an emergency fund exceeds the amount of the maximum sum provided by the certificates issued and in force by the society, the investment income generated by the reserve or an emergency fund shall be added back into that fund. It may apply that excess, or any portion of that excess, (i) in reduction of assessments upon certificate holders, or (ii) in any other equitable division or apportionment that its rules or contracts provide for the payment of claims. When any society discontinues business, delinquency proceedings against the society may be instituted and conducted as provided in Chapter 15 (§ 38.2-1500 et seq.) of this title. In the delinquency proceedings, any unexhausted portion of the reserve for an emergency fund shall be used in payment of accrued claims upon certificates. If this amount is insufficient to pay the claims in full, then the payment of the claims shall be on a pro rata basis; and if a balance remains, the payment of claims shall then be made in the order of their occurrence. Any remaining balance shall be distributed among the members in proportion to their respective premium payments during the latest full year of active business of the society.

Code 1950, § 38-464; 1952, c. 317, § 38.1-537; 1986, c. 562.

§ 38.2-4013. Certificates of membership.
Each burial society shall issue certificates of membership to each member of the society. Each certificate shall state the amount of the benefit payable and the name of the beneficiary.

Code 1950, § 38-150; 1952, c. 317, § 38.1-560; 1986, c. 562.

§ 38.2-4014. Required grace period.
Each certificate shall have a provision that the certificate holder is entitled to a grace period of thirty-one days within which the payment of any call or assessment may be paid after the first month. The provision shall also state that during the grace period the certificate shall continue in full force, but if a claim arises under the policy during the grace period but before the call or assessment is paid, the amount of the call or assessment may be deducted from the amount payable under the certificate.

Code 1950, §§ 38-145, 38-449; 1952, c. 317, §§ 38.1-543, 38.1-555; 1986, c. 562.

§ 38.2-4015. Certificate to specify amount of payment and when to be paid.
Each certificate issued by any burial society shall specify the sum of money payable upon the occurrence of the risk insured against. The amount payable shall not be larger than one assessment upon

the entire membership. Each certificate shall also state that within thirty days after due proof of the occurrence of the insured risk, payment shall be made.

Code 1950, §§ 38-145, 38-450; 1952, c. 317, §§ 38.1-544, 38.1-555; 1986, c. 562.

§ 38.2-4016. Payments become liens on society's property.

Upon the occurrence of the risk insured against, the burial society shall be obligated to the beneficiary for payment of the claim unless the contract is invalid because of fraud or other reason. This indebtedness shall be a lien upon all the property, effects and bills receivable of the society. This indebtedness shall have priority over all future incurred indebtedness, except as provided in this chapter in the case of the distribution of assets of an insolvent corporation, and as to rights of third parties.

Code 1950, §§ 38-145, 38-451; 1952, c. 317, §§ 38.1-545, 38.1-555; 1986, c. 562.

§ 38.2-4017. Notice of assessment.

Each notice of assessment made by any burial society upon any of its members shall state the cause and purpose of the assessment.

Code 1950, §§ 38-145, 38-453; 1952, c. 317, §§ 38.1-547, 38.1-555; 1986, c. 562.

§ 38.2-4018. Liability on officers and directors for failing to levy assessments.

The officers or directors of any society who, after due proof of death has been filed, for sixty days refuse or neglect to levy an assessment to pay a claim not disputed by reason of fraud or validity when the death or emergency fund is insufficient to pay the claim, shall be liable to the beneficiary of the certificate. The liability of the officers or directors shall be for a sum not exceeding the face amount of the claim.

Code 1950, §§ 38-145, 38-454; 1952, c. 317, §§ 38.1-549, 38.1-555; 1986, c. 562.

§ 38.2-4019. Beneficiaries.

No person other than a spouse, relative by blood to the fourth degree, parent-in-law, child-in-law, stepparent, stepchild, or child by legal adoption of the member, or one who is dependent upon the member or one who has an insurable interest in the life of the member as described in § 38.2-301, shall be named a beneficiary of the member's certificate. Within the above limitations, each member shall have the right to designate his beneficiary and to change his beneficiary, upon due notice to the society. If the beneficiary is not living or if no allowable beneficiary has been designated, any proceeds otherwise payable shall be payable to the member's estate.

Code 1950, § 38-151; 1952, c. 317, § 38.1-561; 1986, c. 562; 2020, c. 900.

§ 38.2-4020. When certificate invalid.

A certificate of membership shall be invalid if:

1. The certificate holder was ill at the time the certificate was procured;

2. Any person concerned in the procurement of the certificate had reason to believe that the illness existed at that time;

3. The illness continued to the death of the certificate holder and was a contributing cause of death;

4. Health questions were not asked on the application for coverage; and

5. The certificate holder died within sixty days from the date the certificate was issued.

Code 1950, § 38-153; 1952, c. 317, § 38.1-562; 1986, c. 562.

§ 38.2-4021. Interest in benefits; assignability; liability to attachment, etc.

No beneficiary shall have or obtain any vested interest in a benefit until the benefit has become due and payable upon the death of the member. No certificate of membership in any burial society, nor any interest or rights in the certificate shall be assigned unless the assignment is to a person authorized by § 38.2-4019 to be named as a beneficiary except for the purpose of funding or paying for a preneed funeral contract as defined in § 54.1-2800, notwithstanding the provisions of § 38.2-4022, and so long as such assignment is revocable by the assignor. No money or other benefit provided by any burial society shall be liable to attachment, garnishment or other process, or be seized, taken, appropriated or applied by any legal or equitable process or operation of law to pay any debt or liability of a member or beneficiary, or any other person who may have a right to the benefit, either before or after payment.

Code 1950, § 38-152; 1952, c. 317, § 38.1-563; 1983, c. 94; 1986, c. 562; 1987, c. 647; 1989, c. 684.

§ 38.2-4022. Certain contracts with undertakers, etc., forbidden.

No burial society shall contract to pay or pay benefits provided under certificates of membership, to any official or designated undertaker or mortician or person engaged in the business of conducting and servicing funerals, so as to deprive the representatives or family of the deceased member from, or in any way control them in, obtaining funeral supplies and services in an open competitive market.

Code 1950, § 38-155; 1952, c. 317, § 38.1-565; 1986, c. 562.

Chapter 41 - FRATERNAL BENEFIT SOCIETIES

Article 1 - STRUCTURE AND PURPOSE

§ 38.2-4100. Fraternal benefit societies.

Any society, order or supreme lodge without capital stock, including one exempted under the provisions of subdivision 6 of subsection A of § 38.2-4135 of this chapter, conducted solely for the benefit of its members and their beneficiaries and not for profit, operated on a lodge system with ritualistic form of work, having a representative form of government, and providing benefits in accordance with this chapter, is hereby declared to be a fraternal benefit society.

Code 1950, §§ 38-254, 38.1-569; 1952, c. 317, § 38.1-638.1; 1968, c. 654; 1986, c. 562.

§ 38.2-4101. Lodge system.

A. A society is operating on the lodge system if it has a supreme governing body and subordinate lodges into which members are elected, initiated or admitted in accordance with its laws, rules and

rituals. Subordinate lodges shall be required by the laws of the society to hold regular meetings at least once each month in furtherance of the purposes of the society.

B. A society may, at its option, organize and operate lodges for children under the minimum age for adult membership. Membership and initiation in local lodges shall not be required of such children, nor shall they have a voice or vote in the management of the society.

Code 1950, §§ 38-255, 38.1-570; 1952, c. 317, § 38.1-638.2; 1968, c. 654; 1986, c. 562.

§ 38.2-4102. Representative form of government.

A society has a representative form of government when:

1. It has a supreme governing body constituted in one of the following ways:

a. Assembly. -- The supreme governing body is an assembly composed of delegates elected directly by the members or at intermediate assemblies or conventions of members or their representatives, together with other delegates as may be prescribed in the society's laws. A society may provide for election of delegates by mail. The elected delegates shall constitute a majority in number and shall not have less than two-thirds of the votes and not less than the number of votes required to amend the society's laws. The assembly shall be elected, meet at least once every four years, and elect a board of directors to conduct the business of the society between meetings of the assembly. Vacancies on the board of directors between elections may be filled in the manner prescribed by the society's laws.

b. Direct election. -- The supreme governing body is a board composed of persons elected by the members, either directly or by their representatives in intermediate assemblies, and any other persons prescribed in the society's laws.

A society may provide for election of the board by mail. Each term of a board member may not exceed four years. Vacancies on the board between elections may be filled in the manner prescribed by the society's laws. Those persons elected to the board shall constitute a majority in number and not less than the number of votes required to amend the society's laws. A person filling the unexpired term of an elected board member shall be considered to be an elected member. The board shall meet at least quarterly to conduct the business of the society.

2. The officers of the society are elected either by the supreme governing body or by the board of directors.

3. Only benefit members are eligible for election to the supreme governing body, the board of directors or any intermediate assembly.

4. Each voting member shall have one vote; no vote may be cast by proxy.

Code 1950, §§ 38-256, 38.1-571; 1952, c. 317, § 38.1-638.3; 1968, c. 654; 1986, c. 562.

§ 38.2-4103. Definitions.

As used in this chapter:

"Benefit contract" means the agreement for provision of benefits authorized by § 38.2-4116, as that agreement is described in § 38.2-4119.

"Benefit member" means an adult member who is designated by the laws or rules of the society to be a benefit member under a benefit contract.

"Certificate" means the document issued as written evidence of the benefit contract.

"Laws" means the society's articles of incorporation, constitution and bylaws, however designated.

"Lodge" means subordinate member units of the society, known as camps, courts, councils, branches or by any other designation.

"Premiums" means premiums, rates, dues or other required contributions by whatever name known, which are payable under the certificate.

"Rules" means all rules, regulations or resolutions adopted by the supreme governing body or board of directors which are intended to have general application to the members of the society.

"Society" means fraternal benefit society, unless otherwise indicated.

1986, c. 562.

§ 38.2-4104. Purposes and powers.

A. A society shall operate for the benefit of members and their beneficiaries by:

1. Providing benefits as specified in § 38.2-4116; and

2. Operating for one or more social, intellectual, educational, charitable, benevolent, moral, fraternal, patriotic or religious purposes for the benefit of its members, which may also be extended to others. Such purposes may be carried out directly by the society, or indirectly through subsidiary corporations or affiliated organizations.

B. Every society shall have the power to adopt laws and rules for the government of the society, the admission of its members, and the management of its affairs. It shall have the power to change, alter, add to or amend such laws and rules and shall have any other powers necessary and incidental to effecting the objects and purposes of the society.

Code 1950, §§ 38-277, 38.1-593; 1952, c. 317, § 38.1-638.25; 1968, c. 654, § 38.1-638.36; 1986, c. 562.

Article 2 - MEMBERSHIP

§ 38.2-4105. Qualifications for membership.

A. A society shall specify in its laws or rules:

1. Eligibility standards for every class of membership, provided that if benefits are provided on the lives of children, the minimum age for adult membership shall be set at not less than age fifteen and not greater than age twenty-one;

2. The process for admission to membership for each membership class; and

3. The rights and privileges of each membership class, provided that only benefit members shall have the right to vote on the management of the insurance affairs of the society.

B. A society may also admit social members who shall have no voice or vote in the management of the insurance affairs of the society.

C. Membership rights in the society are personal to the member and are not assignable.

Code 1950, §§ 38-286, 38-293, 38.1-602, 38.1-609; 1952, c. 317, § 38.1-638.29; 1964, c. 355; 1968, c. 654; 1972, cc. 530, 825; 1986, c. 562.

§ 38.2-4106. Location of office; meetings, communications to members; grievance procedures.

A. The principal office of any domestic society shall be located in this Commonwealth. The meetings of its supreme governing body may be held in any state, district, province or territory wherein such society has at least one subordinate lodge, or in any other location determined by the supreme governing body. All business transacted at such meetings shall be as valid in all respects as if such meetings were held in this Commonwealth. The minutes of the proceedings of the supreme governing body and of the board of directors shall be in the English language.

B. 1. A society may provide in its laws for an official publication in which any notice, report, or statement required by law to be given to members, including notice of election, may be published. Such required reports, notices, and statements shall be printed conspicuously in the publication. If the records of a society show that two or more members have the same mailing address, an official publication mailed to one member is deemed to be mailed to all members at the same address unless a member requests a separate copy.

2. Not later than June 1 of each year, a synopsis of the society's annual statement providing an explanation of the facts concerning the condition of the society thereby disclosed shall either (i) be printed and mailed to each benefit member of the society or (ii) published in the society's official publication.

C. A society may provide in its laws or rules for grievance or complaint procedures for members.

Code 1950, §§ 38-259, 38-318, 38.1-576, 38.1-626; 1952, c. 317, §§ 38.1-638.8, 38.1-638.47; 1968, c. 654; 1986, c. 562.

§ 38.2-4107. No personal liability.

A. The officers and members of the supreme governing body or any subordinate body of a society shall not be personally liable for any benefits provided by a society.

B. Any person may be indemnified and reimbursed by any society for expenses reasonably incurred by, and liabilities imposed upon, such person in connection with or arising out of any action, suit or proceeding, or threat of such, in which the person may be involved because he or she is or was a director, officer, employee or agent of the society or of any firm, corporation or organization which he or she served in any capacity at the request of the society. A person shall not be so indemnified or reimbursed in relation to any matter in (i) such action, suit or proceeding as to which he or she was finally adjudged to be or have been guilty of breach of a duty as a director, officer, employee or agent of the

society or (ii) such action, suit or proceeding, or threat thereof, which has been made the subject of a compromise settlement, unless in either case the person acted in good faith for a purpose the person reasonably believed to be in or not opposed to the best interests of the society and, in a criminal action or proceeding, in addition, had no reasonable cause to believe that his or her conduct was unlawful. The determination whether the conduct of such person met the standard required in order to justify indemnification and reimbursement in relation to any matter described in (i) or (ii) of this subsection may be made only by the supreme governing body or board of directors by a majority vote of a quorum consisting of persons who were not parties to such action, suit or proceeding or by a court of competent jurisdiction. The termination of any action, suit or proceeding by judgment, order, settlement, conviction, or upon a plea of no contest, as to such person shall not in itself create a conclusive presumption that the person did not meet the standard of conduct required in order to justify indemnification and reimbursement. The foregoing right of indemnification and reimbursement shall not be exclusive of other rights to which such person may be entitled as a matter of law and shall inure to the benefit of his or her heirs, executors, and administrators.

C. A society shall have power to purchase and maintain insurance on behalf of any person who is or was a director, officer, employee or agent of the society, or who is or was serving at the request of the society as a director, officer, employee or agent of any other firm, corporation, or organization against any liability asserted against such person and incurred by him or her in any such capacity or arising out of his or her status as such, whether or not the society would have the power to indemnify the person against such liability under this section.

Code 1950, §§ 38-260, 38.1-574; 1952, c. 317, § 38.1-638.6; 1968, c. 654; 1986, c. 562.

§ 38.2-4108. Waiver.

The laws of the society may provide that no subordinate body, nor any of its subordinate officers or members, shall have the power or authority to waive any of the provisions of the laws of the society. Such provision shall be binding on the society and every member and beneficiary of a member.

Code 1950, §§ 38-278, 38.1-594; 1952, c. 317, § 38.1-638.26; 1968, c. 654; 1986, c. 562.

Article 3 - GOVERNANCE

§ 38.2-4109. Organization of domestic society on or after October 1, 1986.

A. On or after October 1, 1986, seven or more citizens of the United States, a majority of whom are citizens of this Commonwealth, who desire to form a fraternal benefit society, may make, sign and acknowledge before some officer competent to take acknowledgement of deeds, articles of incorporation, which shall state:

1. The proposed corporate name of the society, which shall not so closely resemble the name of any other society or insurer as to be misleading or confusing;

2. The purposes for which it is being formed and the mode in which its corporate powers are to be exercised. Such purposes shall not include more liberal powers than are granted by this chapter;

3. The names and residences of the incorporators and the names, residences and official titles of all officers, trustees, directors, or other persons who are to have and exercise the general control of the management of the affairs and funds of the society for the first year or until the ensuing election at which all such officers shall be elected by the supreme governing body, which election shall be held not later than one year from the date of issuance of the permanent certificate of authority.

B. Such articles of incorporation, duly certified copies of the society's bylaws and rules, copies of all proposed forms of certificates, applications therefor, and circulars to be issued by the society and a bond conditioned upon the return to applicants of the advanced payments if the organization is not completed within one year shall be filed with the Commission, which may require any further information it deems necessary. The bond, with sureties approved by the Commission, shall be not less than $50,000 nor more than $200,000, as required by the Commission. All documents filed are to be in the English language. If the purposes of the society conform to the requirements of this chapter and all provisions of the law have been complied with, the Commission shall so certify, retain, and file the articles of incorporation and furnish the incorporators a preliminary certificate of authority authorizing the society to solicit members as hereinafter provided.

C. No preliminary certificate of authority granted under the provisions of this section shall be valid after one year from its date or after such further period, not exceeding one year, as may be authorized by the Commission upon cause shown, unless the 500 required applicants have been secured and the organization has been duly completed. The articles of incorporation and all other proceedings under those articles shall become void in one year from the date of the preliminary certificate of authority, or at the expiration of the extended period, unless the society has completed its organization and received a certificate of authority to do business.

D. Upon receipt of a preliminary certificate of authority from the Commission, the society may solicit members for the purpose of completing its organization, shall collect from each applicant the amount of not less than one regular monthly premium in accordance with its table of rates, and shall issue to each such applicant a receipt for the amount collected. No society shall incur any liability other than for the return of such advance premium, nor issue any certificate, nor pay, allow, or offer or promise to pay or allow, any benefit to any person until:

1. Actual bona fide applicants for benefits have been secured on not less than 500 applicants, and any necessary evidence of insurability has been furnished to and approved by the society;

2. At least 10 subordinate lodges have been established into which the 500 applicants have been admitted;

3. There has been submitted to the Commission, a list of such applicants, giving their names, addresses, date each was admitted, name and number of the subordinate lodge of which each applicant is a member, amount of benefits to be granted and their premiums; and

4. It has been shown to the Commission, by sworn statement of the treasurer, or corresponding officer of such society, that at least 500 applicants have each paid in cash at least one regular monthly

premium, which shall total at least $150,000. Advance premiums shall be held in trust during the period of organization and, if the society has not qualified for a certificate of authority within one year, such premiums shall be returned to the applicants.

E. The Commission may examine and require any further information it deems advisable. Upon presentation of satisfactory evidence that the society has complied with all the provisions of law, the Commissioner shall issue to the society a certificate of authority to that effect and that the society is authorized to do business pursuant to the provisions of this chapter. The certificate of authority shall be prima facie evidence of the existence of the society at the date of such certificate. The Commission shall cause a record of such certificate of authority to be made. A certified copy of such record shall have the same effect as the original certificate of authority.

F. Any incorporated society authorized to do business in this Commonwealth at the time this chapter becomes effective shall not be required to reincorporate.

G. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

Code 1950, §§ 38-264 through 38-268, 38.1-582 through 38.1-587; 1952, c. 317, §§ 38.1-638.14 through 38.1-638.19; 1968, c. 654; 1975, c. 262; 1986, c. 562; 2013, c. 751.

§ 38.2-4110. Incorporation of fraternal benefit societies.

Domestic fraternal benefit societies may be incorporated under the provisions of Article 3 (§ 13.1-818 et seq.) of Chapter 10 of Title 13.1, as modified by the provisions of this title, and, except as otherwise provided in this title, shall be subject to all the general restrictions and shall have all the general powers imposed and conferred by law upon companies so incorporated.

Code 1950, §§ 38-264, 38.1-579; 1952, c. 317, § 38.1-638.11; 1956, c. 431; 1968, c. 654; 1986, c. 562.

§ 38.2-4111. Amendments to laws.

A. A domestic society may amend its laws in accordance with the provisions of those laws by action of its supreme governing body at any regular or special meeting or, if its laws so provide, by referendum. Such referendum may be held in accordance with the provisions of its laws by the vote of the voting members of the society, by the vote of delegates or representatives of voting members, or by the vote of local lodges. A society may provide for voting by mail. No amendment submitted for adoption by referendum shall be adopted unless, within six months from the date of submission of the amendment, a majority of the members voting shall have signified their consent to such amendment by one of the methods herein specified.

B. No amendment to the laws of any domestic society shall take effect unless filed with the Commission.

C. Within ninety days from the filing specified in subsection B of this section, all such amendments, or a synopsis of the amendments, shall be furnished to all members of the society either by mail or by

publication in full in the official publication of the society. The affidavit of any officer of the society or of anyone authorized by it to mail any amendments or synopsis of the amendments, stating facts which show that same have been duly addressed and mailed, shall be prima facie evidence that such amendments or their synopsis have been furnished the addressee.

D. At the request of the Commissioner, a foreign or alien society authorized to do business in this Commonwealth shall file with the Commissioner a duly certified copy of all amendments of, or additions to, its laws.

E. Printed copies of the laws as amended, certified by the secretary or corresponding officer of the society, shall be prima facie evidence of their legal adoption.

Code 1950, §§ 38-277, 38-279, 38.1-593, 38.1-595; 1952, c. 317, §§ 38.1-638.25, 38.1-638.27; 1968, c. 654; 1986, c. 562; 2002, c. 147.

§ 38.2-4112. Institutions.

A society may create, maintain and operate, or may establish organizations to operate, not for profit institutions to further the purposes permitted by subdivision 2 of subsection A of § 38.2-4104. Such institutions may furnish services free or at a reasonable charge. Any real or personal property owned, held or leased by the society for this purpose shall be reported in every annual statement. No society shall own or operate funeral homes or undertaking establishments.

1968, c. 654, § 38.1-638.36; 1986, c. 562.

§ 38.2-4113. Reinsurance.

A. A domestic society may, by a reinsurance agreement, cede any individual risk or risks in whole or in part to an insurer, other than another fraternal benefit society, having the power to make such reinsurance and authorized to do business in this Commonwealth, or if not so authorized, one which is approved by the Commission, but no such society may reinsure substantially all of its insurance in force without the written permission of the Commission. It may take credit for the reserves on such ceded risks to the extent reinsured, but no credit shall be allowed as an admitted asset or as a deduction from liability, to a ceding society for reinsurance made, ceded, renewed, or otherwise becoming effective after the effective date of this chapter, unless the reinsurance is payable by the assuming insurer on the basis of the liability of the ceding society under the contract or contracts reinsured without diminution because of the insolvency of the ceding society.

B. Notwithstanding the limitation in subsection A, a society may reinsure the risks of another society in a consolidation or merger approved by the Commission under § 38.2-4114.

Code 1950, §§ 38-270, 38.1-575; 1952, c. 317, § 38.1-638.7; 1968, c. 654; 1986, c. 562.

§ 38.2-4114. Consolidations and mergers.

A. A domestic society may consolidate or merge with any other society by complying with the provisions of this section. It shall file with the Commission:

1. A certified copy of the written contract containing in full the terms and conditions of the consolidation or merger;

2. A sworn statement by the president and secretary or corresponding officers of each society showing its financial condition on a date fixed by the Commission but not earlier than December 31 next preceding the date of the contract;

3. A certificate of such officers, duly verified, that the consolidation or merger has been approved by a two-thirds vote of the supreme governing body of each society, such vote being conducted at a regular or special meeting of each such body, or, if the society's laws permit, by mail; and

4. Evidence that at least sixty days prior to the action of the supreme governing body of each society, the text of the contract has been furnished to all members of each society either by mail or by publication in full in the official publication of each society.

B. If the Commission finds that the contract conforms to the provisions of this section, that the financial statements are correct and that the consolidation or merger is just and equitable to the members of each society, the Commission shall approve the contract and issue a certificate to such effect. Upon such approval, the contract shall be effective unless any society which is a party to the contract is incorporated under the laws of any other state or territory. In such event, the consolidation or merger shall not become effective until it has been approved as provided by the laws of such state or territory and a certificate of such approval filed with the Commission. If the laws of such state or territory contain no such provision, then the consolidation or merger shall not become effective until it has been approved by the Commission of such state or territory and a certificate of such approval filed with the Commission.

C. When the consolidation or merger becomes effective, all the rights, franchises, and interests of the consolidated or merged societies in and to every species of property and things in action belonging to the societies shall be vested in the society resulting from or remaining after the consolidation or merger without any other instrument. Conveyances of real property, however, may be evidenced by proper deeds, and the title to any real estate or interest therein, vested under the laws of this Commonwealth in any of the societies consolidated or merged, shall not revert or be in anyway impaired by reason of the consolidation or merger but shall vest absolutely in the society resulting from or remaining after such consolidation or merger.

D. The affidavit of any officer of the society or of anyone authorized by it to mail any notice or document, stating that such notice or document has been duly addressed and mailed, shall be prima facie evidence that such notice or document has been furnished the addressees.

Code 1950, §§ 38-270, 38.1-575; 1952, c. 317, § 38.1-638.7; 1968, c. 654; 1986, c. 562.

§ 38.2-4115. Conversion of fraternal benefit society into mutual life insurer.

A. Any domestic fraternal benefit society organized or operated under this chapter may, upon a two-thirds vote of its supreme governing body, amend its articles of incorporation and laws if already

incorporated, or, if not incorporated, may incorporate, in a manner to transform itself into a mutual life insurer. It may use the name by which it is already known, or another name, as its supreme governing body shall determine. However, the proposed plan for reorganization or reincorporation shall be submitted to and approved by the Commission. Upon so doing, and upon procuring from the Commission a license to do the business of insurance in this Commonwealth as a mutual life insurer, it shall incur the obligations and enjoy the benefits of a mutual life insurer as if originally incorporated as a mutual life insurer. Any such corporation under its articles and bylaws as so framed or amended shall be a continuation of the original organization, and the officers of the organization shall serve through their respective terms as provided in the original articles and laws. However, their successors shall be elected and serve as the laws of this Commonwealth and the articles of incorporation or bylaws of the reorganized company provide. The incorporation, amendment or reincorporation shall not affect existing suits, rights or contracts. The organization, after reorganization, shall have the power to do business of the same nature done by it before reorganization, as well as the powers conferred in this section and contemplated by its articles of incorporation, in order to protect and perform rights and contracts existing before reorganization, but all new business written shall be as a mutual life insurer.

B. All assets, other than general or expense fund assets, belonging to any reorganized insurer, prior to reorganization or arising or accruing from benefit certificates issued prior to the reorganization, shall be used only for the benefit of the holders of the benefit certificates or their beneficiaries.

C. If at the time of reorganization, or at any time after reorganization, it appears from the last preceding annual report of any such organization, filed with the Commission, or any investigation made by the Commission, that the present value of the contributions to be received from the holders of the benefit certificates, together with all assets, other than general or expense fund assets, owned by the insurer that have been accumulated from payments made by members holding such certificates, are not equal to the present value of the benefits promised to be paid, including all matured liabilities on any benefit certificates, then the insurer so reorganized shall establish, provide for, and maintain a fund, which with the present value of contributions and assets will equal the present value of the benefits, together with all matured liabilities. The fund shall be used for the payment of matured liabilities arising on the benefit certificates when other assets applicable thereto are exhausted. The fund need not be maintained unless required by conditions expressed in this chapter.

D. Members in good standing in any society prior to reorganization shall have the right after reorganization to transfer their insurance in the society to the mutual life plan without further medical examination for the same or lesser amount, and at legal reserve or level premium rates. The interest in the assets of the society of any person so transferring, as determined by the board of directors, trustees or corresponding body, shall be transferred to, and be a part of, the assets of the insurer on the legal reserve or level premium plan.

E. The insurer so organized, and its officials, shall exercise all the rights and powers and perform all the duties conferred or imposed by law upon organizations writing the kinds of insurance written by the insurer so organized. The organization and its officials shall exercise all the rights and powers and

have full authority to perform all the duties necessary to protect rights and contracts existing prior to reorganization. The Commission shall exercise the powers and discharge the duties concerning any such insurer so reorganized that are applicable to insurers writing insurance or issuing policies of the same class, organized or operating in this Commonwealth. The Commission shall issue a certificate of authority to any solvent insurer so reorganized that has fully complied with the laws of this Commonwealth to do such insurance business in this Commonwealth.

F. Any fraternal benefit society reorganized to do mutual life insurance business as provided in this chapter shall value its benefit certificates according to the standard of valuation for fraternal benefit societies used in this Commonwealth, and its legal reserve or level premium policies according to the standard of valuation for those policies in this Commonwealth. The various classes of insurance shall be governed by the law applicable to each class of insurance.

G. The expense of operation and maintenance of a reorganized insurer shall be apportioned between those holding benefit certificates issued before the reorganization and those holding policies issued after the reorganization as may be determined by the board of directors, trustees or corresponding body.

Code 1950, §§ 38-323 through 38-329, 38.1-632 through 38.1-638; 1952, c. 317, §§ 38.1-638.53 through 38.1-638.59; 1968, c. 654; 1986, c. 562.

Article 4 - CONTRACTUAL BENEFITS

§ 38.2-4116. Benefits.

A. A society may apply to the Commission to provide the following contractual benefits in any form:

1. Death benefits;

2. Endowment benefits;

3. Annuity benefits;

4. Temporary or permanent disability benefits;

5. Hospital, medical or nursing benefits;

6. Monument or tombstone benefits to the memory of deceased members; and

7. Such other benefits as authorized for life insurers and which are not inconsistent with this chapter.

B. A society shall specify in its rules those persons who may be issued, or covered by, the contractual benefits in subsection A, consistent with providing benefits to members and their dependents. A society may provide benefits on the lives of children under the minimum age for adult membership upon application of an adult person.

Code 1950, §§ 38-283, 38.1-599; 1952, c. 317, § 38.1-638.31; 1968, c. 654; 1972, c. 530; 1975, c. 262; 1986, c. 562.

§ 38.2-4117. Beneficiaries.

A. The owner of a benefit contract shall have the right at all times to change the beneficiary or beneficiaries in accordance with the laws or rules of the society unless the owner waives this right by specifically requesting in writing that the beneficiary designation be irrevocable. A society may, through its laws or rules, limit the scope of beneficiary designations and shall provide that no revocable beneficiary shall have or obtain any vested interest in the proceeds of any certificate until the certificate has become due and payable in conformity with the provisions of the benefit contract.

B. A society may provide for the payment of funeral benefits from the proceeds of a certificate of no more than $2,000 to any person equitably entitled to them because of expenses incurred by the burial of the member.

C. If, at the death of any person insured under a benefit contract, there is no lawful beneficiary to whom the proceeds are payable, the amount of such benefit, except to the extent that funeral benefits may be paid as previously provided, shall be payable to the personal representative of the deceased insured; however, if the owner of the certificate is other than the insured, the proceeds shall be payable to such owner.

Code 1950, §§ 38-284, 38.1-600; 1952, c. 317, § 38.1-638.32; 1968, c. 654; 1972, c. 530; 1986, c. 562.

§ 38.2-4118. Benefits not attachable.

No money or other benefit, charity, relief or aid to be paid, provided or rendered by any society, shall be liable to attachment, garnishment or other process, or to be seized, taken, appropriated or applied by any legal or equitable process or operation of law to pay any debt or liability of a member or beneficiary, or any other person who may have a right thereunder, either before or after payment by the society.

Code 1950, §§ 38-285, 38.1-601; 1952, c. 317, § 38.1-638.33; 1968, c. 654; 1986, c. 562.

§ 38.2-4119. The benefit contract.

A. Every society authorized to do business in this Commonwealth shall issue to each owner of a benefit contract a certificate specifying the amount of benefits provided thereby. The certificate, together with any attached riders or endorsements, the laws of the society, the application for membership, the application for insurance and declaration of insurability, if any, signed by the applicant, and all amendments to each, shall constitute the benefit contract, as of the date of issuance, between the society and the owner, and the certificate shall so state. A copy of the application for insurance and declaration of insurability, if any, shall be endorsed upon or attached to the certificate. All statements on the application shall be representations and not warranties. Any waiver of this provision shall be void.

B. Any changes, additions or amendments to the laws of the society duly made or enacted subsequent to the issuance of the certificate, shall bind the owner and the beneficiaries, and shall govern and control the benefit contract in all respects the same as though such changes, additions or amendments had been made prior to and were in force at the time of the application for insurance, except

that no change, addition or amendment shall destroy or diminish benefits which the society contracted to give the owner as of the date of issuance.

C. Any person upon whose life a benefit contract is issued prior to attaining the age of majority shall be bound by the terms of the application and certificate and by all the laws and rules of the society to the same extent as though the age of majority had been attained at the time of application.

D. A society shall provide in its laws that if its reserves as to all or any class of certificates become impaired, its board of directors or corresponding body may require that the owner shall pay to the society his equitable proportion of such deficiency as ascertained by its board, and that if the payment is not made, either (i) it shall stand as an indebtedness against the certificate and draw interest not to exceed the rate specified for certificate loans under the certificates; or (ii) in lieu of or in combination with (i), the owner may accept a proportionate reduction in benefits under the certificate. The society may specify the manner of the election and which alternative is to be presumed if no election is made.

E. Copies of any documents mentioned in this section, certified by the secretary or corresponding officer of the society, shall be received in evidence of the terms and conditions thereof.

F. No certificate shall be delivered or issued for delivery in this Commonwealth unless a copy of the form has been filed with and approved by the Commission in the manner provided for in § 38.2-316. Every life, accident, health, or disability insurance certificate and every annuity certificate issued on or after July 1, 1986, shall meet the standard contract provision requirements not inconsistent with this chapter for like policies issued by life insurers in this Commonwealth, except that a society may provide for a grace period for payment of premiums of one full month in its certificates. The certificate shall also contain a provision stating the amount of premiums which are payable under the certificate and a provision reciting or setting forth the substance of any sections of the society's laws or rules in force at the time of issuance of the certificate which, if violated, will result in the termination or reduction of benefits payable under the certificate. If the laws of the society provide for expulsion or suspension of a member, the certificate shall also contain a provision that any member so expelled or suspended, except for nonpayment of a premium or within the contestable period for material misrepresentation in the application for membership or insurance, shall have the privilege of maintaining the certificate in force by continuing payment of the required premium.

G. Benefit contracts issued on the lives of persons below the society's minimum age for adult membership may provide for transfer of control or ownership to the insured at an age specified in the certificate. A society may require approval of an application for membership in order to effect this transfer, and may provide in all other respects for the regulation, government and control of such certificates and all rights, obligations and liabilities incident thereto. Ownership rights prior to such transfer shall be specified in the certificate.

H. A society may specify the terms and conditions on which benefit contracts may be assigned.

Code 1950, §§ 38-280, 38-282, 38-286, 38-293, 38.1-596, 38.1-598, 38.1-602, 38.1-609; 1952, c. 317, §§ 38.1-638.28 through 38.1-638.30, 38.1-638.35; 1964, c. 355; 1968, c. 654; 1972, cc. 530, 825; 1986, c. 562.

§ 38.2-4120. Nonforfeiture benefits, cash surrender values, certificate loans and other options.

A. A society may grant paid-up nonforfeiture benefits, cash surrender values, certificate loans, and any other options its laws permit. Certificates issued on and after June 28, 1968, must contain at least one paid-up nonforfeiture benefit, except in the case of pure endowment, annuity or reversionary annuity contracts, reducing term insurance contracts or contracts of level term insurance for fifteen years or less expiring before age sixty-six.

B. For certificates, other than those for which reserves are computed on the Commissioners 1941 Standard Ordinary Mortality Table, the Commissioners 1941 Standard Industrial Table or the Commissioners 1958 Standard Ordinary Mortality Table, or any more recent table made applicable to life insurance companies, the value of every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan or other option granted shall not be less than any excess of (1) over (2) as follows:

(1) The reserve under the certificate determined on the basis specified in the certificate; and

(2) The sum of any indebtedness to the society on the certificate, including interest due and accrued, and a surrender charge equal to 2 1/2% of the face amount of the certificate, which, in the case of insurance on the lives of persons under the minimum age for adult membership, shall be the ultimate face amount of the certificate, if death benefits provided in the certificate are graded.

C. For certificates issued on a substandard basis or for certificates with reserves computed upon the American Men Ultimate Table of Mortality, the term of any extended insurance benefit granted, including any accompanying pure endowment, may be computed upon the rates of mortality not greater than 130 percent of those shown by the mortality table specified in the certificate for the computation of the reserve.

D. For certificates with reserves computed on the Commissioners 1941 Standard Ordinary Mortality Table, the Commissioners 1941 Standard Industrial Table or the Commissioners 1958 Standard Ordinary Mortality Table, or any more recent table made applicable to life insurance companies, every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan or other option granted shall not be less than the corresponding amount ascertained in accordance with the provisions of the laws of this Commonwealth applicable to life insurers issuing policies containing like insurance benefits based upon such tables.

1968, c. 654, § 38.1-638.34; 1975, c. 262; 1986, c. 562.

Article 5 - FINANCIAL REQUIREMENTS

§ 38.2-4121. Investments.

A society shall invest its funds only in investments authorized by Chapter 14 of this title for the investment of assets of life insurers and subject to the limitations thereon. Any foreign or alien society

permitted or seeking to do business in this Commonwealth which invests its funds in accordance with the laws of the state, district, territory, country or province in which it is incorporated, shall be held to meet the requirements of this section for the investment of funds.

Code 1950, §§ 38-307, 38.1-623; 1952, c. 317, § 38.1-638.43; 1968, c. 654; 1986, c. 562.

§ 38.2-4122. Funds.

A. All assets shall be held, invested, and disbursed for the use and benefit of the society and no member or beneficiary shall have or acquire individual rights therein or become entitled to any apportionment on the surrender of any part thereof, except as provided in the benefit contract.

B. A society may create, maintain, invest, disburse, and apply any special fund or funds necessary to carry out any purpose permitted by the laws of the society.

C. A society may apply to the Commission, pursuant to resolution of its supreme governing body, to establish and operate one or more separate accounts and issue contracts on a variable basis, subject to Article 3 (§ 38.2-1443 et seq.) of Chapter 14 of this title. To the extent the society deems it necessary in order to comply with any applicable federal or state laws, or any rules issued under those laws, the society may (i) adopt special procedures for the conduct of the business and affairs of a separate account; (ii) for persons having beneficial interest therein, provide special voting and other rights, including without limitation special rights and procedures relating to investment policy, investment advisory services, selection of certified public accountants, and selection of a committee to manage the business and affairs of the account; and (iii) issue contracts on a variable basis to which subsections B and D of § 38.2-4119 of this chapter shall not apply.

Code 1950, §§ 38-301, 38.1-617; 1952, c. 317, § 38.1-638.42; 1960, c. 189; 1968, c. 654; 1986, c. 562.

Article 6 - REGULATION

§ 38.2-4123. Exemptions.

Except as herein provided, societies shall be governed by this chapter and §§ 38.2-100 through 38.2-134, Chapters 2 (§ 38.2-200 et seq.) through 9 (§ 38.2-900 et seq.), §§ 38.2-1300 through 38.2-1315, 38.2-1315.1, 38.2-1317 through 38.2-1340, and 38.2-1367, Chapters 14 (§ 38.2-1400 et seq.), 15 (§ 38.2-1500 et seq.), and 18 (§ 38.2-1800 et seq.), §§ 38.2-3100 through 38.2-3125 and 38.2-3300 through 38.2-3317, Chapter 34 (§ 38.2-3400 et seq.), §§ 38.2-3500 through 38.2-3520, Chapter 36 (§ 38.2-3600 et seq.), Chapter 52 (§ 38.2-5200 et seq.), and Chapter 55 (§ 38.2-5500 et seq.), and shall be exempt from all other provisions of this title unless expressly designated therein, or unless they are specifically made applicable by this chapter.

1986, c. 562; 1987, cc. 565, 655; 1993, c. 158; 1994, c. 308; 2000, cc. 46, 532; 2004, c. 315; 2012, c. 156; 2014, c. 571.

§ 38.2-4124. Taxation.

Every society organized or licensed under this chapter is hereby declared to be a charitable and benevolent institution, and all of its funds shall be exempt from every state, county, district, municipal and school tax other than taxes on real estate and office equipment.

Code 1950, §§ 38-262, 38.1-577; 1952, c. 317, § 38.1-638.9; 1968, c. 654; 1986, c. 562.

§ 38.2-4125. Valuations.

A. The report of valuation shall show, as reserve liabilities, the difference between the present midyear value of the promised benefits provided in the certificates of the society in force and the present midyear value of the future net premiums as they are in practice actually collected, not including any value for the right to make extra assessments and not including any amount by which the present midyear value of future net premiums exceeds the present midyear value of promised benefits on individual certificates. At the option of any society, the valuation may show the net tabular value instead of the above value. The net tabular value as to certificates issued prior to June 28, 1969, shall be determined in accordance with the provisions of law applicable prior to June 28, 1968, and as to certificates issued on or after June 28, 1969, shall not be less than the reserves determined according to the Commissioners' reserve valuation method as defined in subsection C of this section. If the premium charged is less than the tabular net premium according to the basis of valuation used, an additional reserve equal to the present value of the deficiency in the premiums shall be set up and maintained as a liability. The reserve liabilities shall be properly adjusted in the event that the midyear or tabular values are not appropriate.

B. A society may value its certificates in accordance with valuation standards authorized by the laws of this Commonwealth for the valuation of policies issued by life insurers.

C. Reserves according to the Commissioners' reserve valuation method, for the life insurance and endowment benefits of certificates providing for a uniform amount of insurance and requiring the payment of uniform premiums shall be any excess of the present value, at the date of valuation, of the future guaranteed benefits provided for by those certificates, over the then present value of any future modified net premiums therefor. The modified net premiums for any such certificate shall be a uniform percentage of the respective contract premiums for the benefits that the present value, at the date of issue of the certificate, of all modified net premiums shall equal the sum of the then present value of the benefits provided for by the certificate and the excess of 1 over 2, as follows:

1. A net-level premium equal to the present value, at the date of issue, of the benefits provided for after the first certificate year, divided by the present value, at the date of issue, of an annual annuity of one dollar payable on each anniversary of the certificate on which a premium falls due. However, the net-level annual premium shall not exceed the net-level annual premium on the nineteen-year premium whole life plan for insurance of the same amount at any age one year higher than the age at issue of the certificate; and

2. A net one-year term premium for the benefits provided for in the first certificate year. Reserves according to the Commissioners' reserve valuation method for (i) life insurance benefits for varying

amounts of benefits or requiring the payment of varying premiums, (ii) annuity and pure endowment benefits, (iii) disability and accidental death benefits in all certificates and contracts, and (iv) all other benefits except life insurance and endowment benefits, shall be calculated by a method consistent with the principles of this subsection.

D. The present value of deferred payments due under incurred claims or matured certificates shall be deemed a liability of the society and shall be computed upon mortality and interest standards prescribed in subsections E through G of this section.

E. The valuation and underlying data shall be certified by a competent actuary or, at the expense of the society, verified by the actuary of the department of insurance of the state of domicile of the society.

F. The minimum standards of valuation for certificates issued prior to June 28, 1969, shall be those provided by the law applicable immediately prior to June 28, 1968, but not lower than the standards used in the calculating of rates for those certificates.

G. The minimum standard of valuation for certificates issued after June 28, 1969, shall be 3 1/2 percent interest and the following tables:

1. For certificates of life insurance, American Men Ultimate Table of Mortality, with Bowerman's or Davis' Extension thereof or with the consent of the Commission, the Commissioners 1941 Standard Ordinary Mortality Table, the Commissioners 1941 Standard Industrial Mortality Table or the Commissioners 1958 Standard Ordinary Mortality Table, using actual age of the insured for male risks and an age not more than three years younger than the actual age of the insured for female risks;

2. For annuity and pure endowment certificates, excluding any disability and accidental death benefits in the certificates, the 1937 Standard Annuity Mortality Table or the Annuity Mortality Table for 1949, Ultimate, or any modification of either of these tables approved by the Commission;

3. For total and permanent disability benefits in or supplementary to life insurance certificates, Hunter's Disability Table, or the Class III Disability Table (1926) modified to conform to the contractual waiting period, or the tables of Period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 Disability Study of the Society of Actuaries with due regard to the type of benefit. Any of these tables shall, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance certificates;

4. For accidental death benefits in or supplementary to life insurance certificates, The Inter-Company Double Indemnity Mortality Table or the 1959 Accidental Death Benefits Table. Either table shall be combined with a mortality table permitted for calculating the reserves for life insurance certificates; and

5. For noncancellable accident and health benefits, the Class III Disability Table (1926) with conference modifications or, with the consent of the Commission, tables based upon the society's own experience.

H. The Commission may, in its discretion, accept other standards for valuation if it finds that the reserves produced by those standards will not be less in the aggregate than reserves computed in accordance with the minimum valuation standard prescribed in this section. The Commission may, in its discretion, vary the standards of mortality applicable to all certificates of insurance on substandard lives or other extra hazardous lives by any society licensed to do business in this Commonwealth. Whenever the mortality experience under all certificates valued on the same mortality table exceeds the expected mortality according to that table for a period of three consecutive years, the Commission may require additional reserves that it deems necessary on account of the certificates.

I. Any society, with the consent of the commissioner of insurance of the state of domicile of the society and under any conditions he may impose, may establish and maintain reserves on its certificates in excess of the reserves required by the state. However, the contractual rights of any insured member shall not be affected by the excess reserves.

Code 1950, §§ 38-316, 38.1-624; 1952, c. 317, § 38.1-638.45; 1968, c. 654; 1975, c. 262; 1986, c. 562.

§ 38.2-4126. Reports to be filed.

A. Every society doing business in this Commonwealth shall annually, by March 1, unless the Commission extends the time for cause shown, file with the Commission a true statement of its financial condition, transactions and affairs for the preceding calendar year. The statement shall be in general form and content as approved by the National Association of Insurance Commissioners for fraternal benefit societies or other form required by the Commission and as supplemented by additional information required by the Commission.

B. As part of the required annual statement, each society shall, by March 1, file with the Commission a valuation of its certificates in force on December 31 of the previous year, provided the Commission may, in its discretion for cause shown, extend the time of filing such valuation for not more than two calendar months. Such valuation shall be done in accordance with the standards specified in § 38.2-4125. Such valuation and underlying data shall be certified by a qualified actuary or, at the expense of the society, verified by the actuary of the department of insurance of the state of domicile of the society.

Code 1950, §§ 38-316, 38.1-624; 1952, c. 317, §§ 38.1-638.44, 38.1-638.45; 1968, c. 654; 1975, c. 262; 1986, c. 562.

§ 38.2-4127. Annual license.

Societies now authorized to do business in this Commonwealth may continue such business until June 30, 1987. The authority of such societies and all societies hereafter licensed may thereafter be renewed annually, but in all cases will terminate on June 30. However, a license so issued shall continue in effect until the new license is issued or specifically refused. For each such license or renewal the society shall pay the Commission twenty dollars. A duly certified copy or duplicate of such license

shall be prima facie evidence that the licensee is a fraternal benefit society within the meaning of this chapter.

Code 1950, §§ 38-271, 38.1-588; 1952, c. 317, § 38.1-638.20; 1968, c. 654; 1978, c. 4; 1986, c. 562.

§ 38.2-4128. Examination of societies; no adverse publications.

A. The Commission, or any person the Commission may appoint, may examine any domestic, foreign or alien society doing business or applying for admission to do business in this Commonwealth in the same manner as authorized for examination of domestic, foreign or alien insurers. Requirements of notice and an opportunity to respond before findings are made public, as provided in the laws regulating insurers, shall also be applicable to the examination of societies.

B. The expense of each examination and of each valuation, including compensation and actual expense of examiners, shall be paid by the society examined or whose certificates are valued, upon statements furnished by the Commission.

Code 1950, §§ 38-319 through 38-321, 38.1-627, 38.1-629, 38.1-630; 1952, c. 317, §§ 38.1-638.48 through 38.1-638.51; 1968, c. 654; 1986, c. 562.

§ 38.2-4129. Admission; foreign or alien society.

No foreign or alien society shall do business in this Commonwealth without a license issued by the Commission. Any such society desiring admission to this Commonwealth shall comply substantially with the requirements and limitations of this chapter applicable to domestic societies. Any such society may be licensed to do business in this Commonwealth upon showing that its assets are invested in accordance with the provisions of this chapter and filing with the Commission:

1. A duly certified copy of its articles of incorporation;

2. A copy of its bylaws, certified by its secretary or corresponding officer;

3. A statement of its business in a form prescribed by the Commission, duly verified by an examination made by the supervising insurance official of its home state or other state, territory, province or country, satisfactory to the Commission;

4. Certification from the proper official of its home state, territory, province or country that the society is legally incorporated and licensed to do business therein;

5. Copies of its certificate forms; and

6. Such other information as the Commission may deem necessary.

Code 1950, §§ 38-272 through 38-274, 38.1-589 through 38.1-591; 1952, c. 317, §§ 38.1-638.21 through 38.1-638.23; 1956, c. 431; 1968, c. 654; 1978, c. 4; 1986, c. 562.

§ 38.2-4130. Injunction; liquidation; receivership of domestic society.

No domestic society shall:

1. Exceed its powers;

2. Fail to comply with any provisions of this chapter;

3. Fail to fulfill its contracts in good faith;

4. Have a membership of less than 400 after an existence of 1 year or more; or

5. Conduct business fraudulently or in a manner hazardous to its members, creditors, the public or the business.

If the Commission, upon investigation, finds such deficiencies, it shall issue a written notice to the society citing the deficiencies, stating the reasons for dissatisfaction, and requiring that the deficiencies be corrected within the period it designates. The period shall be at least thirty days but not more than six months from the service of the notice. If the Commission believes the interest of the certificate holders of the society will be best served by extending the period of time beyond six months, it may do so for the period of time it considers best. If the society does not correct the deficiency to the satisfaction of the Commission, the Commission may institute delinquency proceedings against the society in the manner set out in Chapter 15 (§ 38.2-1500 et seq.) of this title. If the Commission institutes a delinquency proceeding, all the provisions of Chapter 15 of this title with respect to the rehabilitation, liquidation, conservation and reorganization of insurers generally shall be applicable to the society.

Code 1950, §§ 38-261, 38-275, 38-319, 38.1-592, 38.1-628; 1952, c. 317, §§ 38.1-638.24, 38.1-638.49; 1968, c. 654; 1986, c. 562.

§ 38.2-4131. Suspension, revocation or refusal of license of foreign or alien society.

No foreign or alien society doing business or applying to do business in this Commonwealth shall:

1. Exceed its powers;

2. Fail to comply with any of the provisions of this chapter;

3. Fail to fulfill its contracts in good faith; or

4. Conduct its business fraudulently or in a manner hazardous to its members or creditors or the public.

If the Commission, upon investigation, finds such deficiencies, it shall notify the society in writing of its findings, and after reasonable notice require the society to show cause on a date designated in the notice why its license should not be suspended, revoked or refused. If, on the date named in the notice, the grounds for the proposed suspension, revocation or refusal of the society's license have not been removed to the satisfaction of the Commission, or the society does not present good and sufficient reasons why its authority to do business in this Commonwealth should not at that time be suspended, revoked, or refused the Commission may suspend, revoke or refuse the license of the society to do business in this Commonwealth.

Code 1950, §§ 38-322, 38.1-631; 1952, c. 317, § 38.1-638.52; 1968, c. 654; 1986, c. 562.

§ 38.2-4132. Licensing of agents.

A. Agents of societies shall be licensed as life and health agents in accordance with Chapter 18 (§ 38.2-1800 et seq.) of this title regulating the licensing, revocation, suspension or termination of licenses of resident and nonresident agents.

B. No examination or license shall be required of any regular salaried officer, employee or member of a licensed society who devotes substantially all of his or her services to activities other than the solicitation of fraternal insurance contracts from the public, and who receives for the solicitation of such contracts no commission or other compensation directly dependent upon the amount of business obtained.

1968, c. 654, § 38.1-638.37; 1986, c. 562.

§ 38.2-4133. Unfair methods of competition and unfair and deceptive acts and practices.

Every society authorized to do business in this Commonwealth shall be subject to the provisions of Chapter 5 (§ 38.2-500 et seq.) of this title. However, nothing in such provisions shall be construed as applying to or affecting the right of any society to determine its eligibility requirements for membership, or be construed as applying to or affecting the offering of benefits exclusively to members or persons eligible for membership in the society by a subsidiary corporation or affiliated organization of the society.

1968, c. 654, § 38.1-638.60; 1986, c. 562.

§ 38.2-4134. Penalties.

A. Any person who willfully makes a false or fraudulent statement in or relating to an application for membership or for the purpose of obtaining money from or a benefit in any society shall upon conviction be fined not less than $100 nor more than $500 or be imprisoned not less than 30 days nor more than 1 year, or both.

B. Any person who willfully makes a false or fraudulent statement in any report or declaration required or authorized by this chapter, or of any material fact or thing contained in a statement concerning the death or disability of an insured for the purpose of procuring payment of a benefit named in the certificate, shall be guilty of perjury and shall be subject to the penalties therefor prescribed by law.

C. Any person who solicits membership for, or in any manner assists in procuring membership in, any society not licensed to do business in this Commonwealth shall upon conviction be fined not less than $50 nor more than $200.

D. Any other violation of this chapter shall be subject to § 38.2-218.

Code 1950, §§ 38-263, 38.1-578; 1952, c. 317, § 38.1-638.10; 1968, c. 654; 1986, c. 562.

§ 38.2-4135. Exemption of certain societies.

A. Nothing contained in this chapter shall be construed to affect or apply to:

1. Grand or subordinate lodges of Masons, Odd Fellows, or Knights of Pythias, exclusive of the insurance department of the Supreme Lodge Knights of Pythias, or the Junior Order of United American

Mechanics, exclusive of the beneficiary degree or insurance branch of the National Council, Junior Order of United American Mechanics;

2. Similar societies which do not issue insurance certificates;

3. An association of local lodges of a society now doing business in this Commonwealth which provides death benefits of not more than $500 to any 1 person, or disability benefits of not more than $300 in any 1 year to any 1 person, or both;

4. Contracts of reinsurance business on benefits of fraternal benefit societies in this Commonwealth;

5. Grand or subordinate lodges of societies, orders or associations now doing business in this Commonwealth which provide benefits exclusively through local or subordinate lodges;

6. Orders, societies or associations which admit to membership only persons engaged in one or more crafts or hazardous occupations, in the same or similar lines of business, insuring only their own members and their families, and the ladies' societies or ladies' auxiliaries to such orders, societies or associations;

7. Domestic societies which limit their membership to employees of a particular city or town, designated firm, business house or corporation and which provide for a death benefit of not more than $400 to any 1 person, or disability benefits of not more than $350 to any 1 person in any 1 year, or both;

8. Domestic societies or associations of a purely religious, charitable or benevolent description, which provide for a death benefit of not more than $100 or for disability benefits of not more than $150 to any 1 person in any 1 year, or both; or

9. Any association, whether a fraternal benefit society or not, which was organized before 1880 and whose members are officers or enlisted, regular or reserve, active, retired, or honorably discharged members of the Armed Forces or Sea Services of the United States, and a principal purpose of which is to provide insurance and other benefits to its members and their dependents or beneficiaries.

B. Any such society or association described in subdivisions 7 and 8 of subsection A which provides for death or disability benefits for which benefit certificates are issued, and any such society or association included in subdivision 8 of subsection A which has more than 1,000 members, shall comply with all provisions of this chapter.

C. No society which, by the provisions of this section, is exempt from the requirements of this chapter, except any society described in subdivision 6 of subsection A of this section, shall give or allow, or promise to give or allow to any person any compensation for procuring new members.

D. Every society which provides for benefits in case of death or disability resulting solely from accident, and which does not obligate itself to pay natural death or sick benefits, shall have all privileges and be subject to the applicable provisions and regulations of this chapter except that the provisions

relating to medical examination, valuations of benefit certificates, and incontestability shall not apply to such society.

E. The Commission may require from any society or association, by examination or otherwise, such information as will enable the Commission to determine whether such society or association is exempt from the provisions of this chapter.

F. Societies, orders or associations exempted under the provisions of this section shall also be exempt from all other provisions of the insurance laws of this Commonwealth.

Code 1950, §§ 38-258, 38.1-573; 1952, c. 317, § 38.1-638.5; 1968, c. 654; 1986, c. 562; 1995, c. 321.

§ 38.2-4136. Societies previously existing; reincorporation; amendments.

Any incorporated society doing business in this Commonwealth on June 19, 1914, may exercise all of the rights conferred by this chapter, and all of the rights, powers and privileges exercised or possessed by it under its charter or articles of incorporation not inconsistent with law; or, if a voluntary association, it may incorporate as provided herein. No society organized prior to June 19, 1914, shall be required to reincorporate under this section. Any society may amend its certificate of incorporation in the manner provided by law.

Code 1950, §§ 38-269, 38.1-580; 1952, c. 317, § 38.1-638.12; 1968, c. 654; 1986, c. 562.

§ 38.2-4137. Exemption of member representatives of certain societies.

The provisions of § 38.2-4132 shall not apply to the member representatives of any society organized or licensed under this chapter which insures its members against death, dismemberment and disability resulting from accident only, and which pays no commission or other compensation for the solicitation and procurement of such contracts.

1968, c. 654, § 38.1-638.38; 1986, c. 562.

Chapter 42 - HEALTH SERVICES PLANS

Article 1 - IN GENERAL

§ 38.2-4200. Applicability of chapter.

A. Except as otherwise provided by law, no plan shall be organized, conducted or offered in this Commonwealth other than in the manner set forth in this chapter.

B. Nothing contained in this chapter shall prohibit any physician (i) as an individual, (ii) in partnership with other physicians, or (iii) as part of a professional corporation of physicians, from entering into agreements directly with his own patients, or with a parent, guardian, conservator, spouse or other family member acting in a patient's behalf, involving payment for professional services to be rendered or made available in the future.

1979, c. 721, § 38.1-813.1; 1980, c. 682; 1986, c. 562; 1997, c. 801.

§ 38.2-4201. Definitions.

As used in this chapter:

"Contract holder" means a person entering into a subscription contract with a nonstock corporation.

"Nonstock corporation" means a foreign or domestic nonstock corporation which is subject to regulation and licensing under this chapter and which offers or administers subscription contracts to contract holders as part of a plan.

"Health services plan" or "plan" means any arrangement for offering or administering health services or similar or related services by a nonstock corporation licensed under this chapter.

"Hospital services plan" means a health services plan for providing hospital and similar or related services.

"Medical or surgical services plan" means a health services plan for providing medical or surgical services or both, and similar or related services.

"Subscriber" means any person entitled to benefits under the terms and conditions of a subscription contract.

"Subscription contract" means a written contract which is issued to a contract holder by a nonstock corporation and which provides health services or benefits for health services on a prepaid basis.

1986, c. 562; 1988, c. 185.

§ 38.2-4202. Hospital services plans.

A hospital or a group of hospitals may conduct through a nonstock corporation as agent for them a hospital services plan as defined in § 38.2-4201.

Code 1950, § 32-195.1; 1956, c. 268, § 38.1-810; 1960, c. 357; 1979, c. 721; 1980, c. 682; 1986, c. 562.

§ 38.2-4203. Medical or surgical services plans.

A group of physicians may conduct through a nonstock corporation as agent for them a medical or surgical services plan as defined in § 38.2-4201.

Code 1950, § 32-195.2; 1956, c. 268, § 38.1-811; 1960, c. 357; 1979, c. 721; 1980, c. 682; 1986, c. 562.

§ 38.2-4204. Merger of nonstock corporations.

A nonstock corporation operating a hospital services plan pursuant to § 38.2-4202 may be combined with a nonstock corporation operating a medical or surgical services plan pursuant to § 38.2-4203. The nonstock corporation created by such combination may be licensed to conduct a combination plan furnishing both hospital services and similar or related services and medical or surgical services, or both, and similar or related services.

1979, c. 721, § 38.1-812; 1980, c. 682; 1986, c. 562.

§ 38.2-4204.1. Commission approval of mergers of nonstock corporations operating prepaid hospital, medical and surgical services plans.

A. Except as otherwise provided in this chapter, Article 11 (§ 13.1-893.1 et seq.) of Chapter 10 of Title 13.1 shall apply to mergers involving corporations licensed under this chapter.

B. Before any joint agreement for the merger of a corporation licensed under this chapter is submitted to the members, it shall first be submitted to and approved by the Commission. The Commission shall approve the agreement, unless, after giving notice and opportunity to be heard, it determines that:

1. After the merger, the new or surviving corporation would not be able to satisfy the requirements of this chapter for the issuance of a license;

2. The effect of the merger would lessen competition substantially or tend to create a monopoly in insurance, prepaid hospital, medical and surgical services plans, or health care benefit plans in this Commonwealth;

3. The financial condition of any party to the merger might jeopardize the financial stability of the new or surviving corporation, or prejudice the interest of the subscribers;

4. Any plans or proposals of the new or surviving corporation to liquidate the new or surviving corporation, sell its assets or merge it with any person, or to make any other material change in its business or corporate structure or management, are unfair and unreasonable to the subscribers and not in the public interest;

5. The competence, experience, and integrity of those persons who would control the operation of the new or surviving corporation are such that it would not be in the interest of the subscribers and of the public to permit the merger; or

6. After the change of control, the new or surviving corporation's surplus to subscribers would not be reasonable in relation to its outstanding liabilities or adequate to its financial needs.

C. The provisions of subsection B notwithstanding, the Commission has the authority to merge two nonstock corporations licensed under this chapter where it finds that (i) one of the corporations is insolvent or is in such condition that its further transaction of business in this Commonwealth is hazardous to subscribers and the public, (ii) that the merger of such nonstock corporation into another nonstock corporation licensed under this chapter is desirable for the protection of its subscribers, and that such merger of such nonstock corporation is in the public interest, and (iii) that an emergency exists, and if the board of directors of the insolvent or financially hazardous nonstock corporation to be merged approves a plan of merger of such nonstock corporation into another nonstock corporation licensed under this chapter, compliance with the requirements of § 13.1-895 shall be dispensed with as to such nonstock corporation and the approval by the Commission of such plan of merger shall be the equivalent of approval of two-thirds of the members for all purposes of Article 11 (§ 13.1-893.1 et seq.) of Chapter 10 of Title 13.1. The Commission shall provide that prompt notice of its findings, and plan of merger be sent to the members of record of such corporation for the purpose of providing such members an opportunity to challenge the findings of the Commission and the plan of merger. The Commission's findings and plan of merger shall become final if a hearing before the Commission is

not requested by any member in a written request delivered to the Commission within fifteen days after the notice specified herein is sent.

1986, c. 562.

§ 38.2-4205. Dental and optometric services.

Dental services and optometric services may be provided by either subscription contract or endorsement in a plan.

1986, c. 562.

§ 38.2-4206. Nonstock corporation required.

Each plan shall be conducted either by or through (i) a nonstock corporation organized pursuant to the laws of this Commonwealth or (ii) a foreign nonstock corporation that is subject to regulation and licensing under the laws of its domiciliary jurisdiction that are substantially similar to those provided by this chapter.

This section shall not apply to any foreign nonstock corporation already licensed in this Commonwealth as of July 1, 1980.

1980, c. 682, § 38.1-813.2; 1986, c. 562.

§ 38.2-4207. Existing foreign nonstock corporation.

Any foreign nonstock corporation licensed in the Commonwealth as of July 1, 1980, may conduct a plan directly.

1980, c. 682, § 38.1-813.3; 1986, c. 562.

§ 38.2-4208. Nonstock corporation not required to act as agent.

A. A nonstock corporation may offer or administer a plan without being required to act as an agent for providers of health care services.

B. A nonstock corporation applying for its initial license pursuant to this chapter in order to offer or administer a plan must elect in its application whether to act (i) as agent for providers of health care services, in which case §§ 38.2-4210 and 38.2-4211 shall apply, or (ii) as a nonagent, in which case the provisions of subsection D of this section shall apply.

C. A nonstock corporation operating a plan pursuant to §§ 38.2-4202, 38.2-4203, 38.2-4204 or this section prior to June 30, 1985, and any successor nonstock corporation shall continue to operate as either an agent or nonagent nonstock corporation, in accordance with the manner in which it was operating as of that date, provided that it may petition the Commission to change its status as an agent or nonagent nonstock corporation, and if it does so, it shall give notice of the petition to all interested parties. The Commission shall conduct a hearing on the petition if requested by any interested party. A nonstock corporation seeking to change its status shall make application to the Commission within ninety days following the end of any calendar year. A change in status shall only be effective as to subscriber contracts issued or renewed on and after the date of a change in status. The Commission shall enter an order in response to the nonstock corporation's petition.

D. If any nonstock corporation offers or administers a plan without acting as an agent for providers of health care services, the Commission may elect to (i) require the nonstock corporation to maintain its contingency reserves above a minimum level set by the Commission, or (ii) subject the nonstock corporation, notwithstanding the provisions of § 38.2-1700, to the requirements of Chapter 17 of this title, or (iii) both. The minimum level for contingency reserves shall not exceed forty-five days of the anticipated operating expenses and incurred claims expense generated from subscription contracts issued by the nonstock corporation, and shall be computed as the Commission requires.

Code 1950, § 32-195.5:1; 1972, c. 429, § 38.1-816; 1974, c. 54; 1979, c. 721; 1980, c. 682; 1982, c. 129; 1983, c. 464, § 38.1-813.4; 1985, c. 233; 1986, c. 562; 1988, c. 185.

§ 38.2-4209. Preferred provider subscription contracts.

A. As used in this section, a "preferred provider subscription contract" is a contract that specifies how services are to be covered when rendered by providers participating in a plan, by nonparticipating providers, and by preferred providers.

B. Notwithstanding the provisions of §§ 38.2-4218 and 38.2-4221, any nonstock corporation may, as a feature of its plan, offer preferred provider subscription contracts pursuant to the requirements of this section that limit the numbers and types of providers of health care services eligible for payment as preferred providers.

C. Any such nonstock corporation shall establish terms and conditions that shall be met by a hospital, physician or other type of provider listed in § 38.2-4221 in order to qualify for payment as a preferred provider under the subscription contracts. These terms and conditions shall not discriminate unreasonably against or among health care providers. No hospital, physician or type of provider listed in § 38.2-4221 willing to meet the terms and conditions offered to it or him shall be excluded. Differences in prices among hospitals or other institutional providers produced by a process of individual negotiations with the providers or based on market conditions, or price differences among providers in different geographical areas shall not be deemed unreasonable discrimination. The Commission shall have no jurisdiction to adjudicate controversies growing out of this subsection.

D. Mandated types of providers listed in § 38.2-4221 and types of providers whose services are required to be made available and which have been specifically contracted for by the holder of any subscription contract shall, to the extent required by § 38.2-4221, have the same opportunity as do doctors of medicine to qualify for payment as preferred providers.

E. Preferred provider subscription contracts shall provide for payment for services rendered by nonpreferred providers, but the payments need not be the same as for preferred providers.

F. No contract between a nonstock corporation and a provider shall include provisions which require a health care provider or health care provider group to deny covered services that such provider or group knows to be medically necessary and appropriate that are provided with respect to a specific enrollee or group of enrollees with similar medical conditions.

1983, c. 464, § 38.1-813.4; 1986, c. 562; 1999, cc. 643, 649.

§ 38.2-4209.1. Pharmacies; freedom of choice.

A. Notwithstanding any provision of § 38.2-4209, no corporation providing preferred provider subscription contracts or its pharmacy benefits manager, as defined in § 38.2-3465, shall prohibit any person receiving pharmaceutical benefits, including specialty pharmacy benefits, thereunder from selecting, without limitation, the pharmacy of his choice to furnish such benefits. This right of selection extends to and includes pharmacies that are nonpreferred providers and that have previously notified the corporation or its pharmacy benefits manager, by facsimile or otherwise, of their agreement to accept reimbursement for their services at rates applicable to pharmacies that are preferred providers, including any copayment consistently imposed by the corporation, as payment in full. Each corporation or its pharmacy benefits manager shall permit prompt electronic or telephonic transmittal of the reimbursement agreement by the pharmacy and ensure payment verification to the pharmacy of the terms of reimbursement. In no event shall any person receiving a covered pharmacy benefit from a nonpreferred provider that has submitted a reimbursement agreement be responsible for amounts that may be charged by the nonpreferred provider in excess of the copayment and the corporation's reimbursement applicable to all of its preferred pharmacy providers.

B. No such corporation or its pharmacy benefits manager shall impose upon any person receiving pharmaceutical benefits furnished under any such contract:

1. Any copayment, fee or condition that is not equally imposed upon all individuals in the same benefit category, class or copayment level, whether or not such benefits are furnished by pharmacists who are nonpreferred providers;

2. Any monetary penalty that would affect or influence any such person's choice of pharmacy; or

3. Any reduction in allowable reimbursement for pharmacy services related to utilization of pharmacists who are nonpreferred providers.

C. For purposes of this section, a prohibited condition or penalty shall include, without limitation: (i) denying immediate access to electronic claims filing to a pharmacy that is a nonpreferred provider and that has complied with subsection D or (ii) requiring a person receiving pharmacy benefits to make payment at point of service, except to the extent such conditions and penalties are similarly imposed on preferred providers.

D. Any pharmacy that wishes to be covered by this section shall, if requested to do so in writing by a corporation or its pharmacy benefits manager, within 30 days of the pharmacy's receipt of the request, execute and deliver to the corporation or its pharmacy benefits manager the direct service agreement or preferred provider agreement that the corporation requires all of its preferred providers of pharmacy benefits to execute. Any pharmacy that fails to timely execute and deliver such agreement shall not be covered by this section with respect to that corporation or its pharmacy benefits manager unless and until the pharmacy executes and delivers the agreement. No pharmacy shall be precluded from obtaining a direct service agreement or participating provider agreement for any retail and specialty pharmacy if the pharmacy meets the terms and conditions of participation. Any request by a pharmacy for a

direct service agreement or a participating provider agreement shall be acted upon by a corporation or its pharmacy benefits manager within 60 days of receipt of the pharmacy's request or any subsequent submission of supplemental information if requested by the corporation or its pharmacy benefits manager.

E. The Commission shall have no jurisdiction to adjudicate controversies arising out of this section.

F. Nothing in this section shall limit the authority of a corporation issuing preferred provider policies or contracts to select a single mail order pharmacy provider as the exclusive provider of pharmacy services that are delivered to the covered person's address by mail, common carrier, or delivery service. The provisions of this section shall not apply to such contracts. As used in this subsection, "mail order pharmacy provider" means a pharmacy permitted to conduct business in the Commonwealth whose primary business is to dispense a prescription drug or device under a prescriptive drug order and to deliver the drug or device to a patient primarily by mail, common carrier, or delivery service.

1994, c. 963; 1995, c. 467; 2010, cc. 157, 357; 2021, Sp. Sess. I, c. 229.

§ 38.2-4209.2. Repealed.

Repealed by Acts 1995, c. 467.

§ 38.2-4210. Liability of participants.

A. All hospitals, persons, nonstock corporations, and physicians participating in a plan shall be jointly and severally liable on all contracts made for the purposes of the plan by the nonstock corporation as agent for them. Each contract may be executed and signed by their agent on their behalf. A contract so signed shall be binding on the principals and not on the agent.

B. Actions for breach of these contracts may be brought against the principals by naming the agent as the sole defendant. A judgment in favor of the plaintiff may be satisfied out of the assets of the nonstock corporation or out of the assets of each of the principals.

C. Each participant shall be liable for his own torts and not for the torts of any other participant or of the agent.

Code 1950, § 32-195.4; 1956, c. 268, § 38.1-814; 1972, c. 429; 1979, c. 721; 1980, c. 682; 1986, c. 562.

§ 38.2-4211. Change of participants.

A. Any participating hospital, person, nonstock corporation or physician may resign from a plan at any time but will continue to be liable on each subscription contract then in effect. However, this liability shall not extend beyond the end of each such subscription contract's current contract year.

B. Hospitals, persons, nonstock corporations and physicians may be admitted to a plan at any time and will then automatically become liable on all its outstanding contracts.

Code 1950, § 32-195.5; 1956, c. 268, § 38.1-815; 1972, c. 429; 1979, c. 721; 1986, c. 562.

§ 38.2-4212. Board of directors of nonstock corporation operating plan.

A. Notwithstanding the provisions of §§ 13.1-853, 13.1-854 and 13.1-855, a nonstock corporation operating a plan pursuant to §§ 38.2-4202, 38.2-4203, 38.2-4204, or § 38.2-4208 shall be subject to the following:

1. The board of directors of the nonstock corporation shall consist of no more than fifteen members. However, if two or more nonstock corporations merge, the board of directors of the new or surviving nonstock corporation may consist of no more than twenty members. Further, the board of directors may be increased to a size not exceeding the aggregate number of directors on the merging nonstock corporations' boards for the balance of the year in which merger occurs and for the following five years.

2. Except as permitted by subsection B of this section, a majority of the members of the board of directors of the nonstock corporation shall be persons who are covered by subscription contracts issued by the nonstock corporation and who are not providers of health care services, or employees or salaried officers of the nonstock corporation.

B. Notwithstanding the provisions of §§ 13.1-853, 13.1-854 and 13.1-855, any nonstock corporation operating a plan pursuant to § 38.2-4203 may have a board of directors consisting of a majority of providers of health care services.

C. As used in this section, "providers of health care services" shall include, but not be limited to, physicians, pharmacists, nurses, physical therapists, hospital administrators, employees or majority or controlling stockholders of hospitals, and other persons furnishing health-related services.

D. This section shall not apply to any foreign nonstock corporation licensed in this Commonwealth on or before July 1, 1980.

Code 1950, §§ 32-195.5:1, 32-195.5:2; 1972, c. 429, §§ 38.1-816, 38.1-817; 1974, c. 54; 1979, c. 721; 1980, c. 682; 1982, c. 129; 1985, c. 233; 1986, c. 562.

§ 38.2-4213. Liability of participating providers upon merger of nonstock corporation.

If two or more nonstock corporations merge, §§ 38.2-4210 and 38.2-4211 shall not apply to the new or surviving nonstock corporation, its plans or its providers unless the nonstock corporations to be merged notify the Commission in writing at least thirty days prior to the date of the merger that the new or surviving nonstock corporation will remain subject to §§ 38.2-4210 and 38.2-4211. If notice is not given, the Commission may (i) require the new or surviving nonstock corporation to maintain its contingency reserves above minimum level, (ii) subject it, notwithstanding the provisions of § 38.2-1700, to the requirements of Chapter 17 of this title or (iii) both. The minimum level of contingency reserves shall not exceed thirty days of anticipated operating expenses and claims receipts computed as the Commission requires. If the nonstock corporation elects not to file the notice permitted by this section, the nonstock corporation and not its providers shall be liable for the obligations of the plan.

Code 1950, § 32-195.5:1; 1972, c. 429, § 38.1-816; 1974, c. 54; 1979, c. 721; 1980, c. 682; 1982, c. 129; 1985, c. 233; 1986, c. 562.

§ 38.2-4214. Application of certain provisions of law.

No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-218 through 38.2-225, 38.2-230, 38.2-232, 38.2-305, 38.2-316, 38.2-316.1, 38.2-322, 38.2-325, 38.2-326, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-629, 38.2-700 through 38.2-705, 38.2-900 through 38.2-904, 38.2-1017, 38.2-1018, 38.2-1038, and 38.2-1040 through 38.2-1044, Articles 1 (§ 38.2-1300 et seq.) and 2 (§ 38.2-1306.2 et seq.) of Chapter 13, §§ 38.2-1312, 38.2-1314, 38.2-1315.1, 38.2-1317 through 38.2-1328, 38.2-1334, 38.2-1340, 38.2-1400 through 38.2-1442, 38.2-1446, 38.2-1447, 38.2-1800 through 38.2-1836, 38.2-3400, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3405.1, 38.2-3406.1, 38.2-3406.2, 38.2-3407.1 through 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.20, 38.2-3409, 38.2-3411 through 38.2-3419.1, and 38.2-3430.1 through 38.2-3454, Articles 8 (§ 38.2-3461 et seq.) and 9 (§ 38.2-3465 et seq.) of Chapter 34, §§ 38.2-3501 and 38.2-3502, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1 and 38.2-3514.2, §§ 38.2-3516 through 38.2-3520 as they apply to Medicare supplement policies, §§ 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3541, 38.2-3541.2, 38.2-3542, and 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, Chapter 35.1 (§ 38.2-3556 et seq.), §§ 38.2-3600 through 38.2-3607 and 38.2-3610, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.), Chapter 65 (§ 38.2-6500 et seq.), and Chapter 66 (§ 38.2-6600 et seq.) shall apply to the operation of a plan.

Code 1950, § 32-195.8; 1956, c. 268, § 38.1-818; 1960, c. 357; 1973, c. 28; 1975, c. 281; 1976, c. 355; 1977, cc. 606, 607; 1978, c. 496; 1979, cc. 47, 97, 721, 726; 1980, cc. 682, 719; 1981, c. 575; 1982, c. 577; 1983, c. 457; 1984, c. 718; 1986, cc. 550, 562; 1987, cc. 565, 655; 1989, cc. 606, 653; 1990, cc. 301, 393, 439, 531, 795, 802, 826; 1991, c. 369; 1992, c. 800; 1993, cc. 158, 306, 307; 1994, cc. 213, 320, 374, 522; 1995, cc. 420, 522; 1996, cc. 550, 776, 967; 1997, cc. 688, 807, 913; 1998, cc. 154, 891, 908; 1999, cc. 643, 649, 709, 739, 856, 857, 923; 2000, cc. 47, 50, 187, 532, 540, 922; 2004, c. 315; 2006, c. 427; 2009, cc. 796, 877; 2010, cc. 504, 583, 734; 2011, cc. 788, 882; 2012, cc. 634, 641; 2013, cc. 670, 679, 751; 2015, cc. 14, 723; 2016, c. 475; 2019, cc. 661, 662, 666, 684; 2020, cc. 219, 264, 916, 917, 1161, 1288; 2021, Sp. Sess. I, c. 480.

§ 38.2-4214.1. Rehabilitation, liquidation, conservation.

Any rehabilitation, liquidation, or conservation of a health services plan shall be deemed to be the rehabilitation, liquidation, or conservation of an insurer and shall be subject to the provisions of Chapter 15 (§ 38.2-1500 et seq.) of Title 38.2.

1990, c. 331.

§ 38.2-4215. Payments by nonstock corporation.

No payments shall be made by a nonstock corporation to a person included in a subscription contract unless the payment is for breach of contract or for contractually included costs incurred by that person or for services received by that person and rendered by a nonparticipating hospital or nonparticipating health care provider.

In no case shall that person be denied the right to assign his rights to benefits, except that denial may be made where the benefit is eighty percent of covered charges or greater.

Code 1950, § 32-195.8; 1956, c. 268, § 38.1-818; 1960, c. 357; 1973, c. 28; 1975, c. 281; 1976, c. 355; 1977, cc. 606, 607; 1978, c. 496; 1979, cc. 47, 97, 721, 726; 1980, cc. 682, 719; 1981, c. 575; 1982, c. 577; 1983, c. 457; 1984, c. 718; 1986, c. 562.

§ 38.2-4216. Repealed.

Repealed by Acts 1987, cc. 565, 655.

§ 38.2-4216.1. Repealed.

Repealed by Acts 2013, cc. 136 and 210, cl. 2, effective January 1, 2014.

§ 38.2-4217. Reports.

A. In addition to the annual statement required by § 38.2-1300, the Commission shall require each nonstock corporation to file on a quarterly basis any additional reports, exhibits or statements the Commission considers necessary to furnish full information concerning the condition, solvency, experience, transactions or affairs of the nonstock corporation. The Commission shall establish deadlines for submitting any additional reports, exhibits or statements. The Commission may require verification by any officers of the nonstock corporation the Commission designates.

B. In addition to the annual statement required by § 38.2-1300, the Commission shall require each nonstock corporation to file annually, on or before June 1, an annual statement, signed by two of its principal officers subject to § 38.2-1304, showing:

1. The number of Virginia subscribers by the following type of contract or its equivalent:

a. Individual, open enrollment; and

b. Medicare, extended, under 65 disabled;

2. The subscriber income and benefit payments in the aggregate for the types of contracts listed above subject to specific breakdown by type of contract as requested by the Commission; and

3. Expenditures for providing public services, in addition to open enrollment, to the community.

Code 1950, § 32-195.8:1; 1972, c. 429, § 38.1-819; 1979, c. 721; 1986, c. 562; 1987, cc. 565, 655; 1997, cc. 807, 913; 2014, c. 814.

§ 38.2-4218. Subscriber to have free choice of medical practitioners available.

A plan shall be organized and operated to assure that any subscriber shall have free choice of the medical practitioners available and participating in the plan.

Code 1950, § 32-195.8:2; 1972, c. 429, § 38.1-820; 1979, c. 721; 1986, c. 562.

§ 38.2-4219. Subscriber to be advised in writing as to benefits and limitations thereon.

A nonstock corporation shall, prior to and during the term of the subscription contract, fully, fairly and currently advise the subscriber in writing of the benefits available under the contract and all limitations on the benefits available under the contract.

Code 1950, § 32-195.8:3; 1972, c. 429, § 38.1-821; 1979, c. 721; 1980, c. 682; 1986, c. 562.

§ 38.2-4220. Interplan arrangements.

A nonstock corporation may enter into contracts with similar nonstock corporations for the interchange of services to those included in subscription contracts and may provide in subscription contracts for the substitution of services instead of those recited in its subscription contracts. However, no corporation shall enter into any contract to acquire or to attempt to acquire control, as defined in § 38.2-1322, of any person or enter into any material transaction, as defined in § 38.2-1322, if such contract or transaction would jeopardize or adversely affect the interests of the corporation's subscribers as determined by the Commission.

Code 1950, § 32-195.10; 1956, c. 268, § 38.1-823; 1979, c. 721; 1986, c. 562.

§ 38.2-4221. Services of certain practitioners other than physicians to be covered.

A. A nonstock corporation shall not fail or refuse, either directly or indirectly, to allow or to pay to a subscriber for all or any part of the health services rendered by any doctor of podiatry, doctor of chiropody, optometrist, optician, chiropractor, professional counselor, psychologist, physical therapist, clinical social worker, clinical nurse specialist, audiologist, speech pathologist, certified nurse midwife or other advanced practice registered nurse, marriage and family therapist, athletic trainer, or licensed acupuncturist licensed to practice in Virginia, if the services rendered (i) are services provided for by the subscription contract; (ii) are services which the doctor of podiatry, doctor of chiropody, optometrist, optician, chiropractor, professional counselor, psychologist, physical therapist, clinical social worker, clinical nurse specialist, audiologist, speech pathologist, certified nurse midwife or other advanced practice registered nurse, marriage and family therapist, athletic trainer, or licensed acupuncturist is licensed to render in this Commonwealth; and (iii) are, for any services rendered by an athletic trainer, rendered in an office setting.

B. If a subscription contract provides reimbursement for a service that may be legally performed by a licensed pharmacist, reimbursement under the subscription contract by the nonstock corporation shall not be denied because the service is rendered by the licensed pharmacist provided that (i) the service is performed for a subscriber for a condition under the terms of a collaborative agreement, as defined in § 54.1-3300, between a pharmacist and the physician with whom the subscriber is undergoing a course of treatment or (ii) the service is for the administration of vaccines for immunization. Notwithstanding the provisions of § 38.2-4209, the nonstock corporation may require the pharmacist, any pharmacy or provider that may employ such pharmacist, or the collaborating physician to enter into a written agreement with the nonstock corporation as a condition for reimbursement for such services. In addition, reimbursement to pharmacists acting under the terms of a collaborative agreement under this subsection shall not be subject to the provisions of § 38.2-4209.1.

Code 1950, § 32-195.10:1; 1966, c. 276, § 38.1-824; 1973, c. 428; 1979, cc. 13, 721; 1980, c. 682; 1986, c. 562; 1987, cc. 549, 551, 557; 1988, c. 522; 1989, cc. 7, 201; 1997, c. 203; 1998, c. 146; 2001, cc. 102, 475; 2019, cc. 332, 333; 2020, c. 726; 2022, cc. 440, 441; 2023, c. 183.

§ 38.2-4222. Licensing of nonstock corporations.

A. No person shall deliver or issue for delivery in this Commonwealth a subscription contract without a license issued by the Commission. Each nonstock corporation shall apply for a license and furnish

any relevant information the Commission requires. Each license shall expire at midnight on the following June 30. Application for a license shall be accompanied by a nonrefundable application fee of $500.

B. The Commission may refuse to issue or renew a license to a nonstock corporation if it is not satisfied that the financial condition, the method of operation, and the manner of doing business of the nonstock corporation enable it to meet its contractual obligations to all subscribers and that the nonstock corporation has otherwise complied with all the requirements of law.

Code 1950, § 32-195.11; 1956, c. 268, § 38.1-825; 1978, c. 4; 1979, c. 721; 1980, c. 682; 1986, c. 562; 1987, cc. 565, 655; 1988, c. 185; 1994, c. 503.

§ 38.2-4223. Renewal of license.

A. Each nonstock corporation shall renew its license with the Commission annually by July 1. The renewal license shall not be issued unless the nonstock corporation has complied with all requirements of law.

B. The Commission shall not fail or refuse to renew the license of any nonstock corporation without first giving the nonstock corporation ten days' notice of its intention not to renew the license and giving the nonstock corporation an opportunity to be heard and introduce evidence in its behalf. Any such hearing may be informal, and the required notice may be waived by the Commission and the nonstock corporation.

Code 1950, § 32-195.12; 1956, c. 268, § 38.1-826; 1978, c. 4; 1979, c. 721; 1980, c. 682; 1986, c. 562; 1987, cc. 565, 655.

§ 38.2-4224. Licensing of agents.

Subscription contracts may be solicited only through life and health insurance agents licensed in accordance with Chapter 18 of this title. Home office salaried officers whose principal duties and responsibilities do not include the negotiation or solicitation of subscription contracts shall not be required to be licensed.

Code 1950, § 32-195.13; 1956, c. 268, § 38.1-827; 1978, c. 4; 1979, c. 721; 1980, c. 682; 1986, c. 562; 1999, c. 86.

§ 38.2-4225. Repealed.

Repealed by Acts 1987, cc. 565, 655.

§ 38.2-4226. Taxation.

Except as provided by Chapter 4 of this title, the license tax paid by a nonstock corporation under Chapter 25 of Title 58.1 shall be in lieu of all other state and local license fees or license taxes and state income taxes of the nonstock corporation.

Code 1950, § 32-195.15; 1956, c. 268, § 38.1-828; 1969, Ex. Sess., c. 26; 1979, c. 721; 1980, c. 682; 1986, c. 562; 1987, cc. 565, 655.

§ 38.2-4227. Misleading applications or contracts.

In the operation of a plan, no person shall use any misleading subscription applications or contracts.

Code 1950, § 32-195.16; 1956, c. 268, § 38.1-829; 1960, c. 357; 1979, c. 721; 1986, c. 562.

§ 38.2-4228. Controversies involving subscription contracts.

The Commission shall have no jurisdiction to adjudicate controversies growing out of subscription contracts. A breach of contract shall not be deemed a violation of this chapter.

Code 1950, § 32-195.20; 1956, c. 268, § 38.1-833; 1979, c. 721; 1986, c. 562.

§ 38.2-4229. Reinsurance.

Any nonstock corporation licensed under this chapter may by policy, treaty or other agreement cede to any insurer reinsurance upon the whole or any part of any risk, with or without contingent liability or participation, and if a mutual insurer, with or without membership therein.

1986, c. 562.

§ 38.2-4229.1. Conversion to domestic mutual insurer.

A. Any domestic nonstock corporation subject to the provisions of this chapter that has the surplus required by § 38.2-1030 for domestic mutual insurers issuing policies without contingent liability may, at its option and without reincorporation, convert to a domestic mutual insurer by following the procedure set forth in this section.

B. Any nonstock corporation eligible to convert to a domestic mutual insurer under subsection A may effect such conversion by amending its articles of incorporation to delete any reference to this chapter and to comply with the provisions of § 38.2-1002 relating to the articles of incorporation of a domestic mutual insurer. Upon the issuance of a certificate of amendment by the Commission, the conversion shall be effective, such nonstock corporation shall become subject to all of the provisions of this title relating to domestic mutual insurers, and such nonstock corporation shall no longer be subject to the provisions of this chapter.

C. If any nonstock corporation converts from a health services plan organized under this chapter to a domestic mutual insurer, then at least 90 days prior to the effective date of conversion, the nonstock corporation shall comply with § 38.2-316 by filing with the Commission copies of all policies of insurance that it proposes to issue after the effective date of conversion. All subscription contracts issued and outstanding as of the effective date of conversion shall remain in force in accordance with their terms until the expiration or termination of such contracts.

D. No policy of accident and sickness insurance issued by a nonstock corporation after its conversion to a domestic mutual insurer shall deny the policyholder the right to assign his benefit, except that denial may be made where the benefit is 80 percent of covered charges or greater.

1991, c. 87; 1992, c. 473; 1994, c. 294; 1997, cc. 807, 913; 2013, cc. 136, 210.

§ 38.2-4229.2. Hearings and investigations on effect of other state's law.

A. If another state enacts a law or takes any other regulatory action that requires a health services plan operating in the Commonwealth to provide a program or benefits for the residents of the other state or

to distribute or reduce its surplus on grounds that it is excessive in whole or in part, the Commission shall conduct a proceeding to review and evaluate the impact of the law or action on the health services plan. The Commission shall direct the Commissioner to conduct an examination of the health service plan in accordance with Article 4 (§ 38.2-1317 et seq.) of Chapter 13 and report its findings to the Commission, including the impact on (i) surplus; (ii) premium rates for residents of the Commonwealth covered by policies issued or delivered either in the Commonwealth or in any other state; and (iii) solvency.

B. Based on the findings of the Commissioner, the Commission shall determine whether the impact on the health services plan is harmful to the interests of residents of the Commonwealth covered by policies issued or delivered either in the Commonwealth or in any other state.

C. If the Commission determines the program or benefits for the residents of another state or the surplus distribution or reduction has an impact on the health services plan that is harmful to the interests of residents of the Commonwealth covered by policies issued or delivered either in the Commonwealth or in any other state, the Commission shall issue an appropriate order to protect such residents of the Commonwealth. The order may include:

1. A prohibition on the health services plan subsidizing the program or benefits for the residents of another state through:

a. Premiums charged or otherwise allocable to residents of the Commonwealth covered by policies issued or delivered either in the Commonwealth or in any other state; or

b. The use of any earned surplus attributable to residents of the Commonwealth covered by policies issued or delivered either in the Commonwealth or in any other state;

2. A prohibition on the health services plan's distributing or reducing its surplus for the benefit of residents of another state; or

3. Any other action the Commission finds necessary to protect the interests of the residents of the Commonwealth.

The determination of premiums charged or otherwise allocable to residents of the Commonwealth and the determination of surplus attributable to residents of the Commonwealth in each case covered by policies issued or delivered either in the Commonwealth or in any other state shall be based upon the number of residents in the Commonwealth compared with the number of residents in other states covered by the policies of the health services plan.

D. No health services plan shall distribute or reduce its surplus pursuant to a law or regulatory action the impact of which is subject to a proceeding under subsection A except with the approval of the Commission after the examination required by this section.

2010, c. 704; 2015, cc. 519, 520.

Article 2 - HOLDING COMPANIES

§ 38.2-4230. Definitions.

As used in this article:

"Affiliate" of a specific person or a person "affiliated" with a specific person means a person that directly or indirectly, through one or more intermediaries, controls, is controlled by or is under common control with the person specified.

"Control," including the terms "controlling," "controlled by" and "under common control with," means direct or indirect possession of the power to direct or cause the direction of the management and policies of a person through (i) the ownership of voting securities, (ii) by contract other than a commercial contract for goods or nonmanagement services, or (iii) otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person directly or indirectly owns, controls, holds with the power to vote, or holds proxies representing collectively ten percent or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided by subsection H of § 38.2-4231 that control does not exist. After giving all interested persons notice and opportunity to be heard and making specific findings to support its determination, the Commission may determine that control exists, notwithstanding the absence of a presumption to that effect.

"Holding company system" means two or more affiliated persons, one or more of which is a nonstock corporation licensed under this chapter.

"Surplus" means the excess of total admitted assets over the liabilities of a nonstock corporation licensed under this chapter, and shall include any contingency reserves maintained pursuant to § 38.2-4208 and any voluntary reserves.

"Transaction" means any (i) sale, purchase, exchange, renting or leasing arrangement, loan or extension of credit, arrangement for the assumption, extension or renewal of any obligation or liability, guaranty or surety arrangement, or investment; (ii) dividend or distribution of cash or property; (iii) reinsurance treaty or risk-sharing arrangement; (iv) management contract, service contract or cost-sharing arrangement; or (v) other arrangement, relationship or dealings that the Commission by order, rule or regulation determines to be a transaction contemplated by this article. A transaction shall not include any transaction which the Commission by rule or regulation exempts as not being material for the purpose of §§ 38.2-4231 and 38.2-4233. Any series of transactions occurring within a twelve-month period that are sufficiently similar in nature as to be reasonably construed as a single transaction and that in the aggregate exceed any minimum set forth in §§ 38.2-4231 and 38.2-4233 shall be deemed a transaction subject to the provisions of such sections.

"Voting security" means any security that enables the owner to vote for the election of directors. Voting security includes any security convertible into or evidencing a right to acquire a voting security.

1989, c. 606; 1992, c. 588.

§ 38.2-4231. Registration of nonstock corporations that are members of holding company system.

A. Each nonstock corporation licensed under this chapter that is a member of a holding company system shall register with the Commission. Any nonstock corporation subject to registration under this section shall register within fifteen days after it becomes subject to registration, unless the Commission extends the time for registration for good cause shown.

B. 1. This section shall not apply to:

a. Any foreign nonstock corporation subject to disclosure requirements and standards adopted by statute or regulation in the jurisdiction of its domicile that are substantially similar to those contained in this section;

b. Any nonstock corporation licensed under this chapter, information, or transaction if and to the extent that the Commission exempts the same from this section; or

c. Any transaction involving less than one-sixth of one percent of admitted assets or one percent of surplus as of the immediately preceding December 31, whichever is less.

2. Any nonstock corporation licensed under this chapter that is a member of a holding company system but not subject to registration under this section may be required by the Commission to furnish a copy of the registration statement, or other information filed by the nonstock corporation, with the regulatory authority of its domiciliary jurisdiction.

C. Each nonstock corporation subject to registration under this section shall file a registration statement on a form provided by the Commission. Such statement shall contain current information on:

1. The capital structure, general financial condition, ownership, and management of the nonstock corporation and any person controlling the nonstock corporation;

2. The identity of every member of the insurance holding company system;

3. The following agreements in force, continuing relationships and transactions currently outstanding between the nonstock corporation and its affiliates:

a. Loans or extensions of credit, other investments, or purchases, sales or exchanges of securities of the affiliates by the nonstock corporation or of the nonstock corporation by its affiliates;

b. Purchases, sales, renting or leasing arrangements, or exchanges of assets;

c. Guarantees or undertakings for the benefit of an affiliate that result in an actual contingent exposure of the nonstock corporation's assets to liability;

d. All management and service contracts and all cost-sharing arrangements;

e. Reinsurance agreements or other risk-sharing arrangements;

f. Transactions not in the ordinary course of business; and

4. Other matters relating to transactions between a registered nonstock corporation and any affiliates which may be included from time to time in any registration forms adopted or approved by the Commission.

D. Each registered nonstock corporation shall report all additional transactions with affiliates and any changes in previously reported transactions with affiliates on amendment forms provided by the Commission. Each nonstock corporation shall make its report within fifteen days after the end of the month in which it learns of each additional transaction or change in a transaction. Each registered nonstock corporation shall also keep current the information required by subsection C of this section by filing an amendment to its registration statement within 120 days after the end of each fiscal year of the ultimate controlling person of the holding company system.

E. The Commission shall terminate the registration of any nonstock corporation that demonstrates it no longer is a member of a holding company system.

F. The Commission may require or allow two or more affiliated nonstock corporations subject to registration under this section to file a consolidated registration statement or consolidated reports amending their consolidated registration statement or their individual registration statements.

G. The Commission may allow a nonstock corporation which is licensed under this chapter and which is part of a holding company system, to register on behalf of any affiliated nonstock corporation required to register under subsection A of this section and to file all information and material required to be filed under this section.

H. Any person may file with the Commission a disclaimer of affiliation with any licensed nonstock corporation. The disclaimer shall fully disclose all relationships and bases for affiliation between the person and the nonstock corporation as well as the basis for disclaiming the affiliation. After a disclaimer has been filed, the nonstock corporation shall be relieved of any registration or reporting requirements under this section that may arise out of the nonstock corporation's relationship with the person unless and until the Commission disallows the disclaimer. The Commission shall disallow the disclaimer only after giving all interested parties notice and opportunity to be heard. Any disallowance shall be supported by specific findings of fact.

1989, c. 606; 1992, c. 588.

§ 38.2-4232. Standards for transactions with affiliates; adequacy of surplus; dividends and other distributions.

A. Transactions by nonstock corporations licensed under this chapter with their affiliates shall be subject to the following standards:

1. The terms shall be fair and reasonable;

2. Charges and fees for service performed shall be reasonable;

3. Expenses incurred and payments received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied;

4. The books, accounts, and records of each party shall disclose clearly and accurately the precise nature and details of the transactions;

5. The nonstock corporation's surplus following any transaction with affiliates involving more than one-sixth of one percent of admitted assets or one percent of surplus as of the immediately preceding December 31, whichever is less, shall be reasonable in relation to the nonstock corporation's outstanding liabilities and adequate to its financial needs; and

6. The transaction is in the best interest of the subscribers.

B. For purposes of this article, in determining whether a nonstock corporation's surplus is reasonable in relation to the nonstock corporation's outstanding liabilities and adequate to its financial needs, the following factors, among others, shall be considered:

1. The size of the nonstock corporation as measured by its assets, surplus, reserves, business in force, and other appropriate criteria;

2. The nonstock corporation's method of operation and manner of doing business;

3. The nature and extent of the nonstock corporation's risk-sharing arrangements;

4. The quality, diversification, and liquidity of the nonstock corporation's investment portfolio;

5. The recent past and projected future trend in the size of the nonstock corporation's surplus;

6. The adequacy of the nonstock corporation's reserves; and

7. The quality and liquidity of investments in subsidiaries. The Commission in its judgment may classify any investment as a nonadmitted asset for the purpose of determining the adequacy of surplus.

1989, c. 606; 1992, c. 588.

§ 38.2-4233. Commission approval required for certain transactions.

A. Prior written approval of the Commission shall be required for any transaction between a nonstock corporation licensed under this chapter and any of its affiliates, if such transaction involves more than three-fourths of one percent of admitted assets or five percent of surplus as of the immediately preceding December 31, whichever is less. Failure of the Commission to act within sixty days after notification by the nonstock corporation shall constitute approval of the transaction.

B. Nothing contained in this section shall authorize or permit any transaction that would be otherwise contrary to law.

C. The Commission, in reviewing any transaction under this section, shall consider whether the transaction complies with the standards set forth in § 38.2-4232. The Commission shall set forth the specific reasons for the disapproval of any transaction.

D. The approval of any transaction under this section shall be deemed an amendment under subsection D of § 38.2-4231 to a nonstock corporation's registration statement without further filing.

E. The Commission shall have continuing oversight over the terms and conditions of all continuing transactions by a nonstock corporation licensed under this chapter with its affiliates. The Commission may prohibit the continuation of any continuing transaction if the Commission finds that, because of changed circumstances or material information unknown to the Commission at the time of the approval of the transaction, the transaction does not comply with the standards set forth in § 38.2-4232.

F. Existing transactions entered into between a nonstock corporation and its affiliates prior to July 1, 1989, shall be filed with the Commission for approval no later than September 1, 1989, if such transaction involves more than three-fourths of one percent of admitted assets or five percent of surplus as of the immediately preceding December 31, whichever is less. Failure of the Commission to act within 120 days after such filings shall constitute approval of such transactions. The Commission shall not disapprove any transaction entered into prior to July 1, 1989, if such transaction was lawful when entered into, but if any such transaction is found not to meet the standards of this section, such transaction shall not be renewed or extended except upon terms approved by the Commission.

G. Any nonstock corporation aggrieved by a disapproval or withdrawal of approval under this section may proceed under the provisions of § 38.2-222.

H. For the purposes of this section, a "transaction between a nonstock corporation licensed under this chapter and any of its affiliates" includes any transaction between a nonstock corporation licensed under this chapter and a nonaffiliate if such transaction involves (i) any loan or extension of credit where the licensee makes such loan or extension of credit with the agreement or understanding that the proceeds of such transaction, in whole or substantial part, are to be used to make any loan or extension of credit to, to purchase assets of, or to make investments in any affiliate of the licensee or (ii) any reinsurance agreement or risk-sharing arrangement, or modifications thereto, which requires as consideration the transfer of assets from a licensee to a nonaffiliate, if an agreement or understanding exists between the licensee and the nonaffiliate that any portion of such assets will be transferred to one or more affiliates of the licensee.

1989, c. 606; 1993, c. 158.

§ 38.2-4234. Examinations.

A. In addition to the powers the Commission has under Article 4 of Chapter 13 (§ 38.2-1317 et seq.) of this title, the Commission shall also have the power to order any nonstock corporation registered under § 38.2-4231 to produce any records, books, or other information papers in the possession of the nonstock corporation or its affiliates necessary to determine the financial condition or legality of conduct of the nonstock corporation. If the nonstock corporation fails to comply with the order, the Commission shall have the power to examine its affiliates to obtain the information.

B. The Commission shall exercise its power under subsection A of this section only if the examination of the nonstock corporation under Article 4 of Chapter 13 (§ 38.2-1317 et seq.) of this title is inadequate or the interests of the subscribers of the nonstock corporation may be adversely affected.

C. The Commission may retain at the expense of the registered nonstock corporation any attorneys, actuaries, accountants and other experts reasonably necessary to assist in the conduct of the examination under subsection A of this section. Any persons so retained shall be under the direction and control of the Commission and shall act in a purely advisory capacity.

D. Each nonstock corporation producing books and papers for examination records pursuant to subsection A of this section shall be liable for and shall pay the expense of the examination in accordance with the provisions of Article 4 of Chapter 13 (§ 38.2-1317 et seq.) of this title.

1989, c. 606; 1992, c. 588.

§ 38.2-4235. Confidential treatment of information and documents.

All information, documents and copies obtained by or disclosed to the Commission or any other person in the course of an examination or investigation made pursuant to § 38.2-4234, and all information reported pursuant to § 38.2-4231, shall be confidential, shall not be subject to subpoena, and shall not be made public by the Commission or any other person without the prior written consent of the nonstock corporation to which they pertain. However, this provision shall not apply to information disclosed to (i) a regulatory official of any state or country; (ii) the National Association of Insurance Commissioners, its affiliate or its subsidiary; or (iii) a law-enforcement authority of any state or country. Any such disclosure by the Commission shall not constitute a waiver of confidentiality of such information. After the licensed nonstock corporation and its affiliates have been given notice and opportunity to be heard, the Commission may publish all or any part of the information and materials referred to in this section in any manner it considers appropriate, if it determines that the interests of subscribers or the public will be served by the publication.

1989, c. 606; 2001, c. 519.

Chapter 43 - Health Maintenance Organizations

§ 38.2-4300. Definitions.

As used in this chapter:

"Acceptable securities" means securities that (i) are legal investments under the laws of the Commonwealth for public sinking funds or for other public funds, (ii) are not in default as to principal or interest, (iii) have a current market value of not less than $50,000 nor more than $500,000, and (iv) are issued pursuant to a system of book-entry evidencing ownership interests of the securities with transfers of ownership effected on the records of the depository and its participants pursuant to rules and procedures established by the depository.

"Basic health care services" means in and out-of-area emergency services, inpatient hospital and physician care, outpatient medical services, laboratory and radiologic services, mental health and substance use disorder benefits, and preventive health services. In the case of a health maintenance organization that has contracted with the Commonwealth to furnish basic health services to recipients of medical assistance under Title XIX of the United States Social Security Act pursuant to § 38.2-

4320, the basic health services to be provided by the health maintenance organization to program recipients may differ from the basic health services required by this section to the extent necessary to meet the benefit standards prescribed by the state plan for medical assistance services authorized pursuant to § 32.1-325.

"Copayment" means an amount an enrollee is required to pay in order to receive a specific health care service.

"Deductible" means an amount an enrollee is required to pay out-of-pocket before the health care plan begins to pay the costs associated with health care services.

"Emergency services" means those health care services that are rendered by affiliated or nonaffiliated providers after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in (i) serious jeopardy to the mental or physical health of the individual, (ii) danger of serious impairment of the individual's bodily functions, (iii) serious dysfunction of any of the individual's bodily organs, or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus. Emergency services provided within the plan's service area shall include covered health care services from nonaffiliated providers only when delay in receiving care from a provider affiliated with the health maintenance organization could reasonably be expected to cause the enrollee's condition to worsen if left unattended.

"Enrollee" or "member" means an individual who is enrolled in a health care plan.

"Evidence of coverage" means any certificate or individual or group agreement or contract issued in conjunction with the certificate, agreement or contract, issued to a subscriber setting out the coverage and other rights to which an enrollee is entitled.

"Excess insurance" or "stop loss insurance" means insurance issued to a health maintenance organization by an insurer licensed in the Commonwealth, on a form approved by the Commission, or a risk assumption transaction acceptable to the Commission, providing indemnity or reimbursement against the cost of health care services provided by the health maintenance organization.

"Health care plan" means any arrangement in which any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services. A significant part of the arrangement shall consist of arranging for or providing health care services, including emergency services and services rendered by nonparticipating referral providers, as distinguished from mere indemnification against the cost of the services, on a prepaid basis. For purposes of this section, a significant part shall mean at least 90 percent of total costs of health care services.

"Health care services" means the furnishing of services to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability.

"Health maintenance organization" means any person who undertakes to provide or arrange for one or more health care plans.

"Limited health care services" means dental care services, vision care services, and such other services as may be determined by the Commission to be limited health care services. Limited health care services shall not include hospital, medical, surgical, or emergency services except as such services are provided incident to the limited health care services set forth in the preceding sentence.

"Net worth" or "capital and surplus" means the excess of total admitted assets over the total liabilities of the health maintenance organization, provided that surplus notes shall be reported and accounted for in accordance with guidance set forth in the National Association of Insurance Commissioners (NAIC) accounting practice and procedures manuals.

"Nonparticipating referral provider" means a provider who is not a participating provider but with whom a health maintenance organization has arranged, through referral by its participating providers, to provide health care services to enrollees. Payment or reimbursement by a health maintenance organization for health care services provided by nonparticipating referral providers may exceed five percent of total costs of health care services, only to the extent that any such excess payment or reimbursement over five percent shall be combined with the costs for services which represent mere indemnification, with the combined amount subject to the combination of limitations set forth in this definition and in this section's definition of health care plan.

"Participating provider" means a provider who has agreed to provide health care services to enrollees and to hold those enrollees harmless from payment with an expectation of receiving payment, other than copayments or deductibles, directly or indirectly from the health maintenance organization.

"Provider" or "health care provider" means any physician, hospital, or other person that is licensed or otherwise authorized in the Commonwealth to furnish health care services.

"Subscriber" means a contract holder, an individual enrollee, or the enrollee in an enrolled family who is responsible for payment to the health maintenance organization or on whose behalf such payment is made.

1980, c. 720, § 38.1-863; 1986, cc. 76, 528, 562; 1990, c. 224; 1992, cc. 241, 481; 1993, c. 305; 1995, cc. 182, 345; 2000, c. 503; 2003, cc. 752, 767; 2004, c. 175; 2006, c. 448; 2015, c. 649.

§ 38.2-4301. Establishment of health maintenance organizations.

A. No person shall establish or operate a health maintenance organization in the Commonwealth without obtaining a license from the Commission. Any person, including a foreign corporation, may apply to the Commission for a license to establish and operate a health maintenance organization in compliance with this chapter.

B. Each application for a license shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the Commission, and shall set forth or be accompanied by the following:

1. A copy of any basic organizational document of the applicant including, but not limited to, the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments to those documents;

2. A copy of the bylaws, rules and regulations, or any similar document regulating the conduct of the internal affairs of the applicant;

3. A list of the names, addresses, and official positions, and biographical information on forms acceptable to the Commission of each member of the governing body and any person with authority to manage or establish policy; and a full disclosure in the application of (i) any financial interest between such persons or any provider, organization or corporation owned or controlled by such person and the health maintenance organization and (ii) the extent and nature of the financial arrangements between such persons and the health maintenance organization;

4. A disclosure of any person owning or having the right to acquire five percent or more of the voting securities or subordinated debt of the applicant;

5. A copy of any contract made or to be made between any providers, sponsors, or organizers of the health maintenance organization, or persons listed in subdivision 3 of this subsection and the applicant;

6. A copy of the evidence of coverage form to be issued to subscribers;

7. A copy of any group contract form that is to be issued to employers, unions, trustees, or other organizations. All group contracts shall set forth the right of subscribers to convert their coverages to an individual contract issued by the health maintenance organization;

8. Financial statements showing the applicant's assets, liabilities, and sources of financial support and, if the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent certified financial statement unless the Commission directs that additional or more recent financial information is required for the proper administration of this chapter;

9. A complete description of the health maintenance organization and its method of operation, including (i) the method of marketing the plan, (ii) a statement regarding the sources of working capital as well as any other sources of funding, and (iii) a description of any insurance, reinsurance, or alternative coverage arrangements proposed, including excess insurance or stop loss insurance;

10. A description of the mechanism by which enrollees will be given an opportunity to participate in matters of policy and operation as provided in subsection B of § 38.2-4304;

11. A financial feasibility plan which includes, but is not limited to, (i) detailed enrollment projections, (ii) the methodology for determining premium rates to be charged during at least the first three years of operations and extending one year beyond the anticipated break-even point certified by an actuary, and (iii) a projection, along with material assumptions, of balance sheets, cash flow statements showing capital expenditures and purchase and sale of investments, income statements, and statements of

anticipated covered and uncovered expenses on a quarterly basis for at least three years and extending one year beyond the anticipated break-even point; and

12. Any other information the Commission may require to make the determinations required pursuant to § 38.2-4302.

C. Notwithstanding any other provision of this title, no license shall be required of a health maintenance organization duly licensed in a state contiguous to the Commonwealth that contracts on a limited basis with health care providers in the Commonwealth for the provision of health care services to enrollees covered under a group contract neither delivered nor issued for delivery in the Commonwealth, provided that:

1. The number of Virginia residents receiving such health care services shall not exceed 500 enrollees of such health maintenance organization; and

2. The contracts with such providers shall contain a hold harmless clause that is not less favorable in any respect to any enrollee that is a Virginia resident than the "hold harmless clause" set forth in subdivision C 9 of § 38.2-5805.

1980, c. 720, § 38.1-864; 1986, c. 562; 1998, c. 891; 2000, cc. 503, 753; 2004, c. 175.

§ 38.2-4302. Issuance of license; fee; minimum net worth; impairment.

A. The Commission shall issue a license to a health maintenance organization after the receipt of a complete application and payment of a $500 nonrefundable application fee if the Commission is satisfied that the following conditions are met:

1. The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy, and reputable;

2. The health care plan constitutes an appropriate mechanism for the health maintenance organization to provide or arrange for the provision of, as a minimum, basic health care services or limited health care services on a prepaid basis, except to the extent of reasonable requirements for copayments, deductibles, or both;

3. The health maintenance organization is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the Commission may consider:

a. The financial soundness of the health care plan's arrangements for health care services and the schedule of prepaid charges used for those services;

b. The adequacy of working capital;

c. Any agreement with an insurer, a health services plan, a government, or any other organization for insuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage if the health care plan is discontinued;

d. Any contracts with health care providers that set forth the health care services to be performed and the providers' responsibilities for fulfilling the health maintenance organization's obligations to its enrollees;

e. The deposit of acceptable securities in an amount satisfactory to the Commission, submitted in accordance with § 38.2-4310 as a guarantee that the obligations to the enrollees will be duly performed;

f. The applicant's net worth which shall include minimum net worth in an amount at least equal to the sum of uncovered expenses, but not less than $600,000, up to a maximum of $4 million; uncovered expenses shall be amounts determined from the most recently ended calendar quarter pursuant to regulations promulgated by the Commission; and

g. A financial statement of the health maintenance organization on the form required by § 38.2-4307;

4. The enrollees will be given an opportunity to participate in matters of policy and operation as required by § 38.2-4304; and

5. Nothing in the method of operation is contrary to the public interest, as shown in the information submitted pursuant to § 38.2-4301 or Chapter 58 (§ 38.2-5800 et seq.) or by independent investigation. Issuance of a license shall not constitute approval of the forms submitted under subdivisions B 6, 7, and 12 of § 38.2-4301.

B. A licensed health maintenance organization shall have and maintain at all times the minimum net worth described in subdivision A 3 f.

1. If the Commission finds that the minimum net worth of a domestic health maintenance organization is impaired, the Commission shall issue an order requiring the health maintenance organization to eliminate the impairment within a period not exceeding 90 days. The Commission may by order served upon the health maintenance organization prohibit the health maintenance organization from issuing any new contracts while the impairment exists. If at the expiration of the designated period the health maintenance organization has not satisfied the Commission that the impairment has been eliminated, an order for the rehabilitation or liquidation of the health maintenance organization may be entered.

2. If the Commission finds an impairment of the minimum net worth of any foreign health maintenance organization, the Commission may order the health maintenance organization to eliminate the impairment and restore the minimum net worth to the amount required by this section. The Commission may, by order served upon the health maintenance organization, prohibit the health maintenance organization from issuing any new contracts while the impairment exists. If the health maintenance organization fails to comply with the Commission's order within a period of not more than 90 days, the Commission may, in the manner set out in § 38.2-4316, suspend or revoke the license of the health maintenance organization.

3. Prior to December 31, 1999, a health maintenance organization with less than minimum net worth which is licensed on and after June 30, 1998, may continue to operate as a licensed health maintenance organization without a finding of impairment if the licensee has net worth (i) on June 30, 1998, and up to December 31, 1998, in an amount at least equal to the sum of uncovered expenses, but not less than $300,000, up to a maximum of $2 million; (ii) on December 31, 1998, and up to June 30, 1999, in an amount at least equal to the sum of uncovered expenses, but not less than $400,000, up to a maximum of $2.5 million; and (iii) on June 30, 1999, and up to December 31, 1999, in an amount at least equal to the sum of uncovered expenses, but not less than $500,000, up to a maximum of $3 million.

1980, c. 720, § 38.1-865; 1981, c. 317; 1986, c. 562; 1992, c. 481; 1998, cc. 42, 891; 2000, c. 503; 2003, cc. 752, 767; 2004, c. 175; 2018, c. 706.

§ 38.2-4303. Powers.

A. The powers of a health maintenance organization shall include, but shall not be limited to, the following, provided that the activities comply with all applicable state statutes and regulations:

1. The purchase, lease, construction, renovation, operation, or maintenance of hospitals, medical or other health care facilities, and their ancillary equipment and other property reasonably required for its principal office or for other purposes necessary in the transaction of the business of the organization;

2. The making of loans to (i) health care providers under contract with it in advancement of its health care plan or (ii) any corporation under its control for the purpose of acquiring or constructing medical or other health care facilities and hospitals or in advancement of its health care plan providing health care services to enrollees;

3. The furnishing of health care services through providers that are under contract with or employed by the health maintenance organization;

4. The contracting with any person for the performance on its behalf of certain functions including, but not limited to, marketing, enrollment and administration;

5. The contracting with an insurer or with a health services plan licensed in this Commonwealth, for the provision of insurance, indemnity, or reimbursement for the cost of health care services provided by the health maintenance organization;

6. The offering, in addition to basic health care services, of:

a. Additional health care services;

b. Indemnity benefits covering out-of-area services; and

c. Indemnity benefits, in addition to those relating to out-of-area services, provided through insurers or health services plans;

7. The offering of health care plans for limited health care services; and

8. The requirement for the enrollee to pay a deductible or copayment, or both, for any health care services offered pursuant to this chapter.

B. 1. A health maintenance organization shall file notice with the Commission within 30 days after the exercise of any power granted in subdivision 1 or 2 of subsection A of this section that exceeds one percent of the admitted assets of the organization or five percent of net worth, whichever is less. A health maintenance organization shall file notice, with adequate supporting information, with the Commission prior to the exercise of any power granted in subdivision 1 or 2 of subsection A of this section that exceeds five percent of the admitted assets of the organization or 25 percent of net worth, whichever is less. Any series of transactions occurring within a 12-month period that are sufficiently similar in nature to be reasonably construed as a single transaction shall be subject to the limitations set forth in this section. The Commission shall disapprove the exercise of power if the Commission believes such exercise of power would substantially and adversely affect the financial soundness of the health maintenance organization and endanger the health maintenance organization's ability to meet its obligations. If the Commission does not disapprove the exercise of power within 30 days of the filing, it shall be deemed approved.

2. Upon application by the health maintenance organization, the Commission may exempt from the filing requirement of subdivision 1 of subsection B of this section those activities having a minimal effect.

1980, c. 720, § 38.1-866; 1986, c. 562; 1990, c. 224; 1992, c. 481; 2003, cc. 752, 767; 2008, c. 214.

§ 38.2-4304. Governing body.

A. The governing body of any health maintenance organization may include providers of health care services, other individuals, or both, but in no event shall any class of health care provider be excluded from eligibility for membership on the governing body of any health maintenance organization.

B. The governing body shall establish a mechanism to provide the enrollees with an opportunity to participate in matters of policy and operation through (i) the establishment of advisory panels, (ii) the use of advisory referenda on major policy decisions, or (iii) the use of other mechanisms.

1980, c. 720, § 38.1-867; 1985, c. 588; 1986, c. 562.

§ 38.2-4305. Fiduciary responsibilities.

Any director, officer or partner of a health maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of the organization shall be responsible for the funds in a fiduciary relationship with the subscribers and enrollees.

1980, c. 720, § 38.1-868; 1986, c. 562.

§ 38.2-4306. Evidence of coverage and charges for health care services.

A. 1. Each subscriber shall be entitled to evidence of coverage under a health care plan.

2. No evidence of coverage, or amendment to it, shall be delivered or issued for delivery in this Commonwealth until a copy of the form of the evidence of coverage, or amendment to it, has been filed

with and approved by the Commission, subject to the provisions of subsection C of this section. Any evidence of coverage for enrollees in the plans administered by the Department of Medical Assistance Services that provide benefits pursuant to Title XIX or Title XXI of the Social Security Act, as amended, is excluded from the provisions of this section.

3. No evidence of coverage shall contain provisions or statements which are unjust, unfair, untrue, inequitable, misleading, deceptive or misrepresentative.

4. An evidence of coverage shall contain a clear and complete statement if a contract, or a reasonably complete summary if a certificate, of:

a. The health care services and any insurance or other benefits to which the enrollee is entitled under the health care plan;

b. Any limitations on the services, kind of services, benefits, or kind of benefits to be provided, including any deductible or copayment feature, or both;

c. Where and in what manner information is available as to how services may be obtained;

d. The total amount of payment for health care services and any indemnity or service benefits that the enrollee is obligated to pay with respect to individual contracts, or an indication whether the plan is contributory or noncontributory for group certificates;

e. A description of the health maintenance organization's method for resolving enrollee complaints. Any subsequent change may be evidenced in a separate document issued to the enrollee; and

f. A list of providers and a description of the service area which shall be provided with the evidence of coverage, if such information is not given to the subscriber at the time of enrollment.

B. Pursuant to this subsection:

1. No schedule of charges or amendment to the schedule of charges for enrollee coverage for health care services may be used in conjunction with any health care plan until a copy of the schedule, or its amendment, has been filed with the Commission. Any schedule of charges or amendment to the schedule of charges for enrollees in the plans administered by the Department of Medical Assistance Services that provide benefits pursuant to Title XIX or Title XXI of the Social Security Act, as amended, is excluded from the provisions of this subsection.

2. The charges may be established for various categories of enrollees based upon sound actuarial principles, provided that charges applying to an enrollee in a group health plan shall not be individually determined based on the status of his health. A certification on the appropriateness of the charges, based upon reasonable assumptions, may be required by the Commission to be filed along with adequate supporting information. This certification shall be prepared by a qualified actuary or other qualified professional approved by the Commission.

C. The Commission shall, within a reasonable period, approve any form if the requirements of subsection A of this section are met. It shall be unlawful to issue a form until approved. If the Commission

disapproves a filing, it shall notify the filer. The Commission shall specify the reasons for its disapproval in the notice. A written request for a hearing on the disapproval may be made to the Commission within 30 days after notice of the disapproval. If the Commission does not disapprove any form within 30 days of the filing of such form, it shall be deemed approved unless the filer is notified in writing that the waiting period is extended by the Commission for an additional 30 days. Filing of the form means actual receipt by the Commission.

D. The Commission may require the submission of any relevant information it considers necessary in determining whether to approve or disapprove a filing made under this section.

E. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

1980, c. 720, § 38.1-869; 1986, c. 562; 1997, cc. 807, 913; 2003, cc. 752, 767; 2004, c. 185; 2006, c. 866; 2013, c. 751; 2014, c. 814.

§ 38.2-4306.1. Interest on claim proceeds.

A. If an action to recover the claim proceeds due under a health care plan results in a judgment against a health maintenance organization, interest on the judgment at the legal rate of interest shall be paid from the date of presentation to the health maintenance organization of proof of loss to the date judgment is entered.

B. If no action is brought, interest upon the claim proceeds paid to the subscriber, claimant, or assignee entitled thereto shall be computed daily at the legal rate of interest from the date of thirty calendar days from the health maintenance organization's receipt of proof of loss to the date of claim payment.

C. This section shall not apply to individual contracts issued prior to July 1, 1990, but shall apply to any renewals or reissues of group contracts occurring after that date.

D. This section shall not apply to claims for which payment has been or will be made directly to health care providers pursuant to a negotiated reimbursement arrangement requiring uniform or periodic interim payments to be applied against the health maintenance organization's obligation on such claims.

E. For purposes of this section, "proof of loss" means all necessary documentation reasonably required by the health maintenance organization to make a determination of benefit coverage.

1992, c. 23; 1996, c. 75.

§ 38.2-4307. Annual statement.

A. Each health maintenance organization shall file a statement with the Commission annually by March 1. The statement shall be verified by at least two principal officers and shall cover the preceding calendar year. Each health maintenance organization shall also send a copy of the statement to the State Health Commissioner.

B. The statement shall be on forms prescribed by the Commission and shall include:

1. A financial statement of the organization, including its balance sheet and income statement for the preceding year;

2. Any material changes in the information submitted pursuant to subsection B of § 38.2-4301;

3. The number of persons enrolled during the year, the number of enrollees as of the end of the year and the number of enrollments terminated during the year; and

4. Any other information relating to the operations of the health maintenance organization required by the Commission pursuant to this chapter or Chapter 58 (§ 38.2-5800 et seq.) of this title.

C. If the health maintenance organization is audited annually by an independent certified public accountant, a copy of the certified audit report shall be filed annually with the Commission by June 30.

D. The Commission may extend the time prescribed for filing annual statements or other reports or exhibits of any health maintenance organization for good cause shown. However, the Commission shall not extend the time for filing annual statements beyond sixty days after the time prescribed by subsection A of this section. Any health maintenance organization which fails to file its annual statement within the time prescribed by this section shall be subject to a fine as specified in § 38.2-218.

E. The Commission may prescribe the form of the annual statement and supplemental schedules and exhibits to include additional copies in machine-readable format, and may vary the form requirements for different types of health maintenance organizations. However, as far as practicable, the form for annual statements, supplementary schedules, and exhibits shall be the same as other such forms in general use in the United States. Unless otherwise prescribed by the Commission, such annual statements shall be prepared using an annual statement convention blank developed by the National Association of Insurance Commissioners (NAIC). The annual statement, and supplementary schedules and exhibits required by this section, shall be prepared in accordance with the appropriate annual statement instructions and the accounting practices and procedures manual adopted by the NAIC, or any successor publications.

F. At the request of the Commission, a health maintenance organization that is licensed under this chapter shall annually on or before March 1 of each year, file with the NAIC a copy of its annual statement convention blank, along with such additional filings as prescribed by the Commission for the preceding year. Unless otherwise prescribed by the Commission, the information filed with the NAIC shall be in the same format and scope as that required by the Commission and shall include the signed jurat page and any actuarial certification required by the Commission. Any amendments and addenda to the annual statement filed subsequently with the Commission shall also be filed with the NAIC.

1980, c. 720, § 38.1-870; 1986, c. 562; 1987, c. 520; 1998, c. 891; 1999, c. 482.

§ 38.2-4307.1. Additional reports.

A. In addition to the annual statement, the Commission may require a licensed health maintenance organization to file additional reports, exhibits or statements considered necessary to secure complete

information concerning the condition, solvency, experience, transactions or affairs of the health maintenance organization. The Commission shall establish reasonable deadlines for filing these additional reports, exhibits, or statements and may require verification by any officers of the health maintenance organization designated by the Commission.

B. The Commission may require a licensed health maintenance organization to file with the National Association of Insurance Commissioners (NAIC) a copy of its financial statement required to be filed pursuant to § 38.2-4307, on a quarterly basis. Unless otherwise prescribed by the Commission, all such financial statements, whether filed with the Commission or the NAIC, shall be prepared in accordance with applicable provisions of the annual statement instructions and the accounting practices and procedures manual adopted by the NAIC, or any successor publications. The Commission may prescribe that additional copies of financial statements and other reports be filed in machine-readable format.

C. Each annual and quarterly statement shall be accompanied by a statement of covered and uncovered expenses. The statement shall be prepared in accordance with instructions prescribed by the Commission for reporting the expenses of the health maintenance organization during the three months comprising the most recently ended calendar-year quarter. The statement of covered and uncovered expenses shall not be required for any health maintenance organization that reports a capital and surplus amount of at least $4,500,000 on its most recent annual or quarterly financial statement filed with the Commission.

1990, c. 224; 1999, c. 482; 2000, c. 503; 2006, c. 448.

§ 38.2-4308. Repealed.

Repealed by Acts 1998, c. 891.

§ 38.2-4309. Investments.

A health maintenance organization may invest in any Category 1 investment as defined in Chapter 14 of this title or any other investment the Commission may permit pursuant to provisions in Chapter 14 (§ 38.2-1400 et seq.) of this title. For investments made prior to July 1, 1998, by a health maintenance organization which is licensed on and after June 30, 1998, July 1, 1998 may be deemed the date of investment.

1980, c. 720, § 38.1-873; 1986, c. 562; 1998, c. 42.

§ 38.2-4310. Protection against insolvency.

Each health maintenance organization shall deposit and maintain acceptable securities with the State Treasurer in amounts prescribed by § 38.2-4310.1. The deposit shall be held as a special fund in trust, as a guarantee that the obligations to the enrollees who are residents of this Commonwealth will be performed. The securities shall be deposited pursuant to a system of book-entry evidencing ownership interests of the securities with transfers of ownership interests effected on the records of a depository and its participants pursuant to rules and procedures established by the depository. Upon a determination of insolvency or action by the Commission pursuant to Chapter 15 (§ 38.2-1500 et seq.),

the deposit shall be an asset subject to the provisions of Chapter 15 and shall be used to protect the interests of the health maintenance organization's enrollees and to assure continuation of covered services to enrollees. A health maintenance organization shall be subject to the provisions of Chapter 17 (§ 38.2-1700 et seq.).

1980, c. 720, § 38.1-874; 1986, c. 562; 1989, c. 216; 1990, c. 224; 1992, cc. 14, 20; 2000, c. 503; 2014, c. 814; 2018, c. 706; 2021, Sp. Sess. I, c. 158.

§ 38.2-4310.1. Deposits.

A. A health maintenance organization shall make its initial deposit prior to licensure in an amount not less than $300,000. The Commission shall review a health maintenance organization's deposit requirement at least once each year and may require an additional deposit in an amount equal to the greater of (i) the sum of all uncovered expenses for the most recent three months reported in accordance with § 38.2-4307.1 B or (ii) the value of liabilities representing uncovered health care expenses.

B. The Commission may reduce or waive, and also may direct the State Treasurer to return, any or all of a deposit requirement whenever the Commission, in its discretion, is satisfied that the assets of the health maintenance organization or its contracts with insurers, health services plans, governments, or other organizations are sufficient to assure the performance of its obligations to enrollees.

C. A health maintenance organization that has experienced an operating profit for the two most recent years may request that its deposit requirement be reduced. "Operating profit" shall be determined by reference to the annual statements filed by the health maintenance organization and shall mean the excess of total revenue, excluding net investment income, over total expenses.

2000, c. 503.

§ 38.2-4311. Repealed.

Repealed by Acts 1998, c. 891.

§ 38.2-4312. Prohibited practices.

A. No health maintenance organization or its representative may cause or knowingly permit the use of (i) advertising that is untrue or misleading, (ii) solicitation that is untrue or misleading, or (iii) any form of evidence of coverage that is deceptive. For the purposes of this chapter:

1. A statement or item of information shall be deemed to be untrue if it does not conform to fact in any respect that is or may be significant to an enrollee or person considering enrollment in a health care plan;

2. A statement or item of information shall be deemed to be misleading, whether or not it may be literally untrue, if the statement or item of information may be understood by a reasonable person who has no special knowledge of health care coverage as indicating (i) a benefit or advantage if that benefit or advantage does not in fact exist or (ii) the absence of any exclusion, limitation or disadvantage of possible significance to an enrollee or person considering enrollment in a health care plan if the absence of that exclusion, limitation, or disadvantage does not in fact exist; consideration shall be

given to the total context in which the statement is made or the item of information is communicated; and

3. An evidence of coverage shall be deemed to be deceptive if it causes a reasonable person who has no special knowledge of health care plans to expect benefits, services, charges, or other advantages that the evidence of coverage does not provide or that the health care plan issuing the evidence of coverage does not regularly make available for enrollees covered under the evidence of coverage; consideration shall be given to the evidence of coverage taken as a whole and to the typography, format, and language.

B. The provisions of Chapter 5 (§ 38.2-500 et seq.) of this title shall apply to health maintenance organizations, health care plans, and evidences of coverage except to the extent that the Commission determines that the nature of health maintenance organizations, health care plans, and evidences of coverage render any of the provisions clearly inappropriate.

C. No health maintenance organization, unless licensed as an insurer, may use in its name, contracts, or literature (i) any of the words "insurance," "casualty," "surety," "mutual," or (ii) any other words descriptive of the insurance, casualty, or surety business or deceptively similar to the name or description of any insurance or fidelity and surety insurer doing business in this Commonwealth.

D. No health maintenance organization shall discriminate on the basis of race, creed, color, sex or religion in the selection of health care providers for participation in the organization.

E. No health maintenance organization shall unreasonably discriminate against physicians as a class or any class of providers listed in § 38.2-4221 or pharmacists when contracting for specialty or referral practitioners or providers, provided the plan covers services which the members of such classes are licensed to render. Nothing contained in this section shall prevent a health maintenance organization from selecting, in the judgment of the health maintenance organization, the numbers of providers necessary to render the services offered by the health maintenance organization.

F. No contract between a health maintenance organization and a provider shall include provisions which require a health care provider or health care provider group to deny covered services that such provider or group knows to be medically necessary and appropriate that are provided with respect to a specific enrollee or group of enrollees with similar medical conditions.

1980, c. 720, § 38.1-876; 1985, c. 588; 1986, c. 562; 1989, c. 221; 1997, c. 297; 1998, c. 891; 1999, cc. 643, 649.

§ 38.2-4312.1. Pharmacies; freedom of choice.

A. Notwithstanding any other provision in this chapter, no health maintenance organization providing health care plans, or its pharmacy benefits manager, as defined in § 38.2-3465, shall prohibit any person receiving pharmaceutical benefits, including specialty pharmacy benefits, thereunder from selecting, without limitation, the pharmacy of his choice to furnish such benefits. This right of selection extends to and includes any pharmacy that is not a participating provider under any such health care

plan and that has previously notified the health maintenance organization or its pharmacy benefits manager on its own behalf or through an intermediary, by facsimile or otherwise, of its agreement to accept reimbursement for its services at rates applicable to pharmacies that are participating providers, including any copayment consistently imposed by the plan, as payment in full. Each health maintenance organization or its pharmacy benefits manager shall permit prompt electronic or telephonic transmittal of the reimbursement agreement by the pharmacy and ensure prompt verification to the pharmacy of the terms of reimbursement. In no event shall any person receiving a covered pharmacy benefit from a nonparticipating provider that has submitted a reimbursement agreement be responsible for amounts that may be charged by the nonparticipating provider in excess of the copayment and the health maintenance organization's reimbursement applicable to all of its participating pharmacy providers. If a pharmacy has provided notice pursuant to this subsection through an intermediary, the health maintenance organization or its intermediary may elect to respond directly to the pharmacy instead of the intermediary. Nothing in this subsection shall (i) require a health maintenance organization or its intermediary to contract with or to disclose confidential information to a pharmacy's intermediary or (ii) prohibit a health maintenance organization or its intermediary from contracting with or disclosing confidential information to a pharmacy's intermediary.

B. No such health maintenance organization or its pharmacy benefits manager shall impose upon any person receiving pharmaceutical benefits furnished under any such health care plan:

1. Any copayment, fee or condition that is not equally imposed upon all individuals in the same benefit category, class or copayment level, whether or not such benefits are furnished by pharmacists who are not participating providers;

2. Any monetary penalty that would affect or influence any such person's choice of pharmacy; or

3. Any reduction in allowable reimbursement for pharmacy services related to utilization of pharmacists who are not participating providers.

C. For purposes of this section, a prohibited condition or penalty shall include, without limitation: (i) denying immediate access to electronic claims filing to a pharmacy that is a nonparticipating provider and that has complied with subsection E or (ii) requiring a person receiving pharmacy benefits to make payment at point of service, except to the extent such conditions and penalties are similarly imposed on participating providers.

D. The provisions of this section are not applicable to any pharmaceutical benefit covered by a health care plan when those benefits are obtained from a pharmacy wholly owned and operated by, or exclusively operated for, the health maintenance organization providing the health care plan.

E. Any pharmacy that wishes to be covered by this section shall, if requested to do so in writing by a health maintenance organization or its pharmacy benefits manager, within 30 days of the pharmacy's receipt of the request, execute and deliver to the health maintenance organization or its pharmacy benefits manager, the direct service agreement or participating provider agreement that the health maintenance organization or its pharmacy benefits manager requires all of its participating providers

of pharmacy benefits to execute. Any pharmacy that fails to timely execute and deliver such agreement shall not be covered by this section with respect to that health maintenance organization or its pharmacy benefits manager unless and until the pharmacy executes and delivers the agreement. No pharmacy shall be precluded from obtaining a direct service agreement or participating provider agreement for retail and specialty pharmacy if the pharmacy meets the terms and conditions of participation. Any request by a pharmacy for a direct service agreement or a participating provider agreement shall be acted upon by a health maintenance organization or its pharmacy benefits manager within 60 days of receipt of the pharmacy's request or any subsequent submission of supplemental information if requested by the health maintenance organization or its pharmacy benefits manager.

F. The Commission shall have no jurisdiction to adjudicate controversies arising out of this section.

G. Nothing in this section shall limit the authority of a health maintenance organization providing health care plans to select a single mail order pharmacy provider as the exclusive provider of pharmacy services that are delivered to the covered person's address by mail, common carrier, or delivery service. The provisions of this section shall not apply to such contracts. As used in this subsection, "mail order pharmacy provider" means a pharmacy permitted to conduct business in the Commonwealth whose primary business is to dispense a prescription drug or device under a prescriptive drug order and to deliver the drug or device to a patient primarily by mail, common carrier, or delivery service.

1994, c. 963; 1995, cc. 446, 467; 2010, cc. 157, 357; 2017, c. 615; 2021, Sp. Sess. I, c. 229.

§ 38.2-4312.2. Repealed.

Repealed by Acts 1995, c. 467.

§ 38.2-4312.3. Patient access to emergency services.

A. A health maintenance organization shall have a system to provide to its members, on a 24-hour basis: (i) access to medical care or (ii) access by telephone to a physician or licensed health care professional with appropriate medical training who can refer or direct a member for prompt medical care in cases where there is an immediate, urgent need or medical emergency. Access to a nonmedical professional who provides appropriate responses to calls from members and providers concerning after-hours care and covered benefits is not sufficient to meet the requirements of this section.

B. A health maintenance organization shall reimburse a hospital emergency facility and provider, less any applicable copayments, deductibles, or coinsurance, for medical screening and stabilization services rendered to meet the requirements of the Federal Emergency Medical Treatment and Active Labor Act (42 U.S.C. § 1395dd) and related to the condition for which the member presented in the hospital emergency facility if (i) the health maintenance organization or its designee or the member's primary care physician or its designee authorized, directed, or referred a member to use the hospital emergency facility; or (ii) the health maintenance organization fails to have a system for provision of 24-hour access in accordance with subsection A above. For purposes of (i) above, a primary care

physician may include a physician with whom the primary care physician has made arrangements for on-call backup coverage.

C. Each evidence of coverage provided by a health maintenance organization shall include a description of procedures to be followed by the member for emergency services, including: (i) the appropriate use of hospital emergency facilities; (ii) the appropriate use of any urgent care facilities with which the health maintenance organization may contract; (iii) the potential responsibility of the member for payment for nonemergency services rendered in a hospital emergency facility; and (iv) the member's covered benefits for emergency services, including an explanation of the prudent layperson standard included in the definition of emergency services in § 38.2-4300.

D. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

1997, c. 139; 2011, c. 882.

§ 38.2-4313. Licensing of agents.

Enrollee contracts may be solicited only through life and health insurance agents as provided for in Chapter 18 of this title. Home office salaried officers whose principal duties and responsibilities do not include the negotiation or solicitation of enrollee contracts shall not be required to be licensed.

1980, c. 720, § 38.1-877; 1986, c. 562; 1999, c. 86.

§ 38.2-4314. Powers of insurers and health services plans.

A. An insurer or a health services plan licensed in this Commonwealth may, either directly or through a subsidiary or affiliate, organize and operate a health maintenance organization under the provisions of this chapter. Notwithstanding any other law that may be inconsistent with this section, any two or more licensed insurers, health services plans, or their subsidiaries or affiliates, may jointly organize and operate a health maintenance organization.

B. An insurer or a health services plan may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through health maintenance organizations and to provide coverage in the event of the failure of the health maintenance organization to meet its obligations. The enrollees of a health maintenance organization constitute a permissible group for purposes of laws applicable to insurers and health services plans. Under the contracts the insurer or health services plans may make benefit payments to health maintenance organizations for health care services rendered by providers under the health care plan.

1980, c. 720, § 38.1-878; 1986, c. 562.

§ 38.2-4315. Examinations.

A. The Commission shall examine the affairs of each health maintenance organization as provided for in § 38.2-1317 at least once every five years. The Commission may examine the affairs of providers with whom any health maintenance organization has contracts, agreements, or other arrangements

according to its health care plan as often as it considers necessary for the protection of the interests of the people of this Commonwealth.

B. Instead of making its own examination, the Commission may accept the report of an examination of a foreign health maintenance organization certified by the insurance supervisory official, similar regulatory agency, or the state health commissioner of another state.

C. The Commission shall coordinate such examinations with the State Health Commissioner to ensure an appropriate level of regulatory oversight and to avoid any undue duplication of effort or regulation.

1980, c. 720, § 38.1-879; 1986, c. 562; 1990, c. 224; 1997, c. 688.

§ 38.2-4316. Suspension or revocation of license.

A. The Commission may suspend or revoke any license issued to a health maintenance organization under this chapter if it finds that any of the following conditions exist:

1. The health maintenance organization is operating significantly at variance with its basic organizational document, its health care plan, or in a manner contrary to that described in and reasonably inferred from any other information submitted under § 38.2-4301, unless amendments to those submissions have been filed with and approved by the Commission;

2. The health maintenance organization issues an evidence of coverage or uses a schedule of charges for health care services that do not comply with the requirements of § 38.2-4306;

3. The health care plan does not provide or arrange for basic health care services or limited health care services;

4. The health maintenance organization is no longer financially responsible and a reasonable expectation exists that it may be unable to meet its obligations to enrollees or prospective enrollees;

5. The health maintenance organization has failed to implement a mechanism providing the enrollees with an opportunity to participate in matters of policy and operation as provided in § 38.2-4304;

6. The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner;

7. The continued operation of the health maintenance organization would be hazardous to its enrollees; or

8. The health maintenance organization has otherwise failed to substantially comply with the provisions of this chapter.

B. When the license of a health maintenance organization is suspended, the health maintenance organization shall not enroll any additional enrollees during the period of the suspension except newborn children or other newly acquired dependents of existing enrollees, and shall not engage in any advertising or solicitation.

C. The Commission shall not revoke or suspend the license of a health maintenance organization upon any of the grounds set out in subsection A of this section until it has given the organization ten days' notice of the proposed revocation or suspension and the grounds for it, and has given the organization an opportunity to introduce evidence and be heard. Any hearing authorized by this section may be informal. The required notice may be waived by the Commission and the health maintenance organization.

D. When the license of a health maintenance organization is revoked, the organization shall proceed to wind up its affairs immediately following the effective date of the order of revocation. The health maintenance organization shall conduct no further business except as may be essential to the orderly conclusion of its affairs. It shall engage in no further advertising or solicitation. The Commission may, by written order, permit further operation of the organization that it finds to be in the best interests of enrollees for the purpose of giving them the greatest practical opportunity to obtain continuing health care coverage.

1980, c. 720, § 38.1-880; 1986, c. 562; 1992, c. 481; 1998, c. 891.

§§ 38.2-4317 and 38.2-4317.1. Repealed.

Repealed by Acts 2018, c. 706, cl. 2.

§ 38.2-4318. License renewals.

A. Each health maintenance organization licensed under this chapter shall renew its license with the Commission annually by July 1. The renewal license shall not be issued until the health maintenance organization has paid all fees and charges imposed on it and has complied with all other requirements of law.

B. The Commission shall not fail or refuse to renew the license of any health maintenance organization without first giving the health maintenance organization ten days' notice of its intention not to renew the license and giving it an opportunity to be heard and to introduce evidence on its behalf. Any such hearing may be informal. The required notice may be waived by the Commission and the health maintenance organization.

1980, c. 720, § 38.1-883; 1986, c. 562; 1987, c. 519.

§ 38.2-4319. (Effective until January 1, 2024) Statutory construction and relationship to other laws.

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-305, 38.2-316, 38.2-316.1, 38.2-322, 38.2-325, 38.2-326, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-629, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, and 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, and Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.), 5 (§ 38.2-1322 et seq.), 5.1 (§ 38.2-1334.3 et seq.), and 5.2 (§ 38.2-1334.11 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.), 2 (§ 38.2-1412 et seq.), and 4 (§ 38.2-1446 et seq.) of Chapter 14, Chapter 15 (§ 38.2-1500 et seq.), Chapter 17 (§ 38.2-1700 et seq.), §§ 38.2-1800 through 38.2-1836,

38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3406.1, 38.2-3407.2 through 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.20, 38.2-3411, 38.2-3411.2, 38.2-3411.3, 38.2-3411.4, 38.2-3412.1, 38.2-3414.1, 38.2-3418.1 through 38.2-3418.19, 38.2-3418.21, 38.2-3419.1, and 38.2-3430.1 through 38.2-3454, Articles 8 (§ 38.2-3461 et seq.) and 9 (§ 38.2-3465 et seq.) of Chapter 34, § 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3540.2, 38.2-3541.2, 38.2-3542, and 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, Chapter 35.1 (§ 38.2-3556 et seq.), § 38.2-3610, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.), Chapter 65 (§ 38.2-6500 et seq.), and Chapter 66 (§ 38.2-6600 et seq.) shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) except with respect to the activities of its health maintenance organization.

B. For plans administered by the Department of Medical Assistance Services that provide benefits pursuant to Title XIX or Title XXI of the Social Security Act, as amended, no provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-322, 38.2-325, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, and 38.2-600 through 38.2-629, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, and 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.), 5 (§ 38.2-1322 et seq.), 5.1 (§ 38.2-1334.3 et seq.), and 5.2 (§ 38.2-1334.11 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.), 2 (§ 38.2-1412 et seq.), and 4 (§ 38.2-1446 et seq.) of Chapter 14, §§ 38.2-3401, 38.2-3405, 38.2-3407.2 through 38.2-3407.5, 38.2-3407.6, 38.2-3407.6:1, 38.2-3407.9, 38.2-3407.9:01, and 38.2-3407.9:02, subdivisions F 1, 2, and 3 of § 38.2-3407.10, §§ 38.2-3407.10:1, 38.2-3407.11, 38.2-3407.11:3, 38.2-3407.13, 38.2-3407.13:1, 38.2-3407.14, 38.2-3411.2, 38.2-3418.1, 38.2-3418.2, 38.2-3418.16, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, and 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3540.2, 38.2-3541.2, 38.2-3542, and 38.2-3543.2, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.), and Chapter 65 (§ 38.2-6500 et seq.) shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) except with respect to the activities of its health maintenance organization.

C. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

D. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

E. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health maintenance organization providing health care plans pursuant to § 38.2-3431 shall not be required to offer coverage to or accept applications from an employee who does not reside within the health maintenance organization's service area.

F. For purposes of applying this section, "insurer" when used in a section cited in subsections A and B shall be construed to mean and include "health maintenance organizations" unless the section cited clearly applies to health maintenance organizations without such construction.

1980, c. 720, § 38.1-887; 1985, c. 588; 1986, c. 562; 1989, cc. 646, 653; 1990, cc. 301, 393, 439, 531, 826; 1991, cc. 103, 369; 1992, cc. 14, 23, 800; 1993, cc. 148, 158, 306, 307; 1994, cc. 213, 320, 374, 522, 699; 1995, cc. 80, 420, 522, 537; 1996, cc. 22, 155, 201, 550, 611, 776, 967; 1997, cc. 688, 807, 913; 1998, cc. 42, 43, 56, 120, 154, 625, 631, 709, 858, 891, 908; 1999, cc. 35, 643, 649, 709, 739, 856, 857, 858, 923, 941; 2000, cc. 50, 157, 187, 460, 465, 496, 503, 532, 922; 2001, c. 663; 2002, c. 153; 2003, c. 243; 2004, cc. 156, 315, 772; 2006, cc. 427, 866; 2007, cc. 488, 579; 2009, cc. 796, 839; 2010, cc. 222, 272, 504, 515, 583, 687, 734; 2011, cc. 788, 876, 878, 882; 2012, cc. 634, 641; 2013, cc. 653, 670, 679, 751; 2014, cc. 248, 814; 2015, cc. 14, 649, 723; 2016, c. 475; 2017, c. 643; 2018, c. 706; 2019, cc. 661, 662, 666, 684; 2020, cc. 214, 215, 217, 218, 219, 264, 916, 917, 1094, 1161, 1288; 2020, Sp. Sess. I, cc. 44, 53; 2021, Sp. Sess. I, cc. 161, 480; 2023, c. 473.

§ 38.2-4319. (Effective January 1, 2024) Contingent expiration date) Statutory construction and relationship to other laws.

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-305, 38.2-316, 38.2-316.1, 38.2-322, 38.2-325, 38.2-326, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-629, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, and 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, and Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.), 5 (§ 38.2-1322 et seq.), 5.1 (§ 38.2-1334.3 et seq.), and 5.2 (§ 38.2-1334.11 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.), 2 (§ 38.2-1412 et seq.), and 4 (§ 38.2-1446 et seq.) of Chapter 14, Chapter 15 (§ 38.2-1500 et seq.), Chapter 17 (§ 38.2-1700 et seq.), §§ 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3406.1, 38.2-3407.2 through 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.20, 38.2-3411, 38.2-3411.2, 38.2-3411.3, 38.2-3411.4, 38.2-3412.1, 38.2-3414.1, 38.2-3418.1 through 38.2-3418.19, 38.2-3418.21,38.2-3419.1, and 38.2-3430.1 through 38.2-3454, Articles 8 (§ 38.2-3461 et seq.) and 9 (§ 38.2-3465 et seq.) of Chapter 34, § 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3540.2, 38.2-3541.2, 38.2-3542, and 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, Chapter 35.1 (§ 38.2-3556 et seq.), § 38.2-3610, Chapter 52 (§ 38.2-

5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.), Chapter 65 (§ 38.2-6500 et seq.), and Chapter 66 (§ 38.2-6600 et seq.)shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) except with respect to the activities of its health maintenance organization.

B. For plans administered by the Department of Medical Assistance Services that provide benefits pursuant to Title XIX or Title XXI of the Social Security Act, as amended, no provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-322, 38.2-325, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, and 38.2-600 through 38.2-629, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, and 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.), 5 (§ 38.2-1322 et seq.), 5.1 (§ 38.2-1334.3 et seq.), and 5.2 (§ 38.2-1334.11 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.), 2 (§ 38.2-1412 et seq.), and 4 (§ 38.2-1446 et seq.) of Chapter 14, §§ 38.2-3401, 38.2-3405, 38.2-3407.2 through 38.2-3407.5, 38.2-3407.6, 38.2-3407.6:1, 38.2-3407.9, 38.2-3407.9:01, and 38.2-3407.9:02, subdivisions E 1, 2, and 3 of § 38.2-3407.10, §§ 38.2-3407.10:1, 38.2-3407.11, 38.2-3407.11:3, 38.2-3407.13, 38.2-3407.13:1, 38.2-3407.14, 38.2-3411.2, 38.2-3418.1, 38.2-3418.2, 38.2-3418.16, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, and 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3540.2, 38.2-3541.2, 38.2-3542, and 38.2-3543.2, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.), Chapter 65 (§ 38.2-6500 et seq.), and Chapter 66 (§ 38.2-6600 et seq.) shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) except with respect to the activities of its health maintenance organization.

C. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

D. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

E. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health maintenance organization providing health care plans pursuant to § 38.2-3431 shall not be required to offer coverage to or accept applications from an employee who does not reside within the health maintenance organization's service area.

F. For purposes of applying this section, "insurer" when used in a section cited in subsections A and B shall be construed to mean and include "health maintenance organizations" unless the section cited clearly applies to health maintenance organizations without such construction.

1980, c. 720, § 38.1-887; 1985, c. 588; 1986, c. 562; 1989, cc. 646, 653; 1990, cc. 301, 393, 439, 531, 826; 1991, cc. 103, 369; 1992, cc. 14, 23, 800; 1993, cc. 148, 158, 306, 307; 1994, cc. 213, 320, 374, 522, 699; 1995, cc. 80, 420, 522, 537; 1996, cc. 22, 155, 201, 550, 611, 776, 967; 1997, cc. 688, 807, 913; 1998, cc. 42, 43, 56, 120, 154, 625, 631, 709, 858, 891, 908; 1999, cc. 35, 643, 649, 709, 739, 856, 857, 858, 923, 941; 2000, cc. 50, 157, 187, 460, 465, 496, 503, 532, 922; 2001, c. 663; 2002, c. 153; 2003, c. 243; 2004, cc. 156, 315, 772; 2006, cc. 427, 866; 2007, cc. 488, 579; 2009, cc. 796, 839; 2010, cc. 222, 272, 504, 515, 583, 687, 734; 2011, cc. 788, 876, 878, 882; 2012, cc. 634, 641; 2013, cc. 653, 670, 679, 751; 2014, cc. 248, 814; 2015, cc. 14, 649, 723; 2016, c. 475; 2017, c. 643; 2018, c. 706; 2019, cc. 661, 662, 666, 684; 2020, cc. 214, 215, 217, 218, 219, 264, 916, 917, 1094, 1161, 1288; 2020, Sp. Sess. I, cc. 44, 53; 2021, Sp. Sess. I, cc. 161, 480; 2023, cc. 473, 490.

§ 38.2-4320. Authority of Commonwealth to contract with health maintenance organizations.

This Commonwealth is authorized to enter into contracts with health maintenance organizations on behalf of its employees and the citizens of the Commonwealth, including contracts to furnish health care services to recipients of medical assistance under Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq.

1980, c. 720, § 38.1-889; 1986, c. 562.

§ 38.2-4320.1. Explanation of benefits for health maintenance organization enrollees who are recipients of medical assistance services or covered by the Family Access to Medical Insurance Security (FAMIS) Plan.

In the case of any health maintenance organization that has contracted with the Virginia Department of Medical Assistance Services to provide health care services to recipients of medical assistance services pursuant to Title XIX of the Social Security Act, as amended, or to individuals who are covered by the Family Access to Medical Insurance Security (FAMIS) Plan developed pursuant to Title XXI of the Social Security Act, as amended, the requirements for furnishing an explanation of benefits to current or former members and their respective health care providers shall be as authorized and directed in the standards prescribed in the state plan for medical assistance services pursuant to Chapter 10 (§ 32.1-323 et seq.) of Title 32.1 and the FAMIS Plan pursuant to Chapter 13 (§ 32.1-351 et seq.) of Title 32.1. The requirements for an explanation of benefits otherwise addressed in this title shall not apply to such health maintenance organization when contracting to deliver such services to the extent that the statutory requirements differ from the standards of the Department of Medical Assistance Services.

2004, c. 185.

§ 38.2-4321. Health maintenance organization affected by chapter.

Except as otherwise provided by law, no health maintenance organization shall be operated in this Commonwealth other than in the manner set forth in this chapter.

1980, c. 720, § 38.1-890; 1986, c. 562.

§ 38.2-4322. Affiliation period.

A. A health maintenance organization which offers health insurance coverage in connection with a group health plan or group health insurance coverage and which does not impose any preexisting condition exclusion allowed under § 38.2-3432.3, with respect to any particular coverage option may impose an affiliation period for such coverage option, but only if:

1. Such period is applied uniformly without regard to any health status-related factors; and

2. Such period does not exceed two months (or three months in the case of a late enrollee).

B. An affiliation period as described in subsection A shall begin on the enrollment date.

C. An affiliation period under a plan shall run concurrently with any waiting period under the plan.

D. Defined terms as set forth in § 38.2-3431 which are used in this chapter shall have the same meaning here that they have in Chapter 34.

1997, cc. 807, 913.

§ 38.2-4323. Alternative methods.

A health maintenance organization may use alternative methods to an affiliation period to address adverse selection provided that they are approved by the Commission prior to their use.

1997, cc. 807, 913.

Chapter 44 - LEGAL SERVICES PLANS

§ 38.2-4400. Definitions.

As used in this chapter:

"Contract holder" means a person entering into a subscription contract with an organization;

"Fee discount" means predetermined amounts or reduced rates which are not substantially below the usual charge by the same attorney for those services, but not less than 70 percent of the rate usually charged non-participants for the same service, except for simple wills, simple name changes, preparation of non-complex legal documents, legal letters and calls, which may be less than 70 percent of the rate usually charged non-participants;

"Legal services organization" or "organization" means a person subject to regulation and licensing under this chapter who operates, conducts or administers a legal services plan;

"Legal services plan" or "plan" means a contractual obligation or an arrangement, whereby legal services are provided in consideration of a specified payment consisting in whole or in part of prepaid or periodic charges, regardless of whether the payment is made by the subscribers individually or by a third person for them;

"Licensed attorney" means an attorney licensed by the Virginia Board of Bar Examiners or other state licensing authority;

"Participating provider" or "participating providers" means a licensed attorney, group of attorneys or any other person who has agreed through an organization to provide legal services to subscribers enrolled in a legal services plan;

"Simple matters" or "simple legal matters" means legal matters that can be reasonably handled over the telephone, or with one or two office visits, or by a limited review of routine legal documents, and without legal representation to third parties;

"Subscriber" means any person entitled to benefits under the terms and conditions of a subscription contract;

"Subscription contract" means a written contract which is issued to a subscriber by an organization and which provides legal services or benefits for legal services.

1978, c. 658, § 38.1-791; 1986, c. 562; 1994, c. 224.

§ 38.2-4401. Certain contracts, etc., not deemed plans.

For the purposes of this chapter, the following are not deemed to be legal services plans:

1. Retainer contracts made by attorneys with individual clients where fees are based on estimates of the nature and amount of services that will be provided to the specific client, and similar contracts made with a group of clients involved in the same or closely related legal matters;

2. Plans providing no benefits other than a limited amount of consultation and advice on simple matters either alone or in combination with referral services or on the promise of fee discounts for other matters;

3. Plans providing limited benefits on simple legal matters on an informal basis, not involving a legally binding promise, in the context of an employment, educational or similar relationship;

4. Legal services provided by unions or employee associations to their members in matters relating to employment or occupation;

5. Legal services provided by an agency of federal or state government or a subdivision of federal or state government to its employees; or

6. Legal services insurance as provided for in §§ 38.2-127 and 38.2-300 when provided by an insurer licensed pursuant to Chapter 10 (§ 38.2-1000 et seq.) of this title.

1978, c. 658, § 38.1-802; 1986, c. 562; 1994, c. 224.

§ 38.2-4402. Repealed.

Repealed by Acts 1994, c. 224.

§ 38.2-4402.1. Corporate organization required.

Each plan shall be conducted by or through (i) a nonstock or stock corporation organized pursuant to the laws of this Commonwealth; (ii) a foreign corporation that is subject to regulation and licensing under the laws of its domiciliary jurisdiction that are substantially similar to those provided by this chapter; or (iii) a foreign corporation that is licensed as an insurer in its state of domicile and

authorized to operate, conduct, or administer a legal services plan under the laws of any state. Any foreign insurer licensed pursuant to this chapter shall not be authorized to write any other classes of insurance under this title.

1994, c. 224; 2020, c. 408.

§ 38.2-4403. The Virginia State Bar may sponsor plans.

The Virginia State Bar may sponsor, and its member attorneys may, through a nonstock corporation, operate a legal services plan under the following conditions:

1. All members of the Virginia State Bar may participate in the plan.

2. No more than one-fourth of the board of directors of the nonstock corporation operating the plan may be attorneys who shall be appointed to the board by the Virginia State Bar. A majority of the members of the board shall not be providers of legal services to the plan nor employees or officers of the corporation conducting the plan. The nonprovider members of the board may not be elected or appointed by the Virginia State Bar or by attorneys participating in the plan.

3. No part of the dues paid by attorneys to the Virginia State Bar shall be used to financially support the nonstock corporation.

4. The Commission shall require quarterly compliance certification from all plans licensed pursuant to this section.

1982, c. 387, § 38.1-793.1; 1986, c. 562.

§ 38.2-4404. Liability of participating providers.

A. Except for a plan established pursuant to § 38.2-4403, all participating providers in a plan shall be jointly and severally liable on all contracts made for the purposes of the plan by the organization as agent for them. Each contract may be executed and signed by their agent on their behalf. A contract so signed shall be binding on the participating providers and not on the agent.

B. Actions for breach of these contracts may be brought against the participating providers by naming the agent as the sole defendant. A judgment in favor of the plaintiff may be satisfied out of the assets of the legal services organization or out of the assets of each of the participating providers.

C. Each participating provider shall be liable for his own torts and not for the torts of any other participating provider or of the agent.

1978, c. 658, § 38.1-794; 1982, c. 387; 1986, c. 562; 1994, c. 224.

§ 38.2-4405. Change of participating providers.

A. Any participating provider may resign from a plan at any time but will continue to be liable on each subscription contract while effective. However, this liability shall not extend beyond the end of each such subscription contract's current contract year.

B. Participating providers may be admitted to a plan at any time and will then automatically become liable on all its outstanding contracts.

1978, c. 658, § 38.1-795; 1986, c. 562; 1994, c. 224.

§ 38.2-4406. Board of directors of corporation operating plan.

Notwithstanding the provisions of §§ 13.1-675 and 13.1-855, any corporation that operates any plan pursuant to the terms of this chapter shall have a board of directors consisting of no more than fifteen members of whom a majority shall be subscribers to the plan who are not providers of legal services and not employees or officers of any plan. This section does not apply to a plan operated by a group of attorneys except as provided in § 38.2-4403.

1978, c. 658, § 38.1-796; 1982, c. 387; 1986, c. 562.

§ 38.2-4407. Board of directors of plan created by attorneys.

Notwithstanding the provisions of §§ 13.1-675, 13.1-677 and 13.1-855 to the contrary, any legal services organization operating a plan created by a group of attorneys shall have a board of directors consisting of no more than fifteen members of whom a majority may be providers of legal services. This section does not apply to a plan operated under § 38.2-4403.

1978, c. 658, § 38.1-797; 1982, c. 387; 1986, c. 562.

§ 38.2-4408. Application of certain provisions.

No provision of this title except this chapter and insofar as they are not inconsistent with this chapter §§ 38.2-100, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-316, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-629, 38.2-700 through 38.2-704, 38.2-800 through 38.2-806, 38.2-1038, 38.2-1040 through 38.2-1044, and Articles 1 (§ 38.2-1300 et seq.), 2 (§ 38.2-1306.2 et seq.), and 4 (§ 38.2-1317 et seq.) of Chapter 13, insofar as they are not inconsistent with this chapter, and § 58.1-2500 et seq. shall apply to the operation of a plan.

1978, c. 658, § 38.1-798; 1986, c. 562; 1993, c. 158; 1994, c. 224; 2000, c. 50; 2015, c. 14; 2020, c. 264.

§ 38.2-4408.1. Rehabilitation, liquidation, conservation.

Any rehabilitation, liquidation, or conservation of a legal services organization shall be deemed to be the rehabilitation, liquidation, or conservation of an insurer and shall be subject to the provisions of Chapter 15 (§ 38.2-1500 et seq.) of Title 38.2.

1990, c. 331; 1994, c. 224.

§ 38.2-4409. Payments under plan.

The legal services organization shall not indemnify any subscriber for legal services rendered by any participating provider or nonparticipating attorney.

1978, c. 658, § 38.1-798; 1986, c. 562; 1994, c. 224.

§ 38.2-4410. Financial reports.

On or before March 1 of each year, each legal services organization shall file with the Commission a financial statement in accordance with § 38.2-1300. In lieu of a financial statement filed in accordance

with § 38.2-1300, a foreign legal services organization may file a financial statement that is (i) prepared using an annual statement convention blank developed by the National Association of Insurance Commissioners (NAIC); (ii) prepared in accordance with the annual statement instructions and the accounting practices and procedures manuals adopted by the NAIC, or any other successor publications; and (iii) filed by the foreign legal services organization in its state of domicile.

On or before May 15, August 15, and November 15 of each year, each legal services organization shall file with the Commission a financial statement in accordance with § 38.2-1301. In lieu of a financial statement filed in accordance with § 38.2-1301, a foreign legal services organization, may file a financial statement that is (i) prepared using a quarterly statement convention blank developed by the NAIC; (ii) prepared in accordance with the quarterly statement instructions and the accounting practices and procedures manuals adopted by the NAIC, or any other successor publications; and (iii) filed by the foreign legal services organization in its state of domicile.

On or before June 1 of each year, each legal services organization shall file with the Commission an audited financial statement. The Commission may request supplemental financial information to ensure a legal services organization's financial stability.

A legal services organization operating, conducting, or administering a legal services plan shall not be required to file with the Commission any management discussion and analysis of financial condition and results of operations.

1978, c. 658, § 38.1-799; 1986, c. 562; 2020, c. 408.

§ 38.2-4410.1. Examinations.

The Commission may investigate or examine the affairs, transactions, accounts, records, and assets of a legal services organization as it deems necessary. Examinations shall be conducted pursuant to Article 4 (§ 38.2-1317 et seq.) of Chapter 13.

2020, c. 408.

§ 38.2-4411. Subscriber to have free choice of participating providers available.

A legal services organization shall organize and operate a plan in a manner that assures that any subscriber to the plan shall have free choice of the participating providers available and participating in the plan.

1978, c. 658, § 38.1-800; 1986, c. 562; 1994, c. 224.

§ 38.2-4412. Subscriber to be advised in writing as to benefits and limitations thereon.

A legal services organization shall, prior to and during the term of the subscription contract, fully, fairly, and currently advise the subscriber in writing of the benefits available under the contract and all limitations on the benefits available under the contract.

1978, c. 658, § 38.1-801; 1986, c. 562.

§ 38.2-4413. Licensing of organization.

A. No person shall operate a legal services plan in this Commonwealth without a license issued by the Commission. Each organization shall apply for a license and furnish any relevant information the Commission requires. Each license shall expire at midnight on the following June 30. A non-refundable application fee of $500 shall be paid with each application for a license.

B. The Commission shall not issue to or renew a license of an organization unless it is satisfied that the financial condition, the method of operation, and the manner of doing business of the organization enable it to meet its contractual obligations to all subscribers and that the organization has otherwise complied with all the requirements of law.

1978, c. 658, § 38.1-802; 1986, c. 562.

§ 38.2-4414. Renewal of organization license.

A. Each legal services organization shall renew its license with the Commission annually by July 1. The renewal license shall not be issued unless the organization has paid all fees and charges imposed on it, and has complied with all other requirements of law.

B. The Commission shall not fail or refuse to renew the license of any organization without first giving the organization ten days' notice of its intention not to renew the license and giving it an opportunity to be heard and to introduce evidence in its behalf. Any nonrenewal hearing may be informal. The required notice may be waived by the Commission and the organization.

1978, c. 658, § 38.1-803; 1986, c. 562.

§ 38.2-4415. Repealed.

Repealed by Acts 2004, c. 784.

§ 38.2-4416. Taxation.

Except as provided by § 58.1-2501 and Chapter 4 of this title, the application fees paid by a legal services organization under this chapter shall be in lieu of all other state and local license fees or license taxes and state income taxes.

1978, c. 658, § 38.1-802; 1986, c. 562.

§ 38.2-4417. Misleading applications or contracts.

In the operation of a plan, no person shall use any misleading subscription applications or contracts.

1978, c. 658, § 38.1-805; 1986, c. 562.

§ 38.2-4418. Controversies involving subscription contracts.

The Commission shall have no jurisdiction to adjudicate controversies growing out of subscription contracts. A breach of contract shall not be deemed a violation of this chapter.

1978, c. 658, § 38.1-809; 1986, c. 562.

Chapter 45 - Dental or Optometric Services Plans

§ 38.2-4500. Applicability of chapter.

A. Except as otherwise provided by law, no arrangement for furnishing prepaid dental services or prepaid optometric services shall be organized, conducted or offered in this Commonwealth other than in the manner set forth in this chapter.

B. Nothing contained in this chapter prohibits any dentist or optometrist individually, in partnership with other dentists or optometrists, or as part of a professional corporation of dentists or optometrists from entering into agreements directly with his own patients, or with a parent, guardian, conservator, spouse or other family member acting in a patient's behalf, involving payment for professional services to be rendered or made available in the future.

1980, c. 682, § 38.1-894; 1986, c. 562; 1997, c. 801.

§ 38.2-4501. Definitions.

As used in this chapter:

"Contract holder" means a person entering into a subscription contract with a nonstock corporation.

"Dental services plans" means any arrangement for offering or administering prepaid dental services by a nonstock corporation licensed under this chapter.

"Nonstock corporation" means a foreign or domestic nonstock corporation which is subject to regulation and licensing under this chapter and which operates a dental services plan or an optometric services plan.

"Optometric services plan" means any arrangement for offering or administering prepaid optometric services by a nonstock corporation licensed under this chapter.

"Plan" means any dental services plan or any optometric services plan subject to regulation under this chapter.

"Subscriber" means any person entitled to benefits under the terms and conditions of a subscription contract.

"Subscription contract" means a written contract which is issued to a contract holder by a nonstock corporation and which provides dental or optometric services or benefits for dental or optometric services.

1986, c. 562.

§ 38.2-4502. Dental services plans.

A group of licensed dentists may conduct through a nonstock corporation as agent for them a dental services plan as defined in § 38.2-4501.

1980, c. 682, § 38.1-892; 1986, c. 562.

§ 38.2-4503. Optometric services plans.

A group of licensed optometrists may conduct through a nonstock corporation as agent for them an optometric services plan as defined in § 38.2-4501.

1980, c. 682, § 38.1-893; 1986, c. 562.

§ 38.2-4504. Nonstock corporation required.

A. Each plan shall be conducted either by or through (i) a nonstock corporation organized pursuant to the laws of this Commonwealth or (ii) a foreign nonstock corporation that is subject to regulation and licensing under the laws of its domiciliary jurisdiction that are substantially similar to those provided by this chapter.

B. Notwithstanding the provisions of §§ 38.2-4502 and 38.2-4503, a nonstock corporation may offer or administer a plan without being required to act as agent for participating dentists or optometrists.

C. A nonstock corporation applying for its initial license pursuant to this chapter to offer or administer a plan may elect in its application to act as a nonagent, in which case the provisions of this section shall apply to such nonagent.

D. A nonstock corporation operating a plan pursuant to § 38.2-4502 or § 38.2-4503 may petition the Commission to change its status from an agent nonstock corporation to a nonagent nonstock corporation by making application to the Commission no less than ninety days preceding the proposed date of the change. The nonstock corporation shall give notice of the petition to its contract holders and participating dentists or optometrists. The Commission shall not approve the change of status unless it is satisfied that the financial condition of the nonstock corporation and the proposed method of operation and manner of doing business enable the nonstock corporation to meet its contractual obligations to all subscribers and that the nonstock corporation has otherwise complied with the requirements of this chapter. The Commission shall (i) consider, among other things, the sufficiency of the contingency reserve required under subsection E and (ii) subject the nonstock corporation, notwithstanding the provisions of § 38.2-1700, to the requirements of Chapter 17 (§ 38.2-1700 et seq.). If the Commission fails to approve the change of status, it shall state the reason in its order. A change in status shall only be effective as to subscription contracts issued or renewed on and after the date of a change in status.

E. No nonstock corporation shall offer or administer a plan without acting as an agent for participating dentists or optometrists unless it maintains at all times a contingency reserve of at least $4 million. The contingency reserve shall be computed as the Commission requires.

F. The provisions of §§ 38.2-4505, 38.2-4507, 38.2-4508, and 38.2-4512 shall not apply to a nonstock corporation that does not act as agent for participating dentists or optometrists.

1980, c. 682, § 38.1-895; 1986, c. 562; 2000, cc. 171, 204; 2013, c. 11.

§ 38.2-4505. Liability of participants.

A. All dentists or optometrists participating in a plan shall be jointly and severally liable on all contracts made for the purpose of the plan by the nonstock corporation as agent for them. Each contract may be executed and signed by their agent on their behalf. A contract so signed shall be binding on the principals and not on the agent.

B. Actions for breach of these contracts may be brought against the principals by naming the agent as the sole defendant. A judgment in favor of the plaintiff may be satisfied out of the assets of the non-stock corporation or out of the assets of each of the principals.

C. Each participant shall be liable for his own torts and not for the torts of any other participant or of the agent.

1980, c. 682, § 38.1-896; 1986, c. 562.

§ 38.2-4506. Terms of participation.

Each dentist or optometrist participating in any plan shall do so in accordance with the terms and conditions imposed on other participating providers under similar circumstances. Participating providers shall have the right to engage in other practice. A nonstock corporation shall not engage in the practice of dentistry or optometry.

1980, c. 682, § 38.1-897; 1986, c. 562.

§ 38.2-4507. Change of participants.

A. Any participating dentist or optometrist may resign from a plan at any time but will continue to be liable on each subscription contract then in effect. However, this liability shall not extend beyond the end of each such subscription contract's current contract year.

B. Dentists or optometrists may be admitted to a plan at any time and will then automatically become liable on all its outstanding contracts.

1980, c. 682, § 38.1-897; 1986, c. 562.

§ 38.2-4508. Board of directors of nonstock corporation.

Notwithstanding the provisions of § 13.1-855, a nonstock corporation shall have a board of directors consisting of at least twelve but no more than twenty members. A majority of the members of the board of directors of a nonstock corporation operating a dental services plan shall be participating dentists. A majority of the members of the board of directors of a nonstock corporation operating an optometric services plan shall be participating optometrists.

1980, c. 682, § 38.1-898; 1986, c. 562; 1987, c. 520.

§ 38.2-4509. Application of certain laws.

A. No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-316, 38.2-326, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-629, 38.2-900 through 38.2-904, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1 (§ 38.2-1300 et seq.) and 2 (§ 38.2-1306.2 et seq.) of Chapter 13, §§ 38.2-1312, 38.2-1314, 38.2-1315.1, Articles 4 (§ 38.2-1317 et seq.), 5 (§ 38.2-1322 et seq.), and 6 (§ 38.2-1335 et seq.) of Chapter 13, §§ 38.2-1400 through 38.2-1442, 38.2-1446, 38.2-1447, 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3407.1, 38.2-3407.4, 38.2-3407.10, 38.2-3407.10:1, 38.2-3407.13, 38.2-3407.14, 38.2-3407.15, 38.2-3407.17, 38.2-3407.17:1, 38.2-3407.19, 38.2-3415, 38.2-3541, Article 5

(§ 38.2-3551 et seq.) of Chapter 35, §§ 38.2-3600 through 38.2-3603, Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.), and Chapter 65 (§ 38.2-6500 et seq.) shall apply to the operation of a plan.

B. The provisions of subsection A of § 38.2-322 shall apply to an optometric services plan. The provisions of subsection C of § 38.2-322 shall apply to a dental services plan.

C. The provisions of Article 1.2 (§ 32.1-137.7 et seq.) of Chapter 5 of Title 32.1 shall not apply to either an optometric or dental services plan.

D. The provisions of § 38.2-3407.1 shall apply to claim payments made on or after January 1, 2014. No optometric or dental services plan shall be required to pay interest computed under § 38.2-3407.1 if the total interest is less than $5.

1980, c. 682, § 38.1-899; 1983, c. 457; 1986, c. 562; 1989, c. 653; 1993, cc. 158, 307; 1996, c. 776; 1998, cc. 42, 891; 1999, cc. 643, 649, 709, 739; 2000, cc. 47, 50, 922; 2004, c. 315; 2006, c. 427; 2010, cc. 583, 734; 2011, c. 788; 2013, cc. 473, 670, 679; 2014, c. 309; 2015, cc. 14, 723; 2019, c. 655; 2020, cc. 264, 916, 917; 2021, Sp. Sess. I, c. 161.

§ 38.2-4509.1. Rehabilitation, liquidation, conservation.

Any rehabilitation, liquidation, or conservation of a dental or optometric plan shall be deemed to be the rehabilitation, liquidation, or conservation of an insurer and shall be subject to the provisions of Chapter 15 of this title.

1990, c. 331.

§ 38.2-4510. Quarterly reports.

In addition to the annual statement required by § 38.2-1300, the Commission shall require each nonstock corporation to file on a quarterly basis any additional reports, exhibits or statements the Commission considers necessary to furnish full information concerning the condition, solvency, experience, transactions or affairs of the nonstock corporation. The Commission shall establish deadlines for submitting additional reports, exhibits or statements. The Commission may require verification by any officers of the nonstock corporation the Commission designates.

1980, c. 682, § 38.1-900; 1986, c. 562.

§ 38.2-4511. Corporation's contracts with participating dentists or optometrists.

Participating dentists or optometrists shall agree to (i) perform the dental services or optometric services specified by the plan at the rates of compensation determined by the nonstock corporation and filed with the Commission, and (ii) abide by the bylaws, rules and regulations of the nonstock corporation.

1980, c. 682, § 38.1-901; 1986, c. 562.

§ 38.2-4512. Contracts between participating dentists or optometrists and subscribers.

Participating dentists or optometrists, acting through their agents, may enter into contracts with subscribers to furnish specified dental or optometric services at specified rates to a subscriber or subscriber's members, officers, or employees. Contracts may vary as to services and rates.

1980, c. 682, § 38.1-902; 1986, c. 562.

§ 38.2-4513. Subscriber to have free choice of practitioners available.

A plan shall be organized and operated to assure that any subscriber shall have free choice of any participating dentist or optometrist who agrees to accept the subscriber as a patient for services provided by the plan.

1980, c. 682, § 38.1-903; 1986, c. 562.

§ 38.2-4514. Subscriber to be advised in writing as to benefits and limitations thereon.

A nonstock corporation shall, prior to and during the term of the subscription contract, fully, fairly, and currently advise the subscriber in writing of the benefits available under the contract and all limitations on the benefits available under the contract.

1980, c. 682, § 38.1-903; 1986, c. 562.

§ 38.2-4515. Geographical area.

A. Each nonstock corporation seeking to be licensed by the Commission shall specify the geographical area it desires to serve and shall satisfy the Commission that it is able to render the services of the plan.

B. The Commission may, after notice and hearing, license more than one nonstock corporation for the same geographical area unless the Commission finds that the (i) nonstock corporation's proposed method of operation or manner of doing business is not satisfactory or (ii) licensing of more than one nonstock corporation for the same geographical area will not promote the public welfare. If more than one nonstock corporation is licensed in a geographical area, the nonstock corporations in that area shall make arrangements among themselves to see that any claim filed with the wrong nonstock corporation in that area be promptly forwarded to the proper nonstock corporation, if it can be determined.

C. Subscription contracts shall not be sold to persons residing outside the area of the nonstock corporation unless they are regularly employed within the area. The subscription contract of a subscriber who neither lives nor is employed within the area shall be cancelled by notice given in accordance with the terms of the subscription contract.

1980, c. 682, § 38.1-904; 1986, c. 562.

§ 38.2-4516. Interplan arrangements.

A nonstock corporation may enter into contracts with similar nonstock corporations or foreign companies for the interchange of services to those included in subscription contracts and may provide in subscription contracts for the substitution of the services instead of those recited in subscription contracts.

1980, c. 682, § 38.1-905; 1986, c. 562.

§ 38.2-4517. Licensing of nonstock corporation.

A. No person shall operate a dental or optometric services plan in this Commonwealth without a license issued by the Commission. Each nonstock corporation shall apply for a license and furnish any relevant information the Commission requires. Each license shall expire at midnight on the following June 30. Application for a license shall be accompanied by a nonrefundable application fee of $500.

B. The Commission shall not issue to or renew a license of a nonstock corporation unless it is satisfied that the financial condition, the method of operation, and the manner of doing business of the nonstock corporation enable it to meet its contractual obligations to all subscribers and that the nonstock corporation has otherwise complied with all the requirements of law.

1980, c. 682, § 38.1-906; 1986, c. 562; 1987, cc. 565, 655; 1994, c. 503.

§ 38.2-4518. Renewal of nonstock corporation license.

A. Each nonstock corporation licensed under this chapter shall renew its license annually by July 1. The renewal license shall not be issued unless the nonstock corporation has complied with all requirements of law.

B. The Commission shall not fail or refuse to renew the license of any nonstock corporation without first giving the nonstock corporation ten days' notice of its intention not to renew the license and giving it an opportunity to be heard and to introduce evidence in its behalf. Any nonrenewal hearing may be informal, and the required notice may be waived by the Commission and the nonstock corporation.

1980, c. 682, § 38.1-907; 1986, c. 562; 1987, cc. 565, 655.

§ 38.2-4519. Licensing of agents.

Subscription contracts for dental services plans may be solicited only by licensed dental services agents as provided for in Chapter 18 of this title. Subscription contracts for optometric services plans may be solicited only by licensed optometric services agents as provided for in Chapter 18 of this title. Home office salaried officers whose principal duties and responsibilities do not include the negotiation or solicitation of subscription contracts shall not be required to be licensed.

1980, c. 682, § 38.1-908; 1986, c. 562.

§ 38.2-4520. Corporate restrictions.

Any nonstock corporation subject to this chapter shall not engage in any other business. However, a nonstock corporation may assist in the administration of governmental health care programs in a manner provided for by contract or regulations. A nonstock corporation's charter may provide for ex officio directors and directors elected by persons or associations who are not directors or members of the nonstock corporation.

1980, c. 682, § 38.1-909; 1986, c. 562.

§ 38.2-4521. Taxation.

Except as provided by Chapter 4 of this title, the license tax paid by a nonstock corporation under Chapter 25 of Title 58.1 shall be in lieu of all other state and local license fees or license taxes and state income taxes of the nonstock corporation.

1980, c. 682, § 38.1-909; 1986, c. 562; 1987, cc. 565, 655.

§ 38.2-4522. Misleading applications or contracts.

In the operation of a plan, no person shall use any misleading subscription applications or contracts.

1980, c. 682, § 38.1-910; 1986, c. 562.

§ 38.2-4523. Controversies involving subscription contracts.

The Commission shall have no jurisdiction to adjudicate controversies growing out of subscription contracts. A breach of contract shall not be deemed a violation of this chapter.

1980, c. 682, § 38.1-914; 1986, c. 562.

Chapter 46 - TITLE INSURANCE

§ 38.2-4600. Class of insurance and insurance companies to which chapter applies.

Except as otherwise provided, this chapter applies to title insurance as defined in § 38.2-123, and to title insurance companies as defined in § 38.2-4601.

1952, c. 317, § 38.1-720; 1986, c. 562.

§ 38.2-4601. Title insurance company defined.

"Title insurance company" means any company licensed to transact, or transacting, title insurance.

1952, c. 317, § 38.1-721; 1986, c. 562.

§ 38.2-4601.1. Title insurance agency or agent defined.

A "title insurance agency or agent" means any individual or business entity licensed in the Commonwealth, pursuant to Chapter 18 (§ 38.2-1800 et seq.) of this title, as a title insurance agent and appointed by a title insurance company licensed in the Commonwealth, who shall perform all of the following services (for which liability arises) relevant to the issuance of title insurance policies, subject to the underwriting directives and guidelines of the agent's title insurance company. These services shall include (i) the evaluation of the title search to determine the insurability of the title; (ii) a determination of whether or not underwriting objections have been cleared; (iii) the actual issuance of a title commitment or binder and endorsements; and (iv) the actual issuance of the policy or policies and endorsements on behalf of the title insurance company. A title insurance agent holding any funds in escrow shall promptly deposit such funds in a trust account in a financial institution licensed to do business in this Commonwealth. Such trust account shall be separate from all other accounts held by the agent.

1993, c. 147; 1997, c. 426; 2001, c. 706.

§ 38.2-4602. What laws applicable.

Except as otherwise provided, and except where the context otherwise requires, all provisions of this title relating to insurance and insurers generally shall apply to title insurance and title insurance companies.

Code 1950, §§ 38-234, 38-235; 1952, c. 317, § 38.1-722; 1986, c. 562.

§ 38.2-4603. What companies may transact title insurance.

No company other than an insurance company organized as a stock company and licensed to transact title insurance shall transact title insurance in this Commonwealth.

1952, c. 317, § 38.1-723; 1986, c. 562.

§ 38.2-4604. Investment in plant and equipment.

Notwithstanding the provisions of Chapter 14 of this title, any domestic title insurance company may invest in title records and equipment; however, the reporting of all such amounts as an admitted asset shall be subject to the valuation restrictions as provided for in the National Association of Insurance Commissioners accounting practices and procedures manuals.

Code 1950, § 38-236; 1952, c. 317, § 38.1-724; 1983, c. 457; 1986, c. 562; 2000, c. 46.

§ 38.2-4605. Interim binders.

Binders or other temporary insurance contracts may be made and used pending the issuance of a title insurance policy.

1952, c. 317, § 38.1-725; 1986, c. 562.

§ 38.2-4606. Forms to be filed with Commission.

All forms of title insurance policies and interim binders that are customarily used by any title insurance company in connection with the insurance of titles to property located in this Commonwealth shall be filed with the Commission.

1952, c. 317, § 38.1-726; 1986, c. 562.

§ 38.2-4607. Maximum risk.

On and after July 1, 1952, no company transacting title insurance in this Commonwealth shall assume a single risk in an amount in excess of fifty percent of the aggregate amount of its total capital and surplus and its reserves other than its loss or claim reserves. As used in this section, "a single risk" means the risk or hazard attaching to or arising in connection with any one piece or parcel of property, whether or not the policy insures other property. Any risk, or portion of any risk, that has been reinsured as authorized in this title shall be deducted in determining the limitation of risk prescribed in this section.

Code 1950, § 38-167; 1952, c. 317, § 38.1-727; 1986, c. 562.

§ 38.2-4608. Title insurance rates.

A. Title insurance risk rates shall be reasonable and adequate for the class of risks to which they apply. Risk rates shall not be unfairly discriminatory between risks involving essentially the same

hazards and expense elements. The rates may be fixed in an amount sufficient to furnish a reasonable margin for profit after provision for (i) probable losses as indicated by experience within and without this Commonwealth, (ii) exposure to loss under policies, (iii) allocations to reserves, (iv) costs of participating insurance, (v) operating costs, and (vi) other items of expense fairly attributable to the operation of a title insurance business.

B. Policies may be grouped into classes for the establishment of rates. A title insurance policy that is unusually hazardous to the title insurance company because of an alleged defect or irregularity in the title insured or because of uncertainty regarding the proper interpretation or application of the law involved, may be classified separately according to the facts of each case.

C. Title insurance risk rates shall not include charges for abstracting, record searching, certificates regarding the record title, escrow services, closing services, and other related services that may be offered or furnished, or the cost and expenses of examinations of titles.

D. Any title insurance company may issue, publish and use price schedules for title insurance and for any separate or related services, or schedules setting forth one price covering the risk rate and the charges for any separate or related services.

E. A title insurance company or title insurance agent may charge risk rates that it negotiates with any potential insured. Such negotiated rates shall be presumed not to be unfairly discriminatory and not to violate § 38.2-509 if such rates comply in all other respects with subsection A.

1952, c. 317, § 38.1-728; 1986, c. 562; 2005, c. 848.

§ 38.2-4609. Loss or claim reserves.

Each title insurance company licensed in this Commonwealth shall maintain loss and loss adjustment expense reserves in an amount estimated in the aggregate as being sufficient to provide for the payment of all unpaid losses and claims under title insurance contracts of which the company has received written notice from or on behalf of the insured.

1952, c. 317, § 38.1-729; 1986, c. 562; 1990, c. 334.

§ 38.2-4610. Repealed.

Repealed by Acts 1986, c. 404.

§ 38.2-4610.1. Unearned premium reserve.

A. A domestic title insurance company shall establish and maintain an unearned premium reserve computed in accordance with this section, and all sums attributed to such reserve shall at all times and for all purposes be considered and constitute unearned portions of the original premiums. This reserve shall be reported as a liability of the title insurance company in its financial statements.

B. The unearned premium reserve shall be maintained by the title insurance company for the protection of holders of title insurance policies. Except as provided in this section, assets equal in value to the unearned premium reserve are not subject to distribution among creditors or stockholders of the title insurance company until all claims of policyholders or claims under reinsurance contracts have

been paid in full, and all liability on the policies or reinsurance contracts has been paid in full and discharged or lawfully reinsured.

C. Except as provided in § 38.2-4610.1:1, foreign or alien title insurance company licensed to transact title insurance business in the Commonwealth shall maintain at least the same unearned premium reserves on title insurance policies issued on properties located in the Commonwealth as are required of domestic title insurance companies, unless the laws of the jurisdiction of domicile of the foreign or alien title insurance company require a higher amount.

D. The unearned premium reserve shall consist of:

1. The amount of the unearned premium reserve on June 30, 1986; and

2. A sum equal to $1.50 for each policy, contract or agreement of title insurance covering a single risk written after June 30, 1986, plus a sum equal to 12 1/2 cents of each $1,000 of net retained liability under each such policy, contract or agreement of title insurance on a single risk written after June 30, 1986.

E. Amounts placed in the unearned premium reserve in any year in accordance with subdivision 2 of subsection D of this section shall be deducted in determining the net profit of the title insurance company for that year.

F. A title insurance company shall release from the unearned premium reserve a sum equal to ten percent of the amount added to the reserve during a calendar year on July 1 of each of the five years following the year in which the sum was added, and shall release from the unearned premium reserve a sum equal to 3 1/3 percent of the amount added to the reserve during that year on each succeeding July 1 until the entire amount for that year has been released. The amount of the unearned premium reserve maintained before July 1, 1986, shall be released in accordance with the law in effect when the respective sums were reserved.

1986, c. 404, § 38.1-730.1; 2008, c. 248.

§ 38.2-4610.1:1. Unearned premium reserves of foreign title insurance companies.

A foreign title insurance company licensed to transact business in the Commonwealth shall be permitted to establish and maintain an unearned premium reserve on title insurance policies issued on properties located in the Commonwealth pursuant to the reserving laws of that foreign title insurance company's domiciliary regulator so long as the domiciliary regulator is accredited under the National Association of Insurance Commissioner's Financial Regulation Standards and Accreditation Program.

2008, c. 248.

§ 38.2-4610.2. Loss reserves.

A. Each title insurance company licensed in this Commonwealth shall annually evaluate the adequacy of its total recorded loss reserves. Total recorded loss reserves are the sum of claim reserves held under § 38.2-4609 and unearned premium reserves held under § 38.2-4610.1. The evaluation of reserve adequacy shall be prepared by a qualified actuary and shall be based on a

comparison of total recorded reserves to a projection of ultimate losses not yet paid. The actuary shall certify the results of his evaluation in a report complying with such applicable title insurance annual statement instructions as may be issued by the National Association of Insurance Commissioners.

B. A domestic title insurance company shall record an additional reserve to the extent the projection of ultimate losses not yet paid set forth in the report of the qualified actuary exceeds total recorded loss reserves held by the company. For purposes of calculating any additional reserve required, a domestic title insurance company may discount the projection of ultimate losses not yet paid to reflect the time value of money. The interest rate used by the actuary to reflect the time value of money shall be based on a portfolio interest rate approach with appropriate provision for risk margins and subject to published actuarial standards for discounting reserves.

C. A foreign or alien title insurance company licensed in this Commonwealth shall record an additional reserve to the extent the projection of ultimate losses set forth in the report of the qualified actuary exceeds all recorded reserves held by the company as reported in its most recent statutory statement filed with the Commission, including reserves held under subsection C of § 38.2-4610.1 and all reserves held under the laws of the jurisdiction of the domicile of the foreign or alien title insurance company or any other jurisdiction.

1996, c. 494.

§§ 38.2-4611, 38.2-4612. Repealed.

Repealed by Acts 1986, c. 404.

§ 38.2-4613. Unearned premium reserve to be held and administered for benefit of policyholders.

A. The reserve required under § 38.2-4610.1 shall be for the security of policyholders of the title insurance company as provided in this section.

B. If an order of rehabilitation or liquidation of any title insurance company is entered by a court of competent jurisdiction, the rehabilitator or receiver, with the approval of the court, or the Commission if it has been directed to rehabilitate or liquidate the title insurance company under the provisions of Chapter 15 of this title, may (i) use assets equal to the unearned premium reserve to pay any claims for losses sustained by policyholders prior to the time reinsurance is effected to the extent that those losses are in excess of the loss or claim reserves available for their payment, (ii) enter into contracts for the reinsurance of the obligations under the outstanding title insurance policies of the company in accordance with their terms and conditions, and (iii) use assets equal to the unearned premium reserve to pay the cost of reinsurance. After the payments authorized by this subsection have been made, assets equal to any balance in the unearned premium reserve shall become general assets of the company.

C. If no such contract of reinsurance is effected, assets equal to the unearned premium reserve may be applied by the rehabilitator or receiver with the approval of the court, or by the Commission, in the following order of preference: (i) all expenses incurred under this section in connection with the receivership or rehabilitation proceedings, (ii) all allowed and unpaid claims for losses sustained by

policyholders pending at the time fixed by the court or the Commission for the filing of claims, and (iii) all allowed claims for losses asserted within twenty years from the date of the entry of the order of rehabilitation or liquidation, which claims shall be paid in the order of the date of their allowance by the court or the Commission. Assets equal to any balance in the unearned premium reserve after payment of all allowed claims shall become general assets of the company. All title records that the rehabilitator, or the receiver, or the Commission if appointed to rehabilitate or liquidate the company, deems necessary to carry out the provisions of this section shall be preserved for twenty years.

D. In proceedings for the rehabilitation or liquidation of a title insurance company that has not been declared insolvent, no assets of the company shall be distributed to its stockholders until all claims allowed in the proceedings have been paid in full. If the proposed distribution is within twenty years from the date of the entry of the order of rehabilitation or liquidation, the distribution may be made if general assets of the title insurance company sufficient to fund the unearned premium reserve to the required amount as of the date of the entry of such order are first transferred to the unearned premium reserve. Upon the expiration of twenty years from the date of the order, assets equal to any balance in the unearned premium reserve after payment of all allowed claims asserted within the twenty-year period shall become general assets of the company.

1952, c. 317, § 38.1-733; 1986, cc. 404, 562.

§ 38.2-4614. Prohibition against payment or receipt of title insurance kickbacks, rebates, commissions and other payments; penalty.

A. 1. No person selling real property, or performing services as a real estate agent, attorney, or lender incident to any real estate settlement or sale, shall pay or receive, directly or indirectly, any kickback, rebate, commission, thing of value or other payment pursuant to any agreement or understanding, oral or otherwise, that business incident to the issuance of any title insurance be referred to any title insurance company, title insurance agency or agent. No title insurance company, title insurance agency or agent shall give any such kickback, rebate, commission, thing of value or other payment pursuant to any such agreement or understanding. For purposes of this section, "thing of value" means any payment, advance, funds, loan, service or other consideration. This section shall not prevent any federally insured lenders, holding companies to which they belong, or subsidiaries of such lenders or holding companies from being licensed by the Commission as title insurance agents or agencies and receiving commissions from the sale of the title insurance policies in their capacities as title insurance agents or agencies.

2. Nothing in this section shall be construed to prohibit (i) payments of sums spent for bona fide advertising and marketing promotions otherwise permissible under the provisions of the Real Estate Settlement Procedures Act, 12 U.S.C. § 2601 et seq. or (ii) providing educational materials or classes, wherein such materials or classes are provided to a group of persons or entities pursuant to a bona fide marketing or educational effort.

B. Any person who knowingly and willfully violates this section shall be guilty of a misdemeanor and subject to a fine of not more than $1,000 for each violation. Any criminal charge brought under this section shall be by indictment pursuant to Chapter 14 (§ 19.2-216 et seq.) of Title 19.2.

C. No person shall be in violation of this section solely by reason of ownership in a title insurance company, title insurance agency or agent as defined in this chapter, wherein such person receives returns on investments arising from the ownership interest. In addition, this section shall not prohibit (i) the payment to any person of a bona fide salary or compensation or other payment for services actually performed for the business of the title insurance company, title insurance agency or agent or (ii) any employer's payment to its own bona fide employees for referrals. Any employer's payment to its own employees for the referral of title insurance business shall be subject to the requirements of subdivision B 8 of § 38.2-1821.1.

1975, c. 184, § 38.1-733.1; 1986, c. 562; 1987, c. 174; 1993, c. 147; 1996, c. 883; 2002, c. 599.

§ 38.2-4615. Exchange of information.

A. In order to further more equitable adoption, use and adjustment of risk rates and premiums and forms of temporary insurance policies and contracts, the Commission and title insurance companies may (i) exchange information and experience data with each other, and with the insurance supervisory officers and insurers of other states, and with national organizations and associations, including duly licensed rating organizations, and (ii) may consult and cooperate with them with respect to risk rates, premiums, and forms of policies and contracts.

B. Any two or more licensed title insurance companies may act in concert with each other and with others with respect to any or all matters pertaining to the making of risk rates or premiums, or the preparation of forms of title insurance policies, underwriting rules and practices, surveys and investigations, or the furnishing of loss or expense statistics, or other information or data relating thereto.

1952, c. 317, § 38.1-734; 1986, c. 562.

§ 38.2-4616. Notification to buyers of the availability of owner's title insurance.

In connection with any transaction involving the purchase or sale of an interest in residential real property in this Commonwealth, the settlement agent as defined in § 55.1-900, before the disbursement of any funds, shall obtain from the purchaser a statement in writing that he has been notified by the settlement agent that the purchaser may wish to obtain owner's title insurance coverage including affirmative mechanics' lien coverage, if available, and of the general nature of such coverage, and that the purchaser does or does not desire such coverage. The notification shall include language that the value of subsequent improvements to the property may not be covered.

The failure of a settlement agent to provide the information requested by this section shall not of itself be deemed to create a cause of action that would not otherwise exist.

1992, c. 733.

Chapter 47 - INSURANCE PREMIUM FINANCE COMPANIES

§ 38.2-4700. What persons deemed insurance premium finance companies.

A. Any person engaged in whole or in part in financing premiums for insurance on subjects of insurance resident, located or to be performed in this Commonwealth shall be an insurance premium finance company subject to this chapter. Any person who acquires agreements for this financing from an insurance premium finance company shall be deemed an insurance premium finance company subject to this chapter.

B. No person shall be deemed an insurance premium finance company by reason of any transaction lawful under the laws of this Commonwealth without regard to the provisions of this chapter. No bank, trust company, savings institution, industrial loan association, credit union, consumer finance company licensed under Chapter 15 (§ 6.2-1500 et seq.) of Title 6.2, licensed insurance agent extending credit as authorized in § 38.2-1806, or insurer shall be licensed under the provisions of this chapter, nor be subject to the restrictions and obligations imposed by this chapter.

1964, c. 147, § 38.1-735; 1986, c. 562; 1996, c. 77.

§ 38.2-4701. License required; application; fee.

No person shall act as an insurance premium finance company in this Commonwealth until that person has obtained a license from the Commission as provided in this chapter. Application for a license shall be made in writing in the form prescribed by the Commission and shall be accompanied by a nonrefundable application fee of $500.

1964, c. 147, § 38.1-736; 1981, c. 107; 1986, c. 562.

§ 38.2-4702. Investigation of applicant; issuance of license.

Upon the filing of an application and the payment of the application fee, the Commission shall make an investigation of the applicant. The Commission shall issue a license, expiring on June 30 immediately following the date of issuance, if it finds that (i) the application is in proper form and the required fee has been paid; (ii) the financial responsibility, experience, character, and general fitness of the applicant indicate that the business will be operated lawfully, honestly, fairly and efficiently within the purpose of this chapter, the same criteria being applicable to members of the applicant if the applicant is a partnership or association and to officers and directors of the applicant if the applicant is a corporation; (iii) if the applicant is a corporation, it is a corporation of this Commonwealth or a foreign corporation that has a certificate of authority to transact business in this Commonwealth; and (iv) the applicant has assets equal to or greater than its liabilities and has working capital sufficient for the operation of its business.

1964, c. 147, § 38.1-737; 1981, c. 107; 1986, c. 562.

§ 38.2-4703. Renewal of license.

Subject to the provisions of § 38.2-4704, a licensed insurance premium finance company may renew its license on July 1 of each year, upon payment of a nonrefundable annual license fee of $200, unless the license has been surrendered, suspended or revoked.

1964, c. 147, § 38.1-738; 1975, c. 175; 1981, c. 107; 1986, c. 562.

§ 38.2-4704. Suspension, revocation or failure to renew license; imposition of penalty.

The Commission may suspend, revoke or refuse to renew a license of any insurance premium finance company whenever it finds that:

1. The licensee has (i) failed to pay the annual license fee, (ii) violated or failed to comply with any of the provisions of this chapter or with any rule or regulation made by the Commission pursuant to this chapter, or (iii) violated or failed to comply with any order, demand, ruling, provision or requirement of the Commission lawfully made pursuant to or within the authority of this chapter; or

2. The licensee no longer meets the standards required for the initial issuance of a license.

1964, c. 147, § 38.1-739; 1986, c. 562.

§ 38.2-4705. Maximum interest rate and maximum service charge on premium finance agreement.

A. The Commission shall periodically investigate the economic conditions and other factors relating to and affecting the business of insurance premium finance companies. The Commission shall ascertain all pertinent facts necessary to determine what maximum interest rate and what maximum service charge shall be permitted. Upon the basis of those facts and subject to this chapter, the Commission shall determine and fix by regulation or order the maximum interest rate and maximum service charge that may be charged in advance upon the amount financed by any insurance premium finance company.

B. The Commission shall initially fix the maximum interest rate at one percent per month charged in advance upon the entire amount financed payable in installments, and shall initially fix the maximum service charge at fifteen dollars. Thereafter, the maximum interest rate and maximum service charge shall be determined by the Commission after giving due consideration to such factors as (i) prevailing market interest rates, (ii) other relevant cost indices, and (iii) the industry-wide experience of premium finance companies operating in this Commonwealth. Before redetermining the maximum interest rate or maximum service charge, the Commission shall give all licensees notice and opportunity to be heard and to introduce evidence with respect to the maximum interest rate or service charge.

C. Interest at the authorized rate may be charged from the effective date of the premium finance agreement or the inception date of the insurance contract for which the premiums are being financed, whichever is earlier, through the date when the final installment of the premium finance agreement is payable. Interest charged under a premium finance agreement shall not be fully earned at the inception of the agreement. The insurance premium finance company may earn interest through the date the principal amount financed under a premium finance agreement has been paid in full for any reason. Upon such payment in full, a refund credit of any unearned interest shall be due the insured and shall be computed on a short rate or prorata basis as set forth in the agreement, provided that the

interest charged does not exceed the maximum interest rate established by the Commission pursuant to subsection A. The service charge received by an insurance premium finance company shall be fully earned upon its receipt and no portion of the service charge need be refunded upon prepayment of the loan for any reason. Only one service charge shall be made for each premium finance agreement, and no insurance agent or insurance premium finance company shall induce any person to enter into more than one premium finance agreement for the purpose of obtaining more than one service charge. Notwithstanding the foregoing, one additional charge not to exceed ten dollars may be charged if additional premiums are added to an existing finance agreement at the insured's request. Such additional charge may be applied only once during the term of any premium finance agreement. No part of any charges shall be paid to any insurance agent by an insurance premium finance company, nor shall any insurance premium finance company pay, allow or give, or offer to pay, allow or give, directly or indirectly, to any insurance agent, any valuable consideration as an inducement to finance the premium of any insurance policy. No insurance agent shall accept any valuable consideration as an inducement to finance the premium of any insurance policy. No person shall be in violation of this section solely by reason of ownership in an insurance premium finance company.

D. Notwithstanding the foregoing, the Commission by rule or order may exempt any premium finance agreement, any class of premium finance agreements or any market segment from any of the provisions of this section, if it finds their application unnecessary to achieve the purposes of this chapter.

1981, c. 107, § 38.1-740.1; 1986, c. 562; 1994, cc. 8, 123.

§ 38.2-4706. Default charge; bad check charge.

A. If any installment under a premium finance agreement is not paid in full within seven days after it is due, Sundays and holidays included, the insurance premium finance company may charge and collect a default charge not to exceed five percent of the installment. The default charge shall be collected only once on any installment.

B. An insurance premium finance company may charge and collect a fee, not in excess of twenty dollars, for each check returned to the insurance premium finance company because the drawer had no account or insufficient funds in the payor bank.

1981, c. 107, § 38.1-740.2; 1986, c. 562; 1994, c. 123.

§ 38.2-4707. Forms of premium finance agreements and related forms to be approved by Commission; false or misleading statements or omissions prohibited.

No form of premium finance agreement or any related form shall be used until it is approved by the Commission. No such form shall contain any statements that are materially false or misleading or omit statements necessary to prevent the form from being in any material way false or misleading.

1964, c. 147, § 38.1-741; 1981, c. 107; 1986, c. 562.

§ 38.2-4708. Examination of books and records of company; bond; rules and regulations; order by Commission to remedy concerns.

A. 1. The Commission is empowered to examine the books and records of an insurance premium finance company.

2. The Commission is empowered to require an insurance premium finance company to enter into bond with surety approved by the Commission, in the amount determined as reasonable by the Commission, and conditioned to protect its customers and the public in the manner required by law. The aggregate liability of the surety for all breaches of the conditions of the bond shall in no event exceed the penalty of the bond. The surety on the bond shall have the right to cancel the bond upon thirty days' notice in writing to the Commission and shall be relieved of liability for any breach of condition occurring after the effective date of the cancellation.

3. Any rules and regulations issued by the Commission with respect to the operation of insurance premium finance companies may include, without limitation, rules and regulations for the cancellation of policies by insurance premium finance companies, for the notice required to be given to the insured and the insurer, and for the mutual obligations and duties of insurers and insurance premium finance companies with regard to the cancellation of policies and the required notice.

B. If the Commission finds (i) that an insurance premium finance company's financial condition, method of operation or manner of doing business does not satisfy the Commission that the company can meet its obligations to all customers or (ii) that the company's continued operation in this Commonwealth is hazardous to customers and creditors in this Commonwealth and to the public, it may order the company to take appropriate action within a specified time to remedy the concerns of the Commission. The Commission shall give the insurance premium finance company ten days' notice of its finding and shall grant it the opportunity to be heard and to introduce evidence on its behalf. Any hearing with regard to the order may be informal, and the required notice may be waived with the mutual consent of the Commission and the company.

1964, c. 147, § 38.1-742; 1981, c. 107; 1986, c. 562.

§ 38.2-4709. Disposition of license and other fees.

The Commission shall collect and pay directly into the state treasury licensing fees and all other fees. These fees shall be credited to the fund for the maintenance of the Bureau of Insurance.

1964, c. 147, § 38.1-743; 1981, c. 107; 1986, c. 562.

§ 38.2-4710. Penalty for engaging in business without license.

Any person engaging in the business of financing insurance premiums in this Commonwealth without obtaining a license as required under this chapter shall be subject to a fine of not more than $100 for each day that person operates without a license. The fine shall be imposed and judgment entered by the Commission after ten days' notice has been given to the defendant by rule to show cause.

1964, c. 147, § 38.1-744; 1986, c. 562.

§ 38.2-4711. Exemptions.

This chapter shall not apply to the inclusion of a charge for insurance in a sale of property, goods or services payable in installments, or in a loan made for purposes other than the financing of insurance premiums only.

1964, c. 147, § 38.1-745; 1981, c. 107; 1986, c. 562.

§ 38.2-4712. Validity of secured transactions.

No filing of the premium finance agreement or recording of a premium finance transaction shall be necessary to validate the agreement as a secured transaction.

1964, c. 147, § 38.1-745; 1981, c. 107; 1986, c. 562.

Chapter 48 - SURPLUS LINES INSURANCE LAW

§§ 38.2-4800 through 38.2-4805. Repealed.

Repealed by Acts 2001, c. 706, cl. 2, effective September 1, 2002.

§ 38.2-4805.1. Application of chapter.

Except as provided in subsection C of § 38.2-1802, this chapter shall apply to the sale, solicitation, and negotiation of surplus lines insurance coverage for insureds whose home state, as defined in § 38.2-4805.2, is this Commonwealth.

2011, c. 498.

§ 38.2-4805.2. Definitions.

As used in this chapter, unless the context requires a different meaning:

"Admitted insurer" means an insurer licensed in the Commonwealth to engage in the business of insurance.

"Domestic surplus lines insurer" means a domestic surplus lines insurer licensed by the Commission pursuant to § 38.2-1024 with which a surplus lines broker may place surplus lines insurance.

"Eligible nonadmitted insurer" means a nonadmitted insurer approved by the Commission pursuant to § 38.2-4811 or a domestic surplus lines insurer licensed by the Commission pursuant to § 38.2-1024 with which a surplus lines broker may place surplus lines insurance.

"Home state" means (i) the state in which an insured maintains its principal place of business or, in the case of an individual, the individual's principal residence or (ii) if 100 percent of the insured risk is located out of the state referred to in clause (i), "home state" means the state to which the greatest percentage of the insured's taxable premium for that insurance contract is allocated. When more than one insured from an affiliated group are named insureds on a single insurance contract, "home state" means the state of the member of the affiliated group that has the largest percentage of premium attributed to it under such insurance contract.

"NAIC" means the National Association of Insurance Commissioners.

"Nonadmitted insurer" means an insurer not licensed to engage in the business of insurance in this Commonwealth. "Nonadmitted insurer" does not include a risk retention group as defined in § 38.2-5101.

"Principal place of business" means the state where the insured maintains its headquarters and where the insured's high-level officers direct, control, and coordinate the business activities of the insured.

"Property and casualty insurance" means the classes of insurance defined in §§ 38.2-109 through 38.2-122.2 and §§ 38.2-124 through 38.2-134.

"Surplus lines broker" means an individual or business entity licensed pursuant to Article 5.1 (§ 38.2-1857.1 et seq.) of Chapter 18 to sell, solicit, or negotiate insurance on properties, risks, or exposures located or to be performed in the Commonwealth with eligible nonadmitted insurers.

"Surplus lines insurance" means any property and casualty insurance permitted to be placed directly by an insured or through a surplus lines broker with an eligible nonadmitted insurer.

2011, c. 498; 2018, c. 205.

§ 38.2-4806. Notice to insured that insurance is placed with an eligible nonadmitted insurer required.

A notice in a form prescribed by the Commission shall be given to the insured under the provisions of a policy procured pursuant to this chapter by the surplus lines broker procuring the policy or by any duly licensed property and casualty insurance agent placing surplus lines business with the surplus lines broker. The notice shall contain, but not be limited to, statements that the policy is being procured from or has been placed with an insurer approved by the Commission as an eligible nonadmitted insurer and that there is no protection under the Virginia Property and Casualty Insurance Guaranty Association established under Chapter 16 (§ 38.2-1600 et seq.) against financial loss to claimants or policyholders because of the insolvency of an eligible nonadmitted insurer. The notice shall also set forth the name, license number, and mailing address of the broker. The notice shall be given prior to placement of the insurance. In the event coverage must be placed and become effective within 24 hours after referral of the business to the surplus lines broker, the notice may be given promptly following such a placement. In addition, a copy of the notice shall be affixed to the policy.

Code 1950, § 38.-314.7; 1960, c. 503; 1979, c. 513, § 38.1-327.52; 1981, c. 241; 1984, c. 719; 1986, c. 562; 1987, c. 519; 1988, c. 828; 1996, c. 240; 2001, c. 706; 2008, c. 212; 2011, c. 498; 2018, c. 205.

§ 38.2-4807. Licensees to keep records and file annual statement of policies.

A. Every licensed surplus lines broker shall keep in his office a complete record of (i) each policy of insurance procured by him under this chapter during the previous calendar year; (ii) the name and address of the insurer or insurers; (iii) the inception and expiration dates of each policy; (iv) the perils insured against; (v) the location of each risk so insured and the premium rate and the gross premium charged for each such policy of insurance; (vi) the amount of premium returned; and (vii) any other information the Commission requires.

B. The record of each policy of insurance shall be kept open at all reasonable times to examination by the Commission without notice for a period of not less than five years following termination of the policy.

Code 1950, § 38.1-314.8; 1960, c. 503; 1979, c. 513, § 38.1-327.53; 1986, c. 562; 2001, c. 706; 2011, c. 498.

§ 38.2-4808. Effect of payment to surplus lines broker.

A. No surplus lines broker may accept a payment of premium for issuance of surplus lines insurance before placing the insurance with an eligible nonadmitted insurer.

B. A payment of premium to a surplus lines broker shall be deemed to be payment to the insurer notwithstanding any policy conditions or stipulations to the contrary.

1986, c. 562; 2018, c. 205.

§ 38.2-4809. Licensees to pay license taxes on insurers.

A. 1. Every licensed surplus lines broker or any person required to be licensed as a surplus lines broker shall be subject to the annual taxes, license taxes, penalties, and other provisions of Article 1 (§ 58.1-2500 et seq.) of Chapter 25 of Title 58.1 on each policy of insurance procured by him during the preceding calendar year with an eligible nonadmitted insurer. For policies effective on or after July 1, 2011, such payments shall be made based on the direct gross premium income derived from policies for insureds whose home state is the Commonwealth.

2. Every surplus lines broker or any person required to be licensed as a surplus lines broker subject to the provisions of this chapter shall, on or before March 1 of 2012 and 2013 report under oath to the Commission, and on or before March 1 of each year thereafter, report under oath to the Department of Taxation, upon the prescribed form, the direct gross premium income derived from policies for insureds whose home state is the Commonwealth during the preceding year ending December 31.

3. Every surplus lines broker or any person required to be licensed as a surplus lines broker failing to file the report required by this section shall be fined $50 for each day's failure to file the report.

4. Upon the failure of any such surplus lines broker or any person required to be licensed as a surplus lines broker to pay the premium license tax within the time required by this section, there shall be added to such tax a penalty of 10 percent of the amount of the tax and interest at a rate equal to the rate of interest established pursuant to § 58.1-15 for the period between the due date and the date of full payment. The Commission or Department of Taxation shall notify the surplus lines broker of all additional amounts owed, and the surplus lines broker shall pay such amounts within 30 days of the date of the notice.

5. Upon good cause shown, the Department of Taxation may accept late payment of the premium license tax exclusive of penalties; however, interest shall be paid on such tax as prescribed in this subsection.

6. If any person overestimates and overpays the annual taxes, the Department of Taxation shall refund the amount of the overpayment to the person. The overpayment shall be refunded out of the state treasury.

B. 1. Each licensed surplus lines broker or any person required to be licensed as a surplus lines broker whose annual premium license tax liability can reasonably be expected to exceed $1,500 shall file a quarterly tax report with the Department of Taxation. Such report shall be in a form prescribed by the Department of Taxation. This report shall be filed no later than 30 calendar days after the end of each calendar quarter. Notwithstanding any provision to the contrary, each such person shall pay the premium license tax owed for the direct gross premiums adjusted for additional and returned premiums shown by each quarterly tax report when such report is filed with the Department of Taxation.

2. No surplus lines broker or any person required to be licensed as a surplus lines broker shall be subject to any penalty or interest pursuant to Title 58.1 as a result of the failure to timely file a quarterly tax report or make the related quarterly payment when the report is filed pursuant to subdivision 1.

C. In addition to other penalties provided by law, any licensed surplus lines broker or any person required to be licensed as a surplus lines broker who willfully fails or refuses to pay the full amount of the tax or assessment required by this chapter, either by himself or through his agents or employees, or who makes a false or fraudulent return with intent to evade the tax or assessment hereby levied, or who makes a false or fraudulent claim for refund shall be guilty of a Class 1 misdemeanor.

D. If any licensed surplus lines broker or any person required to be licensed as a surplus lines broker charges and collects from the insured the taxes and assessments required by this section and § 38.2-4809.1, such person shall be a fiduciary to this Commonwealth for any taxes and assessments owed to this Commonwealth under this chapter.

Code 1950, § 38.1-314.9; 1960, c. 503; 1979, c. 513, § 38.1-327.54; 1986, c. 562; 1987, c. 519; 1988, c. 153; 2001, c. 706; 2011, cc. 498, 850; 2013, cc. 29, 163; 2018, c. 205.

§ 38.2-4809.1. Licensees to pay assessments on insurers.

Every licensed surplus lines broker or any person required to be licensed as a surplus lines broker shall be subject to the annual maintenance fund assessment, penalties, and other provisions of §§ 38.2-400, 38.2-403, and 38.2-406. If any person overpays the assessment, the Commission shall process a refund.

2011, c. 850; 2013, cc. 29, 163; 2017, c. 39.

§ 38.2-4810. Issuance and delivery of surplus lines policies; prior authority or information required.

Each policy or other written evidence of insurance procured pursuant to this chapter shall be delivered promptly to the named insured shown on the policy's declarations page. No surplus lines broker shall issue or deliver any policy or other written evidence of insurance or represent that insurance will be or has been granted by an eligible nonadmitted insurer unless (i) he has prior written authority from such insurer for the insurance, (ii) he has received information from the insurer in the regular course of business that the insurance has been granted, or (iii) an insurance policy providing the insurance actually

has been issued by the insurer and delivered to the named insured shown on the policy's declarations page.

Code 1950, § 38.1-314.10; 1960, c. 503; 1979, c. 513, § 38.1-327.55; 1984, c. 719; 1986, c. 562; 2011, c. 498; 2018, c. 205.

§ 38.2-4811. Surplus lines coverage to be placed with eligible nonadmitted insurers.

A. No surplus lines broker shall procure a policy of insurance with any nonadmitted insurer unless such nonadmitted insurer has prior approval of the Commission to issue surplus lines insurance.

B. Any unlicensed foreign insurer wishing to be approved by the Commission to issue surplus lines coverage may receive such approval upon providing:

1. Evidence that it is authorized to write the type of insurance in its domiciliary jurisdiction; and

2. Proof that it has capital and surplus or its equivalent under the laws of its domiciliary jurisdiction, which equal the greater of (i) the minimum capital and surplus requirements under §§ 38.2-1028, 38.2-1029, 38.2-1030 or § 38.2-1031, or (ii) $15 million.

C. Notwithstanding the capital and surplus requirements of subdivision B 2, an unlicensed foreign insurer may receive approval upon an affirmative finding of acceptability by the Commission. The finding shall be based upon such factors as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends, market availability, and company record and reputation within the industry. In no event shall the Commission make an affirmative finding of acceptability when the surplus lines insurer's capital and surplus is less than $4.5 million.

D. An unlicensed alien insurer shall be deemed approved by the Commission if such insurer is listed on the Quarterly Listing of Alien Insurers maintained by the NAIC International Insurers Department.

E. Any unlicensed foreign insurer approved by the Commission shall cause to be provided to the Commission, not later than March 1, a copy of its current annual statement certified by the insurer, in accordance with § 38.2-1300.

The Commission, at its discretion, may extend the period for filing an annual statement by a maximum of two months.

F. If at any time the Commission has reason to believe that an eligible nonadmitted insurer (i) is in unsound financial condition, (ii) is no longer eligible under this section, (iii) has willfully violated the laws of the Commonwealth, or (iv) does not make reasonably prompt payment of just losses and claims in the Commonwealth or elsewhere, the Commission may declare it ineligible. The Commission shall promptly mail notice of all such declarations to each surplus lines licensee.

Code 1950, § 38.1-314.11; 1960, c. 503; 1979, c. 513, § 38.1-327.56; 1984, c. 719; 1986, c. 562; 1994, c. 647; 1995, c. 60; 2007, c. 157; 2011, c. 498; 2018, c. 205.

§ 38.2-4811.1. Surplus lines coverage placed with domestic surplus lines insurers.

A. The Commission may license pursuant to § 38.2-1024 an insurer domiciled in the Commonwealth as a domestic surplus lines insurer if all of the following are satisfied:

1. The insurer possesses a policyholder surplus of at least $15 million; and

2. The board of directors of the insurer has passed a resolution seeking to be a domestic surplus lines insurer in the Commonwealth.

B. For the purposes of the federal Nonadmitted and Reinsurance Reform Act of 2010 (15 U.S.C. § 8201 et seq.), a domestic surplus lines insurer shall be considered a nonadmitted insurer as the term is referenced in such Act, with respect to risks insured in the Commonwealth.

C. A domestic surplus lines insurer is only authorized to write the types of insurance in the Commonwealth that a surplus lines broker may procure with a nonadmitted insurer approved by the Commission pursuant to § 38.2-4811.

D. A domestic surplus lines insurer may only write surplus lines insurance in the Commonwealth where placed by a surplus lines broker pursuant to Chapter 48 (§ 38.2-4805.1 et seq.).

E. Notwithstanding any other statute, the policies issued by a domestic surplus lines insurer where the Commonwealth is the home state of the insured shall be subject to taxes and maintenance assessments levied upon surplus lines policies issued by eligible nonadmitted insurers pursuant to §§ 38.2-4809 and 38.2-4809.1 but shall not be subject to other taxes levied upon admitted insurers, whether domestic or foreign, pursuant to Chapter 25 (§ 58.1-2500 et seq.) of Title 58.1.

F. Policies issued by a domestic surplus lines insurer are not subject to protections of or other provisions of the Virginia Property and Casualty Insurance Guaranty Association established under Chapter 16 (§ 38.2-1600 et seq.).

G. All financial and solvency requirements imposed by the Commonwealth's law upon domestic admitted insurers shall apply to domestic surplus lines insurers unless domestic surplus lines insurers are otherwise specifically exempted. For the purposes of handling the rehabilitation, liquidation, or conservation of a domestic surplus lines insurer, the provisions of Chapter 15 (§ 38.2-1500 et seq.) shall apply.

H. Policies issued by a domestic surplus lines insurer shall be exempt from all statutory requirements relating to insurance rating plans, policy forms, policy cancellation and nonrenewal, and premium charged to the insured in the same manner and to the same extent as a nonadmitted insurer domiciled in another state.

2018, c. 205.

§ 38.2-4812. Surplus lines insurers subject to Unlicensed Insurers Process.

Every nonadmitted insurer issuing surplus lines coverage under this chapter shall be subject to the provisions of Article 1 (§ 38.2-800 et seq.) of Chapter 8.

Code 1950, § 38.1-314.12; 1960, c. 503; 1979, c. 513, § 38.1-327.57; 1986, c. 562; 1988, c. 153; 2007, c. 157; 2018, c. 205.

§ 38.2-4813. Commission to make rules and regulations.

The Commission may make, approve and adopt reasonable rules and regulations consistent with this chapter to effect the purposes of this chapter.

Code 1950, § 38.1-314.14; 1960, c. 503; 1979, c. 513, § 38.1-327.58; 1984, c. 719; 1986, c. 562.

§ 38.2-4814. Penalties.

Any violation of this chapter shall be punished as provided for in §§ 38.2-218 and 38.2-1831.

Code 1950, § 38.1-314.15; 1960, c. 503; 1979, c. 513, § 38.1-327.59; 1986, c. 562.

§ 38.2-4815. Effect on other provisions of Title 38.2.

Except as is otherwise provided herein and in Chapter 18 (§ 38.2-1800 et seq.) of this title, the provisions relating to the licensing and control of surplus lines brokers shall have no effect on or in any way alter any of the other provisions of this title.

Code 1950, § 38.1-314.16; 1960, c. 503; 1979, c. 513, § 38.1-327.60; 1986, c. 562; 2001, c. 706.

§ 38.2-4816. Exchange of information.

The Commission and Department of Taxation may exchange information for purposes of enforcing the provisions of this title.

2011, c. 850.

Chapter 49 - Continuing Care Providers and Community-Based Continuing Care Providers

Article 1 - REGISTRATION OF CONTINUING CARE PROVIDERS

§ 38.2-4900. Definitions.

As used in this article and Article 3 (§ 38.2-4924 et seq.):

"Continuing care" means providing or committing to provide board, lodging and nursing services to an individual, other than an individual related by blood or marriage, (i) pursuant to an agreement effective for the life of the individual or for a period in excess of one year, including mutually terminable contracts, and (ii) in consideration of the payment of an entrance fee. A contract shall be deemed to be one offering nursing services, irrespective of whether such services are provided under such contract, if nursing services are offered to the resident entering such contract either at the facility in question or pursuant to arrangements specifically offered to residents of the facility.

"Continuing care" also means providing or committing to provide lodging to an individual, other than an individual related by blood or marriage, (i) pursuant to an agreement effective for the life of the individual or for a period in excess of one year, including mutually terminable contracts, (ii) in consideration of the payment of an entrance fee, and (iii) where board and nursing services are made

available to the resident by the provider, either directly or indirectly through affiliated persons, or through contractual arrangements, whether or not such services are specifically offered in the agreement for lodging.

"Entrance fee" means an initial or deferred transfer to a provider of a sum of money or other property made or promised to be made in advance or at some future time as full or partial consideration for acceptance of a specified individual as a resident in a facility. A fee which in the aggregate is less than the sum of the regular periodic charges for one year of residency shall not be considered to be an entrance fee except as provided in subsection A of § 38.2-4904.1.

"Facility" means the place or places in which a person undertakes to provide continuing care to an individual.

"Provider" means any person, corporation, partnership or other entity that provides or offers to provide continuing care to any individual in an existing or proposed facility in this Commonwealth. Two or more related individuals, corporations, partnerships or other entities may be treated as a single provider if they cooperate in offering services to the residents of a facility.

"Resident" means an individual entitled to receive continuing care in a facility.

"Solicit" means all actions of a provider or his agent in seeking to have individuals enter into a continuing care agreement by any means such as, but not limited to, personal, telephone or mail communication or any other communication directed to and received by any individual, and any advertisements in any media distributed or communicated by any means to individuals.

1985, c. 554, § 38.1-955; 1986, cc. 562, 598; 1993, c. 683; 2012, cc. 208, 303.

§ 38.2-4901. Registration.

A. Except as provided in § 38.2-4912, no provider shall engage in the business of providing or offering to provide continuing care at a facility in this Commonwealth unless the provider has registered with the Commission with respect to such facility.

B. A registration statement shall be filed with the Commission by the provider on forms prescribed by the Commission and shall include:

1. All information required by the Commission pursuant to its enforcement of this chapter; and

2. The initial disclosure statement required by § 38.2-4902.

C. Registration shall be approved or disapproved in writing by the Commission within ninety days of the filing.

1985, c. 554, § 38.1-956; 1986, c. 562.

§ 38.2-4902. Disclosure statement.

A. The disclosure statement of each facility shall contain all of the following information unless such information is contained in the continuing care contract and a copy of that contract is attached to and made a part of the initial disclosure statement:

1. The name and business address of the provider and a statement of whether the provider is a partnership, foundation, association, corporation or other type of business or legal entity.

2. Full information regarding ownership of the property on which the facility is or will be operated and of the buildings in which it is or will be operated.

3. The names and business addresses of the officers, directors, trustees, managing or general partners, and any person having a ten percent or greater equity or beneficial interest in the provider, and a description of such person's interest in or occupation with the provider.

4. For (i) the provider, (ii) any person named in response to subdivision 3 of this subsection or (iii) the proposed management, if the facility will be managed on a day-to-day basis by a person other than an individual directly employed by the provider:

a. A description of any business experience in the operation or management of similar facilities.

b. The name and address of any professional service, firm, association, foundation, trust, partnership or corporation or any other business or legal entity in which such person has, or which has in such person, a 10 percent or greater interest and which it is presently intended will or may provide goods, leases or services to the provider of a value of $500 or more, within any year, including:

(1) A description of the goods, leases or services and the probable or anticipated cost thereof to the provider;

(2) The process by which the contract was awarded;

(3) Any additional offers that were received; and

(4) Any additional information requested by the Commission detailing how and why a contract was awarded.

c. A description of any matter in which such person:

(1) Has been convicted of a felony or pleaded nolo contendere to a criminal charge, or been held liable or enjoined in a civil action by final judgment, if the crime or civil action involved fraud, embezzlement, fraudulent conversion, misappropriation of property or moral turpitude; or

(2) Is subject to an injunctive or restrictive order of a court of record, or within the past five years had any state or federal license or permit suspended or revoked as a result of an action brought by a governmental agency or department, arising out of or relating to business activity or health care, including without limitation actions affecting a license to operate a foster care facility, nursing home, retirement home, home for the aged or facility registered under this chapter or similar laws in another state; or

(3) Is currently the subject of any state or federal prosecution, or administrative investigation involving allegations of fraud, embezzlement, fraudulent conversion, or misappropriation of property.

5. A statement as to:

a. Whether the provider is or ever has been affiliated with a religious, charitable or other nonprofit organization, the nature of any such affiliation, and the extent to which the affiliate organization is or will be responsible for the financial and contractual obligations of the provider.

b. Any provision of the federal Internal Revenue Code under which the provider is exempt from the payment of income tax.

6. The location and description of the real property of the facility, existing or proposed, and to the extent proposed, the estimated completion date or dates of improvements, whether or not construction has begun and the contingencies under which construction may be deferred.

7. The services provided or proposed to be provided under continuing care contracts, including the extent to which medical care is furnished or is available pursuant to any arrangement. The disclosure statement shall clearly state which services are included in basic continuing care contracts and which services are made available by the provider at extra charge.

8. A description of all fees required of residents, including any entrance fee and periodic charges. The description shall include (i) a description of all proposed uses of any funds or property required to be transferred to the provider or any other person prior to the resident's occupancy of the facility and of any entrance fee, (ii) a description of provisions for the escrowing and return of any such funds, assets or entrance fee, the manner and any conditions of return and to whom earnings on escrowed funds are payable and (iii) a description of the manner by which the provider may adjust periodic charges or other recurring fees and any limitations on such adjustments. If the facility is already in operation, or if the provider operates one or more similar facilities within this Commonwealth, there shall be included tables showing the frequency and average dollar amount of each increase in periodic rates at each facility for the previous five years or such shorter period that the facility has been operated by the provider.

9. Any provisions that have been made or will be made to provide reserve funding or security to enable the provider to fully perform its obligations under continuing care contracts, including the establishment of escrow accounts, trusts or reserve funds, together with the manner in which such funds will be invested and the names and experience of persons who will make the investment decisions. The disclosure statement shall clearly state whether or not reserve funds are maintained.

10. Certified financial statements of the provider, including (i) a balance sheet as of the end of the two most recent fiscal years and (ii) income statements of the provider for the two most recent fiscal years or such shorter period that the provider has been in existence.

11. A pro forma income statement for the current fiscal year.

12. If operation of the facility has not yet commenced, a statement of the anticipated source and application of the funds used or to be used in the purchase or construction of the facility, including:

a. An estimate of the cost of purchasing or constructing and equipping the facility including such related costs as financing expense, legal expense, land costs, occupancy development costs and all

other similar costs that the provider expects to incur or become obligated for prior to the commencement of operations.

b. A description of any mortgage loan or other long-term financing intended to be used for any purpose in the financing of the facility and of the anticipated terms and costs of such financing, including without limitation, all payments of the proceeds of such financing to the provider, management or any related person.

c. An estimate of the percentage of entrance fees that will be used or pledged for the construction or purchase of the facility, as security for long-term financing or for any other use in connection with the commencement of operation of the facility.

d. An estimate of the total entrance fees to be received from or on behalf of residents at or prior to commencement of operation of the facility.

e. An estimate of the funds, if any, which are anticipated to be necessary to fund start-up losses and provide reserve funds to assure full performance of the obligations of the provider under continuing care contracts.

f. A projection of estimated income from fees and charges other than entrance fees, showing individual rates presently anticipated to be charged and including a description of the assumptions used for calculating the estimated occupancy rate of the facility and the effect on the income of the facility of any government subsidies for health care services to be provided pursuant to the continuing care contracts.

g. A projection of estimated operating expenses of the facility, including (i) a description of the assumptions used in calculating any expenses and separate allowances for the replacement of equipment and furnishings and anticipated major structural repairs or additions and (ii) an estimate of the percentage of occupancy required for continued operation of the facility.

h. Identification of any assets pledged as collateral for any purpose.

i. An estimate of annual payments of principal and interest required by any mortgage loan or other long-term financing.

13. A description of the provider's criteria for admission of new residents.

14. A description of the provider's policies regarding access to the facility and its services for non-residents.

15. Any other material information concerning the facility or the provider that may be required by the Commission or included by the provider.

16. The procedure by which a resident may file a complaint or disclose any concern.

B. The disclosure statement shall state on its cover that the filing of the disclosure statement with the Commission does not constitute recommendation or endorsement of the facility by the Commission.

C. A copy of the standard form or forms for continuing care contracts used by the provider shall be attached as an exhibit to each disclosure statement.

D. If the Commission determines that the disclosure statement does not comply with the provisions of this chapter, it shall have the right to take action pursuant to § 38.2-4931.

1985, c. 554, § 38.1-957; 1986, cc. 562, 598; 1992, c. 139; 2012, cc. 208, 303.

§ 38.2-4903. Availability of disclosure statement to prospective residents.

At least three days prior to the execution of a continuing care contract or the transfer of any money or other property to a provider by or on behalf of a prospective resident, whichever first occurs, the provider shall deliver to the person with whom the contract is to be entered into a copy of a disclosure statement with respect to the facility in question meeting all requirements of this chapter as of the date of its delivery.

1985, c. 554, § 38.1-958; 1986, c. 562.

§ 38.2-4904. Annual disclosure statements.

A. Within four months following the end of the provider's fiscal year, each provider shall file with the Commission and make available by written notice to each resident at no cost an annual disclosure statement which shall contain the information required for the initial disclosure statement set forth in § 38.2-4902.

B. The annual disclosure statement shall also be accompanied by a narrative describing any material differences between:

1. The prior fiscal year's pro forma income statement, and

2. The actual results of operations during that fiscal year.

C. The annual disclosure statement shall describe the disposition of any real property acquired by the provider from residents of the facility.

D. In addition to filing the annual disclosure statement, the provider shall amend its currently filed disclosure statement at any other time if, in the opinion of the provider, an amendment is necessary to prevent the disclosure statement from containing any material misstatement of fact or failing to state any material fact required to be stated therein. Any such amendment or amended disclosure statement shall be filed with the Commission before it is delivered to any resident or prospective resident and is subject to all the requirements of this chapter, and the provider shall notify each resident of the existence of such amendment or amended disclosure statement.

E. If the Commission determines that the disclosure statement does not comply with the provisions of this chapter, it shall have the right to take action pursuant to § 38.2-4931.

1985, c. 554, § 38.1-959; 1986, c. 562; 2012, cc. 208, 303.

§ 38.2-4904.1. Escrow of entrance fee to continuing care providers and others.

A. A provider shall maintain in escrow with a bank or trust company, or other escrow agent approved by the Commission, all entrance fees or portions thereof in excess of $1,000 per person received by the provider prior to the date the resident is permitted to occupy a unit in the facility. Funds or assets deposited therein shall be kept and maintained in an account separate and apart from the provider's business accounts. For the purposes of this section only, the term "entrance fee" shall include within its meaning any advanced payment or series of advanced payments totaling $5,000 or more and the term "provider" shall include any person or entity that would be included in the definition thereof in § 38.2-4900 if such fee of $5,000 or more constituted an entrance fee for the purposes of the definition of "continuing care" in § 38.2-4900.

B. All funds or assets deposited in the escrow account shall remain the property of the prospective resident until released to the provider in accordance with this section. The funds or assets shall not be subject to any liens, judgments, garnishments or creditor's claims against the provider or facility. The escrow agreement may provide that charges by the escrow agent may be deducted from the funds or assets if such provision is disclosed in the disclosure statement.

C. All funds or assets deposited in escrow pursuant to this section shall be released to the provider when the provider presents to the escrow agent evidence that a unit has been occupied by the resident or a unit of the type reserved is available for immediate occupancy by the resident or prospective resident on whose behalf the fee was received.

D. Notwithstanding any other provision of this section, all funds or assets deposited in escrow pursuant to this section shall be released according to the terms of the escrow agreement to the prospective resident from whom it was received (i) if such funds or assets have not been released within three years after placement in escrow or within three years after construction has started, whichever is later (but in any event within six years after placement in escrow unless specifically approved by the Commission), or within such longer period as determined appropriate by the Commission in writing, (ii) if the prospective resident dies before occupying a unit, (iii) if the construction of a facility, not yet operating is stopped indefinitely before the facility is completed or (iv) upon rescission of the contract pursuant to provisions in the contract or in this chapter. If construction of the unit to be reserved has not started within three years after the deposit of funds or assets into an escrow account, the prospective resident may require the return of such funds or assets unless the Commission determines that construction will begin in a reasonable period of time and the extension of such three-year period is appropriate. However, funds or assets subject to release under item (i) of this subsection or under subsection C of this section may be held in escrow for an additional period at the mutual consent of the provider and the prospective resident; however, the prospective resident may consent to such additional period only after his deposit has been held in escrow for at least two years. Item (i) above shall not apply if fees are refundable within thirty days of request for refund.

E. Unless otherwise specified in the escrow agreement, funds or assets in an escrow account pursuant to this section may be held in the form received or if invested shall be invested in instruments

authorized for the investment of public funds as set forth in Chapter 45 (§ 2.2-4500 et seq.) of Title 2.2 and not in default as to principal or interest.

F. This section shall not apply to entrance fees for initial occupancy of units under construction on June 30, 1986.

G. This section shall not apply to application or reservation fees whether or not such fees are considered to be a portion of the entrance fee, provided such application or reservation fees are not in excess of $1,000 per person.

1986, c. 598, § 38.1-959.1.

§ 38.2-4905. Resident's contract.

A. In addition to other provisions considered proper to effect the purpose of any continuing care contract, each contract executed on or after July 1, 1985, shall:

1. Provide for the continuing care of only one resident, or for two or more persons occupying space designed for multiple occupancy, under appropriate regulations established by the provider.

2. Show the value of all property transferred, including donations, subscriptions, fees and any other amounts paid or payable by, or on behalf of, the resident or residents.

3. Specify all services which are to be provided by the provider to each resident including, in detail, all items that each resident will receive and whether the items will be provided for a designated time period or for life. Such items may include, but are not limited to, food, shelter, nursing care, drugs, burial and incidentals.

4. Describe the physical and mental health and financial conditions upon which the provider may require the resident to relinquish his space in the designated facility.

5. Describe the physical and mental health and financial conditions required for a person to continue as a resident.

6. Describe the circumstances under which the resident will be permitted to remain in the facility in the event of financial difficulties of the resident.

7. State (i) the current fees that would be charged if the resident marries while at the designated facility, (ii) the terms concerning the entry of a spouse to the facility and (iii) the consequences if the spouse does not meet the requirements for entry.

8. Provide that the provider shall not cancel any continuing care contract with any resident without good cause. Good cause shall be limited to: (i) proof that the resident is a danger to himself or others; (ii) nonpayment by the resident of a monthly or periodic fee; (iii) repeated conduct by the resident that interferes with other residents' quiet enjoyment of the facility; (iv) persistent refusal to comply with reasonable written rules and regulations of the facility; (v) a material misrepresentation made intentionally or recklessly by the resident in his application for residency, or related materials, regarding information which, if accurately provided, would have resulted in either a failure of the resident to qualify for

residency or a material increase in the cost of providing to the resident the care and services provided under the contract; or (vi) material breach by the resident of the terms and conditions of the continuing care contract. If a provider seeks to cancel a contract and terminate a resident's occupancy, the provider shall give the resident written notice of, and a reasonable opportunity to cure within a reasonable period, whatever conduct is alleged to warrant the cancellation of the agreement. Nothing herein shall operate to relieve the provider from duties under the Virginia Residential Landlord and Tenant Act (§ 55.1-1200 et seq.) when seeking to terminate a resident's occupancy.

9. Provide in clear and understandable language, in print no smaller than the largest type used in the body of the contract, the terms governing the refund of any portion of the entrance fee and the terms under which such fee can be used by the provider.

10. State the terms under which a contract is cancelled by the death of the resident. The contract may contain a provision to the effect that, upon the death of the resident, the money paid for the continuing care of such resident shall be considered earned and become the property of the provider.

11. Provide for at least 30 days' advance notice to the resident, before any change in fees, charges or the scope of care or services may be effective, except for changes required by state or federal assistance programs.

12. Provide that charges for care paid in one lump sum shall not be increased or changed during the duration of the agreed upon care, except for changes required by state or federal assistance programs.

B. A resident shall have the right to rescind a continuing care contract, without penalty or forfeiture, within seven days after making an initial deposit or executing the contract. A resident shall not be required to move into the facility designated in the contract before the expiration of the seven-day period.

C. If a resident dies before occupying the facility, or is precluded through illness, injury or incapacity from becoming a resident under the terms of the continuing care contract, the contract is automatically rescinded and the resident or his legal representative shall receive a full refund of all money paid to the provider, except those costs specifically incurred by the provider at the request of the resident and set forth in writing in a separate addendum, signed by both parties to the contract.

D. No standard continuing care contract form shall be used in this Commonwealth until it has been submitted to the Commission. If the Commission determines that the contract does not comply with the provisions of this chapter, it shall have the right to take action pursuant to § 38.2-4931 to prevent its use. The failure of the Commission to object to or disapprove of any contract shall not be evidence that the contract does or does not comply with the provisions of this chapter. However, individualized amendments to any standard form need not be filed with the Commission.

1985, c. 554, § 38.1-960; 1986, cc. 562, 598; 2012, cc. 208, 303.

§§ 38.2-4906 through 38.2-4909. Repealed.

Repealed by Acts 2012, cc. 208 and 303, cl. 2.

§ 38.2-4910. Right of organization.

A. Residents shall have the right of self-organization. No retaliatory conduct shall be permitted against any resident for membership or participation in a residents' organization or for filing any complaint. The provider shall be required to provide to the organization a copy of all submissions to the Commission.

B. The board of directors, its designated representative or other such governing body of a continuing care facility shall hold meetings at least quarterly with the residents or representatives elected by the residents of the continuing care facility for the purpose of free discussion of issues relating to the facility. These issues may include income, expenditures and financial matters as they apply to the facility and proposed changes in policies, programs, facilities and services. Residents shall be entitled to seven days' notice of each meeting.

1985, c. 554, § 38.1-965; 1986, c. 562; 1992, c. 139.

§ 38.2-4911. Repealed.

Repealed by Acts 2012, cc. 208 and 303, cl. 2.

§ 38.2-4912. Special provisions for existing providers; rights of residents with certain existing providers.

A. Providers existing prior to July 1, 1986, shall comply with its provisions within six months of July 1, 1986. However, the Commission may extend the period within which an existing facility shall comply with this chapter for an additional six months with good cause shown.

B. Continuing care contracts entered into prior to the effective date of this chapter or prior to registration of the provider shall be valid and binding upon both parties in accordance with their terms.

1985, c. 554, § 38.1-967; 1986, c. 562.

§§ 38.2-4913 through 38.2-4916. Repealed.

Repealed by Acts 2012, cc. 208 and 303, cl. 2.

§ 38.2-4917. Certain providers exempted.

Notwithstanding any provisions to the contrary, this chapter shall not apply to providers that do not charge an entrance fee and which only accept assignments of government transfer payments, contributions from charitable organizations and third-party health care coverages as their regular periodic charges.

1986, c. 265, § 38.1-972.

Article 2 - COMMUNITY-BASED CONTINUING CARE PROVIDERS

§ 38.2-4918. Definitions.

As used in this article and Article 3 (§ 38.2-4924 et seq.):

"Community-based continuing care" or "CBCC" means a program providing or committing to provide a range of services, including long-term care services, to an individual, other than an individual related

by blood or marriage, (i) pursuant to an agreement, including mutually terminable contracts, effective for the life of the individual or for a period in excess of one year; and (ii) in consideration of the payment of an entrance fee. "Community-based continuing care" or "CBCC" also means the provision of the enumerated services in the individual's private residence as long as medically feasible and the provision of facility-based long-term care services when required, either directly or indirectly through affiliated services or through contractual arrangements.

"Community-based continuing care entrance fee" or "CBCC entrance fee" means an initial or deferred transfer to a CBCC provider of a sum of money or other property made or promised to be made in advance or at some future time as full or partial consideration for acceptance of a specified individual as a participant. A fee that in the aggregate is less than the sum of the regular periodic charges for one year of participation shall not be considered to be an entrance fee except as provided in § 38.2-4922.

"Community-based continuing care provider" or "CBCC provider" means any person, corporation, partnership, or other entity that provides or offers to provide community-based continuing care and that has operated a Continuing Care Retirement Community facility for a minimum of three years.

"Continuing Care Retirement Community facility" or "CCRC facility" means a facility, as defined in § 38.2-4900, that is registered with the Commission pursuant to § 38.2-4901.

"Participant" means an individual who has entered into a community-based continuing care contract.

"Range of services" means, without limitation, coordinated in-home care management, wellness programs, health assessments, health information and referral, home safety evaluation, homemaker services, assistance with activities of daily living, personal emergency response systems, chronic disease management, professional nursing services, services provided by a home care organization as defined in § 32.1-162.7, facility-based assisted living care provided pursuant to Article 1 (§ 63.2-1800 et seq.) of Chapter 18 of Title 63.2, and care in a certified nursing facility as defined in § 32.1-123.

"Solicit" means all actions of a CBCC provider or his agent in seeking to have individuals enter into a community-based continuing care contract by any means such as, but not limited to, personal, telephone, or mail communication or other communication directed to and received by any individual, and any advertisements in any media distributed or communicated by any means to individuals.

2012, cc. 208, 303.

§ 38.2-4919. Required filing.

A. No CBCC provider shall engage in the business of providing or offering to provide community-based continuing care in the Commonwealth unless the CBCC provider (i) is registered with the Commission pursuant to Article 1 (§ 38.2-4900 et seq.) and (ii) has filed a statement with the Commission with respect to such CBCC program as provided in subsection B.

B. A statement shall be filed with the Commission by the CBCC provider on forms prescribed by the Commission and shall include:

1. All information required by the Commission pursuant to its enforcement of this article; and

2. The initial disclosure statement required by § 38.2-4920.

C. The statement shall be approved or disapproved in writing by the Commission within 90 days of the filing.

2012, cc. 208, 303.

§ 38.2-4920. Community-based continuing care disclosure statement; availability of disclosure statement to prospective participants.

A. The initial disclosure statement of each community-based continuing care program shall contain the following information unless such information is contained in the CBCC contract and a copy of that contract is attached and made a part of the initial disclosure statement:

1. The name and business address of the CBCC provider and a statement of whether the provider is a partnership, foundation, association, corporation, or other type of business or legal entity;

2. Full information regarding ownership of the CCRC facility that the CBCC provider has operated for the minimum three-year period as required in the definition of CBCC provider in § 38.2-4918;

3. A complete listing of all CCRC facilities owned or operated, or both, by the CBCC provider and, for each, total liquid assets on the balance sheet and current occupancy percentages in independent living units;

4. The names and business addresses of the officers, directors, trustees, managing or general partners, and any person having a 10 percent or greater equity or beneficial interest in the CBCC provider, and a description of such person's interest in or occupation with the provider;

5. For (i) the CBCC provider, (ii) any person named in response to subdivision 4, and (iii) the proposed management, if the CBCC program will be managed on a day-to-day basis by a person other than an individual directly employed by the provider:

a. A description of any business experience in the operation or management of community-based continuing care or long-term care programs;

b. The name and address of any professional service, firm, association, foundation, trust, partnership, or corporation or any other business or legal entity in which such person has, or which has in such person, a 10 percent or greater interest and which it is presently intended will or may provide goods, leases, or services to the CBCC provider of a value of $500 or more, within any year, including:

(1) A description of the goods, leases, or services and the probable or anticipated cost thereof to the CBCC provider;

(2) The process by which the contract was awarded;

(3) Any additional offers that were received; and

(4) Any additional information requested by the Commission detailing how and why a contract was awarded; and

c. A description of any matter in which such person:

(1) Has been convicted of a felony or pleaded nolo contendere to a criminal charge or has been held liable or enjoined in a civil action by final judgment, if the crime or civil action involved fraud, embezzlement, fraudulent conversion, misappropriation of property, or moral turpitude;

(2) Is subject to an injunctive or restrictive order of a court of record, or within the past five years had any state or federal license or permit suspended or revoked as a result of an action brought by a governmental agency or department, arising out of or relating to business activity or health care, including without limitation action affecting a license to operate a home care company, foster care facility, nursing home, retirement home, home for the aged, or facility registered under this article or similar laws in another state; or

(3) Is currently the subject of any state or federal prosecution or administrative investigation involving allegations of fraud, embezzlement, fraudulent conversion, or misappropriation of property;

6. A statement as to:

a. Whether the CBCC provider is or ever has been affiliated with a religious, charitable, or other nonprofit organization, the nature of any such affiliation, and the extent to which the affiliate organization is or will be responsible for the financial and contractual obligations of the CBCC provider; and

b. Any provision of the federal Internal Revenue Code under which the CBCC provider is exempt from the payment of income tax;

7. A description of the services provided or proposed to be provided under community-based continuing care contracts, including the extent to which medical care is furnished or is available pursuant to any arrangement. The disclosure statement shall clearly state which services are included in basic community-based continuing care contracts and which services are made available by the CBCC provider at extra charge. The disclosure statement shall also clearly state which services are offered by the CBCC provider and which services are offered through contractual arrangements. The name and address of the party providing such services shall be disclosed. A definition of the services shall also be provided;

8. A description of all fees required of participants, including any entrance fee and periodic charges. The description shall include (i) a description of all proposed uses of any funds or property required to be transferred to the CBCC provider or any other person prior to the participant's enrollment in the program and of any entrance fee; (ii) a description of provisions for the escrowing and return of any such funds, assets, or entrance fee, the manner and any conditions of return, and to whom earnings on escrowed funds are payable; and (iii) a description of the manner by which the CBCC provider may adjust periodic charges or other recurring fees and any limitations on such adjustments. If the program is already in operation, or if the CBCC provider operates one or more similar programs within the

Commonwealth, there shall be included tables showing the frequency and average dollar amount of each increase in periodic rates at each program for the previous five years or such shorter period that the program has been operated by the CBCC provider;

9. A description of any provisions that have been made or will be made to provide reserve funding or security to enable the CBCC provider to fully perform its obligations under community-based continuing care contracts, including the establishment of escrow accounts, trusts, or reserve funds, together with the manner in which such funds will be invested and the names and experience of persons who will make the investment decisions. The disclosure statement shall clearly state whether or not reserve funds are maintained;

10. Certified financial statements of the CBCC provider, including (i) a balance sheet as of the end of the two most recent fiscal years and (ii) income statements of the CBCC provider for the two most recent fiscal years;

11. A pro forma income statement for the current fiscal year for the community-based continuing care program and for the provider of the CBCC;

12. A description of the CBCC provider's criteria for enrollment of participants;

13. A description of the CBCC provider's policies regarding community-based services to non-participants;

14. Any other material information concerning the program or the CBCC provider that may be required by the Commission or included by the CBCC provider; and

15. The procedure by which a participant may file a complaint or disclose any concerns, to include the CBCC provider's process for resolving complaints and concerns.

B. The disclosure statement shall state on its cover that the filing of the disclosure statement with the Commission does not constitute recommendation or endorsement of the CBCC program by the Commission.

C. A copy of the standard form or forms for CBCC contracts used by the CBCC provider shall be attached as an exhibit to each disclosure statement.

D. If the Commission determines that the disclosure statement does not comply with the provisions of this article, it shall have the right to take action pursuant to § 38.2-4931.

E. Three days prior to the execution of a community-based continuing care contract or the transfer of any money or other property to a provider by or on behalf of a prospective participant, whichever first occurs, the CBCC provider shall deliver to the person with whom the CBCC contract is to be entered into a copy of a disclosure statement with respect to the program in question meeting all requirements of this article as of the date of its delivery.

2012, cc. 208, 303.

§ 38.2-4921. Annual community-based continuing care disclosure statements.

A. Within four months following the end of the CBCC provider's fiscal year, the CBCC provider shall file with the Commission and make available by written notice to each participant at no cost an annual disclosure statement that shall contain the information required for the initial disclosure statement set forth in § 38.2-4920.

B. The annual disclosure statement shall also be accompanied by a narrative describing any material differences between:

1. The prior fiscal year's pro forma income statement, and

2. The actual results of operations during that fiscal year.

C. The annual disclosure statement shall describe the disposition of any real property acquired by the CBCC provider from participants.

D. In addition to filing the annual disclosure statement, the CBCC provider shall amend its currently filed disclosure statement at any other time if, in the opinion of the provider, an amendment is necessary to prevent the disclosure statement from containing any material misstatement of fact or failing to state any material fact required to be stated therein. Any such amendment or amended disclosure statement shall be filed with the Commission before it is delivered to any participant or prospective participant and is subject to all the requirements of this article, and the CBCC provider shall notify each participant of the existence of such amendment or amended disclosure statement.

E. If the Commission determines that the disclosure statement does not comply with the provisions of this article, it shall have the right to take action pursuant to § 38.2-4931.

2012, cc. 208, 303.

§ 38.2-4922. Escrow of entrance fee to community-based continuing care providers and others.

A. A CBCC provider shall maintain in escrow with a bank or trust company, or other escrow agent approved by the Commission, all CBCC entrance fees or portions thereof in excess of $1,000 per person received by the CBCC provider prior to the date the participant is permitted to enroll and receive services in the CBCC program. Funds or assets deposited therein shall be kept and maintained in an account separate and apart from the CBCC provider's business accounts. For the purposes of this section only, the term "CBCC entrance fee" shall include within its meaning any advanced payment or series of advanced payments totaling $1,000 or more, and the term "CBCC provider" shall include any person or entity that would be included in the definition thereof in § 38.2-4918 if such fee of $1,000 or more constituted a CBCC entrance fee for the purposes of the definition of "community-based continuing care" in § 38.2-4918.

B. All funds or assets deposited in the escrow account shall remain the property of the prospective participant until released to the CBCC provider in accordance with this section. The funds or assets shall not be subject to any liens, judgments, garnishments, or creditor's claims against the provider or facility. The escrow agreement may provide that charges by the escrow agent may be deducted from the funds or assets if such provision is disclosed in the disclosure statement.

C. All funds or assets deposited in escrow pursuant to this section shall be released to the CBCC provider when the provider presents to the escrow agent evidence that the corporation has been deemed eligible to begin service and enter into permanent contracts.

D. Notwithstanding any other provision of this section, all funds or assets deposited in escrow pursuant to this section shall be released according to the terms of the escrow agreement to the prospective participant from whom it was received (i) if such funds or assets have not been released within three years after placement in escrow (but in any event within six years after placement in escrow unless specifically approved by the Commission) or within such longer period as determined appropriate by the Commission in writing, (ii) if the prospective participant dies before enrolling and receiving services from the program, or (iii) upon rescission of the CBCC contract pursuant to provisions in the CBCC contract or in this article. Funds or assets subject to release under clause (i) of this subsection or under subsection C may be held in escrow for an additional period at the mutual consent of the provider and the prospective participant; however, the prospective participant may consent to such additional period only after his deposit has been held in escrow for at least two years. Clause (i) of this subsection shall not apply if fees are refundable within 30 days of request for refund.

E. Unless otherwise specified in the escrow agreement, funds or assets in an escrow account pursuant to this section may be held in the form received or if invested shall be invested in instruments authorized for the investment of public funds as set forth in Chapter 45 (§ 2.2-4500 et seq.) of Title 2.2 and not in default as to principal or interest.

F. This section shall not apply to application or reservation fees whether or not such fees are considered to be a portion of the CBCC entrance fee, provided such application or reservation fees are not in excess of $1,000 per person.

2012, cc. 208, 303.

§ 38.2-4923. Participant's contract.

A. In addition to other provisions considered proper to affect the purpose of any community-based continuing care contract, each CBCC contract executed on or after July 1, 2012, shall:

1. Provide for community-based continuing care;

2. Show the value of all property transferred, including donations, subscriptions, fees, and any other amounts paid or payable by, or on behalf of, the participant;

3. Specify all services that are to be provided by the CBCC provider to each participant including, in detail, all items that each participant will receive, whether the items will be provided at a certain percentage for a designated time period or for life, and what criteria will be used to distinguish eligibility for certain services;

4. Describe the physical and mental health and financial conditions upon which the CBCC provider may require the participant to relinquish his participation in the program, if any exist;

5. Describe the circumstances under which the participant will be permitted to remain in the program in the event of financial difficulties of the participant;

6. Provide that the CBCC provider shall not cancel any community-based continuing care contract with any participant without good cause. Good cause shall be limited to (i) proof that the participant is a danger to himself or others; (ii) nonpayment by the participant of a monthly or periodic fee; (iii) repeated conduct by the participant that interferes with other participants' quiet enjoyment of a facility or service, if applicable; (iv) persistent refusal to comply with reasonable written rules and regulations of the program; (v) a material misrepresentation made intentionally or recklessly by the participant in his application for participation in the program, or related materials, regarding information which, if accurately provided, would have resulted in either a failure of the participant to qualify for participation or a material increase in the cost of providing to the participant the care and services provided under the CBCC contract; or (vi) material breach by the participant of the terms and conditions of the community-based continuing care contract. If a CBCC provider seeks to cancel a CBCC contract and terminate a participant's participation, the provider shall give the participant written notice of, and a reasonable opportunity to cure within a reasonable period, whatever conduct is alleged to warrant the cancellation of the CBCC contract;

7. Provide in clear and understandable language, in print no smaller than the largest type used in the body of the CBCC contract, the terms governing the refund of any portion of the CBCC entrance fee and the terms under which such fee can be used by the CBCC provider;

8. State the terms under which a CBCC contract is cancelled by the death of the participant. The CBCC contract may contain a provision to the effect that, upon the death of the participant, the money paid for the community-based continuing care of such participant shall be considered earned and become the property of the CBCC provider; and

9. Provide for at least 30 days' advance notice to the participant before any change in fees, charges, or the scope of care or services may be effective, except for changes required by state or federal assistance programs.

B. A participant shall have the right to rescind a community-based continuing care contract, without penalty or forfeiture, within seven days after making an initial deposit or executing the contract. A participant shall not be required to initiate the program outlined in the contract before the expiration of the seven-day period.

C. If a participant dies before initiating the program, or is precluded through illness, injury, or incapacity from becoming a participant under the terms of the community-based continuing care contract, the contract is automatically rescinded and the participant or his legal representative shall receive a full refund of all money paid to the CBCC provider, except those costs specifically incurred by the CBCC provider at the request of the participant and set forth in writing in a separate addendum, signed by both parties, to the contract.

D. No standard community-based continuing care contract form shall be used in the Commonwealth until it has been submitted to the Commission. If the Commission determines that the CBCC contract does not comply with the provisions of this article, it shall have the right to take action pursuant to § 38.2-4931 to prevent its use. The failure of the Commission to object to or disapprove of any CBCC contract shall not be evidence that the contract does or does not comply with the provisions of this article. However, individualized amendments to any standard form need not be filed with the Commission.

2012, cc. 208, 303.

Article 3 - General Provisions

§ 38.2-4924. Sale or transfer of ownership or change in management.

A. No provider and no person or entity owning a provider shall sell or transfer, directly or indirectly, more than 50 percent of the ownership of the provider or of a continuing care facility or community-based continuing care without giving the Commission written notice of the intended sale or transfer at least 30 days prior to the consummation of the sale or transfer. A series of sales or transfers to one person or entity, or one or more entities controlled by one person or entity, consummated within a six-month period that constitute, in the aggregate, a sale or transfer of more than 50 percent of the ownership of a provider or of a continuing care facility or community-based continuing care shall be subject to the foregoing notice provisions.

B. A provider of community-based continuing care or of a continuing care facility that shall change its chief executive officer, or its management firm if managed under a contract with a third party, shall promptly notify the Commission and the residents or participants of each such change.

2012, cc. 208, 303.

§ 38.2-4925. Financial instability.

The Commission may act as authorized by § 38.2-4931 to protect residents, prospective residents, participants, or prospective participants when the Commission determines that:

1. A provider has been or will be unable to meet the pro forma income or cash flow projections previously filed by the provider and such failure may endanger the ability of the provider to perform fully its obligation pursuant to its continuing care contracts or community-based continuing care contracts; or

2. A provider is bankrupt, insolvent, under reorganization pursuant to federal bankruptcy laws, or in imminent danger of becoming bankrupt or insolvent.

2012, cc. 208, 303.

§ 38.2-4926. Waivers.

No act, agreement, or statement of any resident or participant or by an individual purchasing care for a resident or participant under any agreement to furnish care to the resident or participant shall con-

stitute a valid waiver of any provision of this chapter intended for the benefit or protection of the resident or participant or the individual purchasing care for the resident or participant.

2012, cc. 208, 303.

§ 38.2-4927. Untrue, deceptive, or misleading advertising.

The provisions of § 18.2-216 shall apply to all providers.

2012, cc. 208, 303.

§ 38.2-4928. Civil liability.

A. A person contracting with a provider for continuing care or community-based continuing care may terminate the continuing care or CBCC contract and such provider shall be liable to the person contracting for continuing care or CBCC for repayment of all fees paid to the provider, facility, or person violating this chapter, together with interest thereon at the legal rate for judgments, court costs, and reasonable attorney fees, less the reasonable value of care and lodging provided to the resident prior to the termination of the contract, and for damages if, after the effective date of this chapter, such provider or a person acting on his behalf, with or without actual knowledge of the violation, enters into a contract with such person:

1. For continuing care at a facility or community-based continuing care which has not registered under this chapter; or

2. Without having first provided to such person a disclosure statement that does not (i) contain any untrue statement of a material fact or (ii) omit a material fact required to be stated therein or necessary in order to make the statements made therein not misleading, in light of the circumstances under which they are made.

B. A person who willfully or recklessly aids or abets a provider in the commission of any act prohibited by this section shall be liable as set out in subsection A.

C. The Commission shall have no jurisdiction to adjudicate controversies concerning continuing care contracts or community-based continuing care contracts. A breach of contract shall not be deemed a violation of this chapter. Termination of a contract pursuant to subsection A shall not preclude the resident or participant from seeking any other remedies available under any law.

2012, cc. 208, 303.

§ 38.2-4929. Regulations.

A. The Commission shall have the authority to adopt, amend, or repeal rules and regulations that are reasonably necessary for the enforcement of the provisions of this chapter. The Commission may issue regulations setting forth those transactions that shall require the payment of fees by a provider and the fees that shall be charged.

B. Any provider may be given a reasonable time, not to exceed 120 days from the date of publication of any applicable rules and regulations or amendments thereto adopted pursuant to this chapter, within which to comply with the rules and standards.

2012, cc. 208, 303.

§ 38.2-4930. Investigations and subpoenas.

A. The Commission may make public or private investigations within or outside of the Commonwealth it deems necessary to determine whether any person has violated any provision of this chapter or any rule, regulation, or order promulgated by the Commission.

B. For the purpose of any investigation or proceeding under this chapter, the Commission or any officer designated by it may administer oaths and affirmations, subpoena witnesses, compel their attendance, take evidence, and require the production of any books, papers, correspondence, memoranda, agreements, or other documents or records that the Commission deems relevant or material to the inquiry.

2012, cc. 208, 303.

§ 38.2-4931. Cease and desist orders; injunctions.

Whenever it appears to the Commission that any person has engaged in, or is about to engage in, any act or practice constituting a violation of this chapter or any rule, regulation, or order issued under this chapter, the Commission may:

1. Issue an order directed at any such person requiring him to cease and desist from engaging in such act or practice; and

2. Upon a proper showing, issue a permanent or temporary injunction or a restraining order to enforce compliance with this chapter or any rule, regulation, or order issued under this chapter.

2012, cc. 208, 303.

§ 38.2-4932. Penalties.

A. Any person who willfully and knowingly violates any provision of this chapter, or any rule, regulation, or order issued under this chapter, shall be subject to payment of a fine as provided in § 38.2-218.

B. Nothing in this chapter limits the power of the Commonwealth to punish any person for any conduct that constitutes a crime under any other statute.

2012, cc. 208, 303.

Chapter 50 - VIRGINIA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION ACT

§ 38.2-5000. Short title.

The provisions of this chapter shall be known and may be cited as the Virginia Birth-Related Neurological Injury Compensation Act.

1987, c. 540.

§ 38.2-5001. Definitions.

As used in this chapter:

"Birth-related neurological injury" means injury to the brain or spinal cord of an infant caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery or resuscitation necessitated by a deprivation of oxygen or mechanical injury that occurred in the course of labor or delivery, in a hospital which renders the infant permanently motorically disabled and (i) developmentally disabled or (ii) for infants sufficiently developed to be cognitively evaluated, cognitively disabled. In order to constitute a "birth-related neurological injury" within the meaning of this chapter, such disability shall cause the infant to be permanently in need of assistance in all activities of daily living. This definition shall apply to live births only and shall not include disability or death caused by genetic or congenital abnormality, degenerative neurological disease, or maternal substance abuse.

"Claimant" means any person who files a claim pursuant to § 38.2-5004 for compensation for a birth-related neurological injury to an infant. Such claims may be filed by any legal representative on behalf of an injured infant; and, in the case of a deceased infant, the claim may be filed by an administrator, executor, or other legal representative.

"Commission" means the Virginia Workers' Compensation Commission.

"Participating hospital" means a general hospital licensed in Virginia which at the time of the injury (i) had in force an agreement with the Commissioner of Health or his designee, in a form prescribed by the Commissioner, whereby the hospital agreed to participate in the development of a program to provide obstetrical care to patients eligible for Medical Assistance Services and to patients who are indigent, and upon approval of such program by the Commissioner of Health, to participate in its implementation, (ii) had in force an agreement with the State Department of Health whereby the hospital agreed to submit to review of its obstetrical service, as required by subsection C of § 38.2-5004, and (iii) had paid the participating hospital assessment pursuant to § 38.2-5020 for the period of time in which the birth-related neurological injury occurred. The term also includes employees of such hospitals, excluding physicians or nurse-midwives who are eligible to qualify as participating physicians, acting in the course of and in the scope of their employment.

"Participating physician" means a physician licensed in Virginia to practice medicine, who practices obstetrics or performs obstetrical services either full or part time or, as authorized in the plan of operation, a licensed nurse-midwife who performs obstetrical services, either full or part time, within the scope of such licensure and who at the time of the injury (i) had in force an agreement with the Commissioner of Health or his designee, in a form prescribed by the Commissioner, whereby the physician agreed to participate in the development of a program to provide obstetrical care to patients eligible for Medical Assistance Services and to patients who are indigent, and upon approval of such program by the Commissioner of Health, to participate in its implementation, (ii) had in force an agreement with the Board of Medicine whereby the physician agreed to submit to review by the Board of Medicine as required by subsection B of § 38.2-5004, and (iii) had paid the participating physician assessment pursuant to § 38.2-5020 for the period of time in which the birth-related neurological injury occurred. The term "participating physician" includes a partnership, corporation, professional corporation, professional limited liability company or other entity through which the participating physician practices.

"Program" means the Virginia Birth-Related Neurological Injury Compensation Program established by this chapter.

1987, c. 540; 1989, c. 523; 1990, cc. 234, 534; 1994, c. 872; 1995, c. 302; 1999, c. 806; 2000, c. 207; 2003, c. 897; 2004, cc. 896, 931; 2017, c. 756.

§ 38.2-5002. Virginia Birth-Related Neurological Injury Compensation Program; exclusive remedy; exception.

A. There is hereby established the Virginia Birth-Related Neurological Injury Compensation Program.

B. Except as provided in subsection D, the rights and remedies herein granted to an infant on account of a birth-related neurological injury shall exclude all other rights and remedies of such infant, his personal representative, parents, dependents or next of kin, at common law or otherwise arising out of or related to a medical malpractice claim with respect to such injury to the infant, including any claims by the infant's personal representative, parents, dependents or next of kin that, by substantive law, are derivative of the medical malpractice claim with respect to the infant's injury, including but not limited to claims of emotional distress proximately related to the infant's injury. This subsection shall not be construed to exclude other rights and remedies available to the infant's mother arising out of or related to a physical injury, separate and distinct from an injury to the infant, that is suffered by the infant's mother during the course of the infant's delivery.

C. Notwithstanding anything to the contrary in this section, a civil action shall not be foreclosed against a physician or a hospital where there is clear and convincing evidence that such physician or hospital intentionally or willfully caused or intended to cause a birth-related neurological injury, provided that such suit is filed prior to and in lieu of payment of an award under this chapter. Such suit shall be filed before the award of the Commission becomes conclusive and binding as provided for in § 38.2-5011.

D. Notwithstanding anything to the contrary in this section, a civil action arising out of or related to a birth-related neurological injury under this chapter, brought by an infant, his personal representative, parents, dependents, or next of kin, shall not be foreclosed against a nonparticipating physician or hospital, provided that (i) no participating physician or hospital shall be made a party to any such action or related action, and (ii) the commencement of any such action, regardless of its outcome, shall constitute an election of remedies, to the exclusion of any claim under this chapter; provided that if claim is made, accepted and benefits are provided by the Fund established under this Virginia Birth-Related Neurological Injury Compensation Program, the Fund shall have the right, and be subrogated, to all of the common law rights, based on negligence or malpractice, which the said infant, his personal representative, parents, dependents or next of kin may have or may have had against the non-participating physician or hospital, as the case may be.

1987, c. 540; 1990, c. 535; 2003, c. 897.

§ 38.2-5002.1. Representation by Office of Attorney General; applicability of Public Procurement Act, Freedom of Information Act, and Administrative Process Act.

A. The Office of the Attorney General shall provide requested legal services to the Program as provided in this subsection. The Program shall compensate the Office of the Attorney General for its provision of such legal services based on a reasonable hourly rate as shall be agreed upon periodically by the Board and the Attorney General. If the Office of the Attorney General is unable to provide such legal services as the result of a conflict of interest or other disqualifying circumstances, the Board may employ such other counsel as it deems necessary.

B. The board of directors of the Program shall adopt and implement rules consistent with the provisions of the Virginia Public Procurement Act (§ 2.2-4300 et seq.) that specify policies and procedures regarding the contracting for services not related to the health care provided for claimants, which rules shall be based on competitive principles generally applicable to the procurement of services by state agencies.

C. The Program and its board of directors shall be public bodies for purposes of the Virginia Freedom of Information Act (§ 2.2-3700 et seq.).

D. The procedure for adoption of rules and regulations by the board of directors of the Program shall be consistent with the provisions of Article 2 (§ 2.2-4006 et seq.) of the Administrative Process Act.

2003, c. 897.

§ 38.2-5002.2. Confidentiality of certain information; penalty.

The following records of the Program shall be confidential: (i) records subject to the attorney-client privilege; (ii) medical and mental records of claimants obtained by the board of directors in the course of administering the Program; (iii) records concerning deliberations of the board of directors in connection with specific claims; (iv) reports of expert witnesses retained by the board of directors that have not become part of the record before the Commission; and (v) all records required to be kept confidential by federal law. Except as herein authorized, an officer, agent or employee of the Program, and any person who has held any such position, shall not disclose, directly or indirectly, any such confidential record or information.

2003, c. 897.

§ 38.2-5003. Virginia Workers' Compensation Commission authorized to hear and determine claims.

The Virginia Workers' Compensation Commission is authorized to hear and pass upon all claims filed pursuant to this chapter. The Commission may exercise the power and authority granted to it in Chapter 2 of Title 65.2 as necessary to carry out the purposes of this chapter.

When a circuit court refers a civil action to the Commission pursuant to § 8.01-273.1 for the purposes of determining whether the cause of action satisfies the requirements of this chapter, the Commission shall set the matter for hearing pursuant to § 38.2-5006. The Commission shall communicate its decision to the referring circuit court in due course.

1987, c. 540; 1999, c. 822.

§ 38.2-5004. Filing of claims; review by Board of Medicine; review by Department of Health; filing of responses; medical records.

A. 1. In all claims filed under this chapter, the claimant shall file with the Commission a petition, setting forth the following information:

a. The name and address of the legal representative and the basis for his representation of the injured infant;

b. The name and address of the injured infant;

c. The name and address of any physician providing obstetrical services who was present at the birth and the name and address of the hospital at which the birth occurred;

d. A description of the disability for which claim is made;

e. The time and place where the birth-related neurological injury occurred;

f. A brief statement of the facts and circumstances surrounding the birth-related neurological injury and giving rise to the claim;

g. All available relevant medical records relating to the person who allegedly suffered a birth-related neurological injury and an identification of any unavailable records known to the claimant and the reasons for their unavailability;

h. Appropriate assessments, evaluations, and prognoses and such other records and documents as are reasonably necessary for the determination of the amount of compensation to be paid to, or on behalf of, the injured infant on account of a birth-related neurological injury;

i. Documentation of expenses and services incurred to date, which indicates whether such expenses and services have been paid for, and if so, by whom; and

j. Documentation of any applicable private or governmental source of services or reimbursement relative to the alleged impairments.

2. The claimant shall furnish the Commission with as many copies of the petition as required for service upon the Program, any physician and hospital named in the petition, the Board of Medicine and the Department of Health, along with a $15 filing fee. Upon receipt of the petition the Commission shall immediately serve the Program by service upon the agent designated to accept service on behalf of the Program in the plan of operation by registered or certified mail, and shall mail copies of the petition to any physician and hospital named in the petition, the Board of Medicine and the Department of Health.

B. Upon receipt of the petition or the filing of a claim relating to the conduct of a participating physician, the Department of Health Professions shall investigate the petition or claim, utilizing the same process as it does in investigating complaints filed under any provision contained in Title 54.1. Conduct of health care providers giving rise to disciplinary action shall be referred to the Board of Medicine for action consistent with the authority granted to the Board in Article 2 (§ 54.1-2911 et seq.) of

Chapter 29 of Title 54.1. If a notice or order is issued by the Board of Medicine, a copy shall be mailed to the petitioner or claimant.

C. Upon receipt of the petition or the filing of a claim relating to the conduct of a participating hospital, the Department of Health shall investigate the petition or claim, utilizing the same process as it does in investigating complaints filed under any provision of Title 32.1. If it determines that there is reason to believe that the alleged injury resulted from, or was aggravated by, substandard care on the part of the hospital at which the birth occurred, it shall take any appropriate action consistent with the authority granted to the Department of Health in Title 32.1.

D. The Program shall file a response to the petition and submit relevant written information relating to the issue of whether the injury alleged is a birth-related neurological injury within the meaning of this chapter within 10 days after the date the panel report prepared pursuant to subsection C of § 38.2-5008 is filed with the Commission.

E. Any hospital at which a birth occurred, upon receipt of written notice from the legal representative of an injured infant that he intends to file a petition under this chapter, shall promptly deliver to such person all available medical records relating to the infant who allegedly suffered a birth-related neurological injury.

F. As used in this chapter, fetal monitoring strips, whether printed or in electronic format, shall be deemed to constitute part of the medical records relating to an infant who allegedly suffered a birth-related neurological injury.

1987, c. 540; 1989, c. 523; 2003, c. 897; 2005, cc. 50, 52; 2013, c. 144.

§ 38.2-5004.1. Notification of possible beneficiaries.

A. Each physician, hospital, and nurse midwife shall disclose in writing to their obstetrical patients, at such time or times and in such detail as the board of directors of the Program shall determine to be appropriate, whether such physician, hospital or nurse midwife is or is not a participating provider under the Program.

B. In addition to any other postpartum materials provided to the mother or other appropriate person, every hospital shall provide for each infant who was hospitalized in a neonatal intensive care unit an informational brochure prepared or approved by the board of directors of the Program. The brochure shall describe the rights and limitations under the Program, including the Program's exclusive remedy provision under subsection B of § 38.2-5002.

C. When a claim is made to an insurance company, as described in § 38.2-5020.1, licensed to do business in the Commonwealth of Virginia or to any self-insurer, alleging that a possible birth-related neurological injury or a severe adverse outcome related to a birth has occurred, such insurance company or self-insurer shall report such claim to the Program on a form provided by the Program. Upon receipt of such report, the Program shall inform the parent or parents or guardians of the child on whose behalf such claim has been made of the Program's existence and eligibility requirements.

D. No liability or inference of liability or eligibility shall attach to the making of such report. The making of such report shall not be admissible in any court.

1999, c. 825; 2000, c. 1038; 2003, c. 897.

§ 38.2-5005. Tolling of statute of limitations.

The statute of limitations with respect to any civil action that may be brought by or on behalf of an injured infant allegedly arising out of or related to a birth-related neurological injury shall be tolled by the filing of a claim in accordance with this chapter, and the time such claim is pending shall not be computed as part of the period within which such civil action may be brought.

1987, c. 540; 1989, c. 523; 2003, c. 897.

§ 38.2-5006. Hearing; parties.

A. Immediately after the Program's response is filed pursuant to subsection D of § 38.2-5004, the Commission shall set the date for a hearing, which shall be held no sooner than 15 days and no later than 90 days after the filing of the Program's response, and shall notify the parties to the hearing of the time and place of such hearing. The hearing shall be held in the city or county where the birth-related neurological injury occurred, or in a contiguous city or county, unless otherwise agreed to by the parties and authorized by the Commission.

B. The parties to the hearing required under this section shall include the claimant and the Program.

1987, c. 540; 1989, c. 523; 2005, cc. 50, 52.

§ 38.2-5007. Interrogatories and depositions.

Any party to a proceeding under this chapter may, upon application to the Commission setting forth the materiality of the information requested, serve interrogatories or cause the depositions of witnesses residing within or without the Commonwealth to be taken, the costs to be taxed as expenses incurred in connection with the filing of a claim, in accordance with § 38.2-5009. Such depositions shall be taken after notice and in the manner prescribed by law, for depositions in actions at law, except that they shall be directed to the Commission, the Commissioner or the Deputy Commissioner before whom the proceedings may be pending.

1987, c. 540; 1989, c. 523; 2003, c. 897.

§ 38.2-5008. (For expiration date, see Acts 2023, cc. 756 and 778, cl. 5) Determination of claims; presumption; finding of Virginia Workers' Compensation Commission binding on participants; medical advisory panel.

A. The Commission shall determine, on the basis of the evidence presented to it, the following issues:

1. Whether the injury claimed is a birth-related neurological injury as defined in § 38.2-5001.

a. A rebuttable presumption shall arise that the injury alleged is a birth-related neurological injury where it has been demonstrated, to the satisfaction of the Virginia Workers' Compensation Commission, that the infant has sustained a brain or spinal cord injury caused by oxygen deprivation or mechanical injury, and that the infant was thereby rendered permanently motorically disabled and (i)

developmentally disabled or (ii) for infants sufficiently developed to be cognitively evaluated, cognitively disabled.

If either party disagrees with such presumption, that party shall have the burden of proving that the injuries alleged are not birth-related neurological injuries within the meaning of the chapter.

b. A rebuttable presumption of fetal distress, an element of a birth-related injury, shall arise if the hospital fails to provide the fetal heart monitor tape to the claimant, as required by subsection E of § 38.2-5004.

2. Whether obstetrical services were delivered by a participating physician at the birth.

3. Whether the birth occurred in a participating hospital.

4. How much compensation, if any, is awardable pursuant to § 38.2-5009.

5. If the Commission determines (i) that the injury alleged is not a birth-related neurological injury as defined in § 38.2-5001, or (ii) that obstetrical services were not delivered by a participating physician at the birth and that the birth did not occur in a participating hospital, it shall dismiss the petition and cause a copy of its order of dismissal to be sent immediately to the parties by registered or certified mail.

6. All parties are bound for all purposes including any suit at law against a participating physician or participating hospital, by the finding of the Virginia Workers' Compensation Commission (or any appeal therefrom) with respect to whether such injury is a birth-related neurological injury.

B. The deans of the schools of medicine of the Eastern Virginia Medical School, University of Virginia School of Medicine, and Medical College of Virginia of Virginia Commonwealth University shall develop a plan whereby each claim filed with the Commission is reviewed by a panel of three qualified and impartial physicians drawn from the fields of obstetrics, pediatrics, pediatric neurology, neonatology, physical medicine and rehabilitation, or any other specialty particularly appropriate to the facts of a particular case. Such plan shall provide that each of the three aforementioned medical schools shall maintain a review panel of physicians to review claims, with responsibility for reviewing claims rotating among each medical school's panel on a case-by-case basis. The chair of the panel shall be determined by the school's dean. In no event shall the panel contain more than one panel member from the field of obstetrics. The Commission shall direct the Program to pay to the medical school that performed the assessment and prepared a report in conformity with this provision the sum of $3,000 per claim reviewed.

C. The panel created pursuant to subsection B shall prepare a report that provides a detailed statement of the opinion of the panel's members regarding whether the infant's injury does or does not satisfy each of the criteria of a birth-related neurological injury enumerated in such term's definition in § 38.2-5001. The report shall include the panel's basis for its determination of whether each such criteria was or was not satisfied. In addition, the report shall include such supporting documentation as the board of directors of the program may reasonably request. The panel shall file its report with the

Commission 60 days from the date the petition was filed with the Commission. At the same time that the panel files its report with the Commission, the panel shall send copies thereof to the Program and all parties in the proceeding. At the request of the Commission, at least one member of the panel shall be available to testify at the hearing. The Commission shall consider, but shall not be bound by, the recommendation of the panel.

1987, c. 540; 1989, c. 523; 1990, cc. 534, 535; 2003, c. 897; 2008, cc. 267, 520.

§ 38.2-5008.1. Right to confront and cross-examine witnesses.

Upon a timely motion, all parties to a claim under this chapter shall have the right to confront and cross-examine witnesses. In pursuing that right, a party shall not be precluded from conducting depositions by oral examination or cross-examination at a hearing of any witnesses from whom evidence is elicited.

2008, c. 145.

§ 38.2-5008. (For effective date, see Acts 2023, cc. 756 and 778, cl. 5) Determination of claims; presumption; finding of Virginia Workers' Compensation Commission binding on participants; medical advisory panel.

A. The Commission shall determine, on the basis of the evidence presented to it, the following issues:

1. Whether the injury claimed is a birth-related neurological injury as defined in § 38.2-5001.

a. A rebuttable presumption shall arise that the injury alleged is a birth-related neurological injury where it has been demonstrated, to the satisfaction of the Virginia Workers' Compensation Commission, that the infant has sustained a brain or spinal cord injury caused by oxygen deprivation or mechanical injury, and that the infant was thereby rendered permanently motorically disabled and (i) developmentally disabled or (ii) for infants sufficiently developed to be cognitively evaluated, cognitively disabled.

If either party disagrees with such presumption, that party shall have the burden of proving that the injuries alleged are not birth-related neurological injuries within the meaning of the chapter.

b. A rebuttable presumption of fetal distress, an element of a birth-related injury, shall arise if the hospital fails to provide the fetal heart monitor tape to the claimant, as required by subsection E of § 38.2-5004.

2. Whether obstetrical services were delivered by a participating physician at the birth.

3. Whether the birth occurred in a participating hospital.

4. How much compensation, if any, is awardable pursuant to § 38.2-5009.

5. If the Commission determines (i) that the injury alleged is not a birth-related neurological injury as defined in § 38.2-5001, or (ii) that obstetrical services were not delivered by a participating physician at the birth and that the birth did not occur in a participating hospital, it shall dismiss the petition and

cause a copy of its order of dismissal to be sent immediately to the parties by registered or certified mail.

6. All parties are bound for all purposes including any suit at law against a participating physician or participating hospital, by the finding of the Virginia Workers' Compensation Commission (or any appeal therefrom) with respect to whether such injury is a birth-related neurological injury.

B. The deans of the schools of medicine of the Eastern Virginia Health Sciences Center at Old Dominion University, University of Virginia School of Medicine, and Medical College of Virginia of Virginia Commonwealth University shall develop a plan whereby each claim filed with the Commission is reviewed by a panel of three qualified and impartial physicians drawn from the fields of obstetrics, pediatrics, pediatric neurology, neonatology, physical medicine and rehabilitation, or any other specialty particularly appropriate to the facts of a particular case. Such plan shall provide that each of the three aforementioned medical schools shall maintain a review panel of physicians to review claims, with responsibility for reviewing claims rotating among each medical school's panel on a case-by-case basis. The chair of the panel shall be determined by the school's dean. In no event shall the panel contain more than one panel member from the field of obstetrics. The Commission shall direct the Program to pay to the medical school that performed the assessment and prepared a report in conformity with this provision the sum of $3,000 per claim reviewed.

C. The panel created pursuant to subsection B shall prepare a report that provides a detailed statement of the opinion of the panel's members regarding whether the infant's injury does or does not satisfy each of the criteria of a birth-related neurological injury enumerated in such term's definition in § 38.2-5001. The report shall include the panel's basis for its determination of whether each such criteria was or was not satisfied. In addition, the report shall include such supporting documentation as the board of directors of the program may reasonably request. The panel shall file its report with the Commission 60 days from the date the petition was filed with the Commission. At the same time that the panel files its report with the Commission, the panel shall send copies thereof to the Program and all parties in the proceeding. At the request of the Commission, at least one member of the panel shall be available to testify at the hearing. The Commission shall consider, but shall not be bound by, the recommendation of the panel.

1987, c. 540; 1989, c. 523; 1990, cc. 534, 535; 2003, c. 897; 2008, cc. 267, 520; 2023, cc. 756, 778.

§ 38.2-5009. Commission awards for birth-related neurological injuries; notice of award.

A. Upon determining (i) that an infant has sustained a birth-related neurological injury and (ii) that obstetrical services were delivered by a participating physician at the birth or that the birth occurred in a participating hospital, the Commission shall make an award providing compensation for the following items relative to such injury:

1. Actual medically necessary and reasonable expenses of medical and hospital, rehabilitative, therapeutic, nursing, attendant, residential and custodial care and service, medications, supplies, special equipment or facilities, and related travel, such expenses to be paid as they are incurred.

Reimbursement may be provided for nursing and attendant care that is provided by a relative or legal guardian of a Program beneficiary so long as that care is beyond the scope of child care duties and services normally and gratuitously provided by family members to uninjured children. However, such expenses shall not include:

a. Expenses for items or services that the infant has received, or is entitled to receive, under the laws of any state or the federal government except to the extent prohibited by federal law;

b. Expenses for items or services that the infant has received, or is contractually entitled to receive, from any prepaid health plan, health maintenance organization, or other private insuring entity;

c. Expenses for which the infant has received reimbursement, or for which the infant is entitled to receive reimbursement, under the laws of any state or federal government except to the extent prohibited by federal law; and

d. Expenses for which the infant has received reimbursement, or for which the infant is contractually entitled to receive reimbursement, pursuant to the provisions of any health or sickness insurance policy or other private insurance program.

Expenses of medical and hospital services under this subdivision shall be limited to such charges as prevail in the same community for similar treatment of injured persons of a like standard of living when such treatment is paid for by the injured person.

In order to provide coverage for expenses of medical and hospital services under this subdivision, the Commission, in all cases where a comparative analysis of the costs, including the effects on the infant's family's health insurance coverage, and benefits indicates that such action is more cost-effective than awarding payment of medical and hospital expenses, shall (i) require the claimant to purchase private health insurance providing coverage for such expenses, provided that the premium or other costs of such coverage shall be paid by the Fund; (ii) require the claimant to participate in the State Medicaid Program, the Children's Health Insurance Program or other state or federal health insurance program for which the infant is eligible; or (iii) if the Commission determines that it would be unreasonably burdensome to require the claimant to purchase private health insurance and that the infant is ineligible for a health insurance program described in clause (ii), to make an award providing compensation for the cost of private accident and sickness insurance for the infant.

2. Loss of earnings from the age of 18 are to be paid in regular installments beginning on the eighteenth birthday of the infant. An infant found to have sustained a birth-related neurological injury shall be conclusively presumed to have been able to earn income from work from the age of 18 through the age of 65, if he had not been injured, in the amount of 50 percent of the average weekly wage in the Commonwealth of workers in the private, nonfarm sector. Payments shall be calculated based on the Commonwealth's reporting period immediately preceding the 18th birthday of the claimant child, and subsequently adjusted based upon the succeeding annual reports of the Commonwealth. The provisions of § 65.2-531 shall apply to any benefits awarded under this subdivision.

3. Reasonable expenses incurred by the claimant in connection with the filing of a claim under this chapter, including reasonable attorneys' fees of the claimant's attorney, but excluding attorney fees incurred in opposing a claimant's admission pursuant to § 8.01-273.1. Any award for expenses, including attorney's fees, incurred by the claimant in connection with the filing of a claim under this chapter shall be subject to the approval and award of the Commission.

A copy of the award shall be sent immediately by registered or certified mail to the parties.

B. Regardless of whether the Commission makes either of the determinations described in clauses (i) and (ii) of subsection A, the Commission shall not award compensation in connection with a claim under this chapter, or any claim pursuant to § 8.01-273.1, for any attorney's fees or other expenses incurred by any physician, hospital, or nurse midwife that is party to a proceeding under this chapter, or pursuant to § 8.01-273.1, or by a medical malpractice liability insurer of such party. This prohibition shall not affect the requirement that the Program make reimbursement for photocopying costs as set forth in § 8.01-273.1, or the requirement under § 38.2-5002.1 that the Program compensate the Office of the Attorney General for its provision of legal services to the Program.

C. The amendments to this section enacted pursuant to Chapter 535 of the Acts of Assembly of 1990 shall be retroactively effective in all cases arising prior to July 1, 1990, that have been timely filed and are not yet final.

1987, c. 540; 1989, c. 523; 1990, c. 535; 1999, c. 823; 2000, c. 1038; 2003, c. 897; 2004, cc. 896, 931; 2008, cc. 267, 520; 2011, c. 84.

§ 38.2-5009.1. Infants dying shortly after birth.

A. For births occurring on or after July 1, 2003, if the Commission determines that an infant has sustained a birth-related neurological injury and that obstetrical services were delivered by a participating physician at the birth or that the birth occurred in a participating hospital, and the infant dies within 180 days of birth, the Commission, in its discretion, may make an award in an amount not exceeding $100,000 to the infant's family, which award shall be in addition to and not in lieu of any other award providing compensation as provided in § 38.2-5009.

B. Prior to making an award pursuant to this section, the Commission shall conduct a hearing for the purpose of determining whether such award is appropriate and, if so, the proper amount of such an award and how it should be paid, after receiving evidence pertaining to sorrow, mental anguish, solace, grief associated with the death of the infant, and all other material factors that are relevant.

C. The hearing referred to in subsection B may be conducted as part of a hearing conducted pursuant to § 38.2-5009. The same procedural requirements applicable to a hearing conducted pursuant to § 38.2-5009 shall apply to a hearing conducted hereunder.

D. As used in this section, an infant's family means the infant's father, mother, or both, or if neither is a party to the proceeding, the infant's legal guardian.

2003, c. 897.

§ 38.2-5010. Rehearing on Commission determination or award.

If an application for review is made to the Commission within twenty days from the date of a determination pursuant to subdivisions A 1 through A 3 of § 38.2-5008, or within twenty days from the date of an award by the Commission pursuant to § 38.2-5009, the full Commission, excluding any member of the Commission who made the determination or award, if the first hearing was not held before the full Commission, shall review the evidence. If deemed advisable and as soon as practicable, the Commission instead may hear the parties, their representatives and witnesses and shall make a determination or award, as appropriate. Such review or determination, together with a statement of the findings of fact, rulings of law and other matters pertinent to the questions at issue, shall be filed with the record of the proceedings and shall be sent immediately to the parties.

1987, c. 540; 1999, c. 806; 2006, c. 919.

§ 38.2-5011. Conclusiveness of determination or award; appeal.

A. The determination of the Commission pursuant to subdivisions A 1 through A 3 of § 38.2-5008, or the award of the Commission, as provided in § 38.2-5009, if not reviewed within the time prescribed by § 38.2-5010, or a determination or award of the Commission upon such review, as provided in § 38.2-5010, shall be conclusive and binding as to all questions of fact. No appeal shall be taken from the decision of one commissioner until a review of the case has been held before the full Commission, as provided in § 38.2-5010. Appeals shall lie from the full Commission to the Court of Appeals in the manner provided in the Rules of the Supreme Court.

B. The notice of appeal shall be filed with the clerk of the Commission within thirty days from the date of such determination or award or within thirty days after receipt by registered or certified mail of such determination or award whichever occurs last. A copy of the notice of appeal shall be filed in the office of the clerk of the Court of Appeals as provided in the Rules of the Supreme Court.

C. Cases so appealed shall be placed upon the privileged docket of the Court and be heard at the next ensuing term thereof. In case of an appeal from an award of the Commission to the Court of Appeals, the appeal shall operate as a suspension of the award, and the Program shall not be required to make payment of the award involved in the appeal until the questions at issue therein shall have been fully determined in accordance with the provisions of this chapter.

1987, c. 540; 1989, c. 523.

§ 38.2-5012. Enforcement, etc., of orders and awards.

The Commission has full authority to enforce its orders and protect itself from deception. While the language of this section is permissive and provides that a party may enforce an award in court, it must be read and considered in pari materia with the Commission's power pursuant to § 65.2-202 to punish for disobedience of its orders.

1987, c. 540.

§ 38.2-5013. Limitation on claims.

Any claim under this chapter that is filed more than ten years after the birth of an infant alleged to have a birth-related neurological injury is barred.

1987, c. 540; 1999, c. 806; 2006, c. 919.

§ 38.2-5014. Scope.

This chapter applies to all claims for birth-related neurological injuries occurring in this Commonwealth on and after January 1, 1988. The chapter shall not apply to disability or death caused by genetic or congenital abnormalities.

1987, c. 540.

§ 38.2-5015. Birth-Related Neurological Injury Compensation Fund; assets of the Fund; audit.

A. There is established the Birth-Related Neurological Injury Compensation Fund to finance the Virginia Birth-Related Neurological Injury Compensation Program created by this chapter. The assets of the Fund administered by the board of directors of the Program are trust funds and shall be used solely in the interest of the recipients of awards pursuant to § 38.2-5009 and to administer the Program.

B. An independent certified public accountant selected by the board of directors of the Program shall annually audit the accounts of the Fund, and the cost of such audit services shall be borne by the Program and be paid from moneys designated for such purposes in the Fund. The audit shall be performed at least each fiscal year, in accordance with generally accepted auditing standards and, accordingly, include such tests of the accounting records and such auditing procedures as considered necessary under the circumstances. The board of directors shall furnish copies of the audit to the same persons who are entitled to receive copies of the board's report on investment of the Fund's assets.

1987, c. 540; 1999, c. 826; 2003, c. 897.

§ 38.2-5016. Board of directors; appointment; vacancies; term; list of Program claimants.

A. The Birth-Related Neurological Injury Compensation Program shall be governed by a board of nine directors.

B. Except as provided in subsection C, directors shall be appointed for a term of three years or until their successors are appointed and have qualified.

C. 1. The directors shall be appointed by the Governor as follows:

a. Six citizen representatives. One of the members shall have a minimum of five years of professional investment experience. One of the members shall have a minimum of five years of professional experience in finance and be licensed as a certified public accountant or hold a similar professional designation. One of the members shall have professional experience working with the disabled community. One of the members shall be the relative of a disabled child experienced in the care of the disabled child. One of the members shall be an attorney with a minimum of three years of experience in the practice of law representing clients with physical personal injuries. One of the members shall be

an at large representative consisting of a person deemed qualified to serve by knowledge, education, training, interest or experience;

b. One representative of participating physicians. The initial term of the member appointed in 1999 shall commence when appointed and shall be for one year;

c. One representative of participating hospitals. The initial term of the member appointed in 1999 shall commence when appointed and shall be for two years; and

d. One representative of liability insurers. The initial term of the member appointed in 1999 shall commence when appointed and shall be for three years.

2. The Governor may select the representative of the participating physicians from a list of at least three names to be recommended by the Virginia Society of Obstetrics and Gynecology; the representative of participating hospitals from a list of at least three names to be recommended by the Virginia Hospital & Healthcare Association; and the representative of liability insurers from a list of at least three names, one of whom is recommended by the American Insurance Association and two of whom are recommended by the Property Casualty Insurers Association of America. The Governor may select the attorney member from a list of at least four names to be recommended by the Virginia State Bar. The Governor may select the parent of a disabled child member and the at large member from applications duly submitted. Nothing contained herein shall preclude qualified applicants for any position on the Board from submitting an application to the Governor to serve as a member of the Board. In no case shall the Governor be bound to make any appointment from among the nominees of the respective associations.

D. The Governor shall promptly notify the appropriate association, which may make nominations, of any vacancy other than by expiration among the members of the board representing a particular interest and like nominations may be made for the filling of the vacancy.

E. The directors shall act by majority vote with five directors constituting a quorum for the transaction of any business or the exercise of any power of the Program. The directors shall serve without salary, but each director shall be reimbursed for actual and necessary expenses incurred in the performance of his official duties as a director of the Program. The directors shall not be subject to any personal liability with respect to the administration of the Program or the payment of any award.

F. The board shall have the power to (i) administer the Program, (ii) administer the Birth-Related Neurological Injury Compensation Fund, which shall include the authority to purchase, hold, sell or transfer real or personal property and the authority to place any such property in trust for the benefit of claimants who have received awards pursuant to § 38.2-5009, (iii) appoint a service company or companies to administer the payment of claims on behalf of the Program, (iv) direct the investment and reinvestment of any surplus in the Fund over losses and expenses, provided any investment income generated thereby remains in the Fund, (v) reinsure the risks of the Fund in whole or in part, and (vi) obtain and maintain directors' and officers' liability insurance. The board shall discharge its duties with respect to the Fund solely in the interest of the recipients of awards pursuant to §§ 38.2-5009 and

38.2-5009.1 and shall invest the assets of the Fund with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims. Any decisions regarding the investment of the assets of the Fund shall be based on the advice of one or more investment advisors retained by the board, provided that any investment advisor retained by the board shall be registered pursuant to the provisions of Article 3 (§ 13.1-504 et seq.) of Chapter 5 of Title 13.1 or shall be a federal covered advisor as defined in § 13.1-501 who has filed such documents and paid such fees as may be necessary to transact business in the Commonwealth pursuant to § 13.1-504. The board shall report annually to the Governor and to the Speaker of the House of Delegates and the Clerk of the House of Delegates and to the Chairman of the Senate Rules Committee and the Clerk of the Senate regarding the investment of the Fund's assets. The board shall establish a procedure in the plan of operation for notice to be given to obstetrical patients concerning the no-fault alternative for birth-related neurological injuries provided in this chapter, such notice to include a clear and concise explanation of a patient's rights and limitations under the program.

G. The board shall establish a procedure in the plan of operation for maintaining a list of Program claimants. Each claimant may consent to have his name, address, phone number, and other personal information included on such list, for distribution to other Program claimants. The Board shall distribute the list to Program claimants who have given consent to be included on such list, and to no other person.

1987, c. 540; 1989, c. 523; 1994, c. 872; 1996, c. 232; 1997, c. 399; 1999, c. 824; 2002, c. 857; 2003, c. 897; 2006, c. 777; 2008, cc. 267, 520.

§ 38.2-5016.1. Investment strategy advice; expected returns.

The investment advisor or advisors retained by the board pursuant to subsection F of § 38.2-5016 shall provide the board with annual statements explaining the expected returns on its equities and fixed income portfolios.

2003, c. 897; 2006, c. 777.

§ 38.2-5017. Plan of operation.

A. On or before September 30, 1987, the directors of the Program shall submit to the State Corporation Commission for review a proposed plan of operation consistent with this chapter.

B. The plan of operation shall provide for the efficient administration of the Program and for the prompt processing of claims made against the Fund pursuant to an award under this chapter. The plan shall contain other provisions including:

1. Establishment of necessary facilities;

2. Management of the Fund;

3. Appointment of servicing carriers or other servicing arrangements to administer the processing of claims against the Fund;

4. Initial and annual assessment of the persons and entities listed in § 38.2-5020 to pay awards and expenses, which assessments shall be on an actuarially sound basis subject to the limits set forth in § 38.2-5020; and

5. Any other matters necessary for the efficient operation of the Program.

C. The plan of operation shall be subject to approval by the State Corporation Commission after consultation with representatives of interested individuals and organizations. If the State Corporation Commission disapproves all or any part of the proposed plan of operation, the directors shall within thirty days submit for review an appropriate revised plan of operation. If the directors fail to do so, the State Corporation Commission shall promulgate a plan of operation. The plan of operation approved or promulgated by the State Corporation Commission shall become effective and operational upon order of the State Corporation Commission.

D. Amendments to the plan of operation may be made by the directors of the Program, subject to the approval of the State Corporation Commission.

1987, c. 540; 1994, c. 872.

§ 38.2-5018. Assessments to be held in restricted cash account.

All assessments paid pursuant to the plan of operation, shall be held in a separate restricted cash account under the sole control of an independent fund manager to be selected by the directors. The Fund, and any income from it, shall be disbursed for the payment of awards as provided in this chapter and for the payment of the expenses of administration of the Fund and the Program, including the reasonable expenses of the Commission.

1987, c. 540; 1989, c. 523; 1990, c. 244.

§ 38.2-5019. Repealed.

Repealed by Acts 1989, c. 523.

§ 38.2-5020. Assessments.

A. A physician who otherwise qualifies as a participating physician pursuant to this chapter may become a participating physician in the Program for a particular calendar year by paying an annual participating physician assessment to the Program in the amount of $5,000 on or before December 1 of the previous year, in the manner required by the plan of operation. Effective January 1, 2009, the total annual assessment shall be $5,600, and shall increase by $300 for the 2010 assessment and by $100 each year thereafter, to a maximum of $6,200 per year. The board may authorize a prorated participating physician or participating hospital assessment for a particular year in its plan of operation, but such prorated assessment shall not become effective until the physician or hospital has given at least 30 days' notice to the Program of the request for a prorated assessment.

B. Notwithstanding the provisions of subsection A, a participating hospital with a residency training program accredited to the American Council for Graduate Medical Education may pay an annual participating physician assessment to the Program for residency positions in the hospital's residency

training program, in the manner provided by the plan of operation. However, any resident in a duly accredited family practice or obstetrics residency training program at a participating hospital shall be considered a participating physician in the Program and neither the resident nor the hospital shall be required to pay any assessment for such participation. No resident shall become a participating physician in the Program, however, until 30 days following notification by the hospital to the Program of the name of the resident or residents filling the particular position for which the annual participating physician assessment payment, if required, has been made.

C. A hospital that otherwise qualifies as a participating hospital pursuant to this chapter may become a participating hospital in the Program for a particular year by paying an annual participating hospital assessment to the Program, on or before December 1 of the previous year, amounting to $50 per live birth for the prior year, as reported to the Department of Health in the Annual Survey of Hospitals. Effective January 1, 2009, the annual participating hospital assessment shall increase by $2.50 per live birth for the prior year, as reported to the Department of Health in the Annual Survey of Hospitals, and shall be increased at that rate each year thereafter to a maximum of $55 per live birth so reported for the prior year. The participating hospital assessment shall not exceed $150,000 for any participating hospital in any 12-month period until January 1, 2005. Effective January 1, 2005, the maximum total annual assessment shall be $160,000, and shall increase by $10,000 each year thereafter, to a maximum of $200,000 in any 12-month period.

D. All licensed physicians practicing in the Commonwealth on September 30 of a particular year, other than participating physicians, shall pay to the Program an annual assessment of $250 for the following year, in the manner required by the plan of operation until January 1, 2005. Effective January 1, 2005, the total annual assessment shall be $260, and shall increase by $10 each year thereafter to a maximum of $300 per year.

Upon proper certification to the Program, the following physicians shall be exempt from the payment of the annual assessment under this subsection:

1. A physician who is employed by the Commonwealth or federal government and whose income from professional fees is less than an amount equal to 10 percent of the annual salary of the physician.

2. A physician who is enrolled in a full-time graduate medical education program accredited by the American Council for Graduate Medical Education.

3. A physician who has retired from active clinical practice.

4. A physician whose active clinical practice is limited to the provision of services, voluntarily and without compensation, to any patient of any clinic which is organized in whole or in part for the delivery of health care services without charge as provided in § 54.1-106.

E. Taking into account the assessments collected pursuant to subsections A through D of this section, if required to maintain the Fund on an actuarially sound basis, all insurance carriers licensed to write and engaged in writing liability insurance in the Commonwealth of a particular year, shall pay into the

Fund an assessment for the following year, in an amount determined by the State Corporation Commission pursuant to subsection A of § 38.2-5021, in the manner required by the plan of operation. Liability insurance for the purposes of this provision shall include the classes of insurance defined in §§ 38.2-117, 38.2-118, and 38.2-119 and the liability portions of the insurance defined in §§ 38.2-124, 38.2-125, 38.2-130, 38.2-131, and 38.2-132.

1. All annual assessments against liability insurance carriers shall be made on the basis of net direct premiums written for the business activity which forms the basis for each such entity's inclusion as a funding source for the Program in the Commonwealth during the prior year ending December 31, as reported to the State Corporation Commission, and shall be in the proportion that the net direct premiums written by each on account of the business activity forming the basis for their inclusion in the Program bears to the aggregate net direct premiums for all such business activity written in this Commonwealth by all such entities. For purposes of this chapter "net direct premiums written" means gross direct premiums written in this Commonwealth on all policies of liability insurance less (i) all return premiums on the policy, (ii) dividends paid or credited to policyholders, and (iii) the unused or unabsorbed portions of premium deposits on liability insurance.

2. The entities listed in this subsection shall not be individually liable for an annual assessment in excess of one quarter of one percent of that entity's net direct premiums written.

3. Liability insurance carriers shall be entitled to recover their initial and annual assessments through (i) a surcharge on future policies, (ii) a rate increase applicable prospectively, or (iii) a combination of the two, at the discretion of the State Corporation Commission.

F. On and after January 1, 1989, a participating physician covered under the provisions of this section who has paid an annual assessment for a particular calendar year to the Program and who retires from the practice of medicine during that particular calendar year shall be entitled to a refund of a prorated share of his or her annual assessment for the calendar year that corresponds to the portion of the calendar year remaining following his or her retirement.

G. Whenever the State Corporation Commission determines the Fund is actuarially sound in conjunction with actuarial investigations conducted pursuant to § 38.2-5021, it shall enter an order suspending the assessment required under subsection D. The annual assessment shall be reinstated whenever the State Corporation Commission determines that such assessment is required to maintain the Fund's actuarial soundness.

1987, c. 540; 1989, cc. 361, 463, 523; 1990, c. 498; 1991, c. 486; 1992, cc. 414, 767; 1994, c. 872; 2004, cc. 896, 931; 2008, cc. 267, 520.

§ 38.2-5020.1. Credits against malpractice insurance premiums.

A. Each insurer issuing or issuing for delivery in the Commonwealth any personal injury liability policy which provides medical malpractice liability coverage for the obstetrical practice of any participating physician under this chapter shall provide a credit on such physician's annual medical malpractice liability insurance premium in an amount that will produce premiums that are neither inadequate,

excessive nor unfairly discriminatory, as required by § 38.2-1904, and as determined by the Commission.

B. Each insurer issuing or issuing for delivery in the Commonwealth any personal injury liability policy which provides medical malpractice liability coverage for the obstetrical services of any participating hospital under this chapter shall provide a credit on such hospital's annual medical malpractice liability insurance premium in an amount that will produce premiums that are neither inadequate, excessive nor unfairly discriminatory, as required by § 38.2-1904, and as determined by the Commission.

1990, c. 498.

§ 38.2-5021. Actuarial investigation, valuations, gain/loss analysis; notice if assessments prove insufficient.

A. The Bureau of Insurance of the State Corporation Commission shall undertake an actuarial investigation of the requirements of the Fund based on the Fund's experience in the first year of operation, including without limitation the assets and liabilities of the Fund. Pursuant to such investigation, the State Corporation Commission shall establish the rate of contribution of the entities listed in subsection E of § 38.2-5020 for the tax year beginning January 1, 1989.

Following the initial valuation, the State Corporation Commission shall cause an actuarial valuation to be made of the assets and liabilities of the Fund no less frequently than biennially. Pursuant to the results of such valuations, the State Corporation Commission shall prepare a statement as to the contribution rate applicable to contributors listed in subsection E of § 38.2-5020. However, at no time shall the rate be greater than one quarter of one percent of net direct premiums written.

In conducting the actuarial evaluation, a loss reserving methodology consistent with the one employed by the Florida Birth-Related Neurological Injury Compensation Association as of July 1, 2007, may be employed in order to account for individual participant costs and injury characteristics to the extent that the data are available to perform such methodology and the State Corporation Commission's actuary determines that such methodology is actuarially appropriate.

B. In the event that the State Corporation Commission finds that the Fund cannot be maintained on an actuarially sound basis subject to the maximum assessments listed in § 38.2-5020, the Commission shall promptly notify the Speaker of the House of Delegates, the President of the Senate, the board of directors of the Program, and the Virginia Workers' Compensation Commission.

1987, c. 540; 1989, c. 523; 2008, cc. 267, 520.

Chapter 51 - RISK RETENTION GROUPS AND PURCHASING GROUPS

§ 38.2-5100. Purpose.

The purpose of this chapter is to regulate the formation and operation of risk retention groups and purchasing groups in this Commonwealth formed pursuant to the provisions of the federal Liability Risk Retention Act of 1986 to the extent permitted by such law.

1987, c. 585; 1992, c. 588.

§ 38.2-5101. Definitions.

As used in this chapter:

"Commissioner" means the commissioner, director, or superintendent of insurance in a state other than the Commonwealth of Virginia.

"Completed operations liability" means liability arising out of the installation, maintenance, or repair of any product at a site which is not owned or controlled by (i) any person who performs that work or (ii) any person who hires an independent contractor to perform that work; but shall include liability for activities which are completed or abandoned before the date of the occurrence giving rise to the liability.

"Domicile," for purposes of determining the state in which a purchasing group is domiciled, means (i) for a corporation, the state in which the purchasing group is incorporated; and (ii) for an unincorporated entity, the state of its principal place of business.

"Hazardous financial condition" means that, based on its present or reasonably anticipated financial condition, a risk retention group, although not yet financially impaired or insolvent, is unlikely to be able (i) to meet obligations to policyholders with respect to known claims and reasonably anticipated claims or (ii) to pay other obligations in the normal course of business.

"Insurance" means primary insurance, excess insurance, reinsurance, surplus lines insurance, and any other arrangement for shifting and distributing risk which is determined to be insurance under the laws of this Commonwealth.

"Liability" means legal liability for damages, including costs of defense, legal costs and fees, and other claims expenses, because of injuries to other persons, damage to their property, or other damage or loss to such other persons resulting from or arising out of (i) any business, whether profit or nonprofit, trade, product, services, including professional services, premises, or operations or (ii) any activity of any state or local government, or any agency or political subdivision thereof. Liability does not include personal risk liability and an employer's liability with respect to its employees other than legal liability under the federal Employers Liability Act (45 U.S.C. § 51 et seq.).

"Personal risk liability" means liability for damages because of injury to any person, damage to property, or other loss or damage resulting from any personal, familial, or household responsibilities or activities.

"Plan of operation" or "feasibility study" means an analysis which presents the expected activities and results of a risk retention group including, at a minimum:

1. Information sufficient to verify that its members are engaged in businesses or activities similar or related with respect to the liability to which such members are exposed by virtue of any related, similar or common business, trade, product, services, premises or operations;

2. For each state in which it intends to operate, the coverages, deductibles, coverage limits, rates, and rating classification systems for each line of insurance the group intends to offer;

3. Historical and expected loss experience of the proposed members and national experience of similar exposures, to the extent this experience is reasonably available;

4. Pro forma financial statements and projections;

5. Appropriate opinions by a qualified independent casualty actuary, including a determination of minimum premium or participation levels required to commence operations and to prevent a hazardous financial condition;

6. Identification of management, underwriting and claims procedures, marketing methods, managerial oversight methods, investment policies, and reinsurance agreements;

7. Identification of each state in which the risk retention group has obtained, or sought to obtain, a charter and license, and a description of its status in each such state; and

8. Such other matters as may be prescribed by the commissioner or commission for liability insurance companies authorized by the insurance laws of the state in which the risk retention group is chartered.

"Product liability" means liability for damages because of any personal injury, death, emotional harm, consequential economic damage, or property damage, including damages resulting from the loss of use of property, arising out of the manufacture, design, importation, distribution, packaging, labeling, lease, or sale of a product, but does not include the liability of any person for those damages if the product involved was in the possession of such a person when the incident giving rise to the claim occurred.

"Purchasing group" means any group which:

1. Has as one of its purposes the purchase of liability insurance on a group basis;

2. Purchases such insurance only for its group members and only to cover their similar or related liability exposure, as described in subdivision 3;

3. Is composed of members whose businesses or activities are similar or related with respect to the liability to which members are exposed by virtue of any related, similar, or common business, trade, product, services, premises, or operations; and

4. Is domiciled in any state.

"Risk retention group" means any corporation or other limited liability association:

1. Whose primary activity consists of assuming and spreading all, or any portion, of the liability exposure of its group members;

2. Which is organized for the primary purpose of conducting the activity described under subdivision 1;

3. Which (i) is chartered and licensed as a liability insurance company and authorized to engage in the business of insurance under the laws of any state or (ii) before January 1, 1985, was chartered or licensed and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands and, before such date, had certified to the insurance commissioner of at least one state

that it satisfied the capitalization requirements of such state, except that any such group shall be considered to be a risk retention group only if it has been engaged in business continuously since such date and only for the purpose of continuing to provide insurance to cover product liability or completed operations liability;

4. Which does not exclude any person from membership in the group solely to provide for members of such a group a competitive advantage over such a person;

5. Which (i) has as its members only persons who have an ownership interest in the group and which has as its owners only persons who are members who are provided insurance by the risk retention group or (ii) has as its sole member and sole owner an organization which is owned by persons who are provided insurance by the risk retention group;

6. Whose members are engaged in businesses or activities similar or related with respect to the liability of which such members are exposed by virtue of any related, similar, or common business, trade, product, services, premises, or operations;

7. Whose activities do not include the provision of insurance other than (i) liability insurance for assuming and spreading all or any portion of the liability of its group members and (ii) reinsurance with respect to the liability of any other risk retention group, or any members of such other group, which is engaged in businesses or activities so that such group or member meets the requirement described in subdivision 6 from membership in the risk retention group which provides such reinsurance; and

8. The name of which includes the phrase "Risk Retention Group" and does not include deceptive or misleading words, designations or phrases.

"State" means any state of the United States or the District of Columbia.

1987, c. 585; 1992, c. 588.

§ 38.2-5102. Risk retention groups chartered in this Commonwealth.

A. A risk retention group seeking to be chartered in this Commonwealth shall be chartered and licensed as a liability insurance company authorized by the insurance laws of this Commonwealth to write only liability insurance pursuant to this chapter and, except as provided elsewhere in this chapter, shall comply with (i) all of the laws, rules, regulations and requirements applicable to such insurers chartered and licensed in this Commonwealth and with (ii) § 38.2-5103 to the extent such requirements are not a limitation on laws, rules, regulations or requirements of this Commonwealth.

B. Notwithstanding any other provision to the contrary, all risk retention groups chartered in this Commonwealth shall file with the Commission and the National Association of Insurance Commissioners (NAIC), an annual statement in a form prescribed by the NAIC and in diskette form, if required by the Commission, and completed in accordance with its instructions and the NAIC Accounting Practices and Procedures Manual.

C. Before it may offer insurance in any state, each risk retention group shall also submit for approval to the Commission a plan of operation or feasibility study. The risk retention group shall submit an

appropriate revision in the event of any subsequent material change in any item of the plan of operation or feasibility study, within ten days of any such change. The group shall not offer any additional kinds of liability insurance, in this Commonwealth or any other state, until a revision of the plan or study is approved by the Commission.

D. At the time of filing its application for licensure, the risk retention group shall provide to the Commission in summary form the following information: the identity of the initial members of the group, the identity of those individuals who organized the group or who will provide administrative services or otherwise influence or control the activities of the group, the amount and nature of initial capitalization, the coverages to be afforded, and the states in which the group intends to operate.

1987, c. 585; 1992, c. 588.

§ 38.2-5103. Risk retention groups not chartered in this Commonwealth.

Risk retention groups chartered in states other than this Commonwealth and seeking to do business as a risk retention group in this Commonwealth shall observe and abide by the laws of this Commonwealth as follows:

1. Before offering insurance in this Commonwealth, a risk retention group shall submit to the Commission on a form prescribed by the Commission:

a. A statement identifying the state or states in which the risk retention group is chartered and licensed as a liability insurance company, date of chartering, its principal place of business, and such other information including information on its membership, as the Commission may require to verify that the risk retention group is qualified under the definition set forth in this chapter;

b. A copy of its plan of operations or a feasibility study and revisions of such plan or study submitted to its state of domicile; however, the provision relating to the submission of a plan of operation or a feasibility study shall not apply with respect to product liability or completed operations liability as defined in this chapter which was offered before October 27, 1986, by any risk retention group which had been chartered and operating for not less than three years before such date;

c. A copy of any revision to its plan of operation or feasibility study required by this chapter at the same time that the revision is submitted to the Commissioner of its chartering state; and

d. A statement of registration which designates the clerk of the Commission as its agent for the purpose of receiving service of legal documents or process.

2. Any risk retention group doing business in this Commonwealth shall submit to the Commission:

a. A copy of the group's financial statement submitted to its state of domicile, which shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or a loss reserve specialist who is qualified under criteria established by the National Association of Insurance Commissioners;

b. A copy of each examination of the risk retention group as certified by the commissioner or public official conducting the examination;

c. Upon request by the Commission, a copy of any information or document pertaining to any outside audit performed with respect to the risk retention group; and

d. Such information as may be required to verify its continuing qualification as a risk retention group under the definition set forth in this chapter.

3. All premiums paid for coverages within this Commonwealth to risk retention groups shall be subject to taxation, including the assessment set forth in § 38.2-400, at the same rate and subject to the same interest, fines and penalties for nonpayment as applicable to foreign admitted insurers. Each risk retention group shall pay the taxes for risks insured within the Commonwealth. Further, each risk retention group shall report all premiums paid to it for risks insured within this Commonwealth.

4. Any risk retention group, its agents and representatives, shall comply with § 38.2-510.

5. Any risk retention group shall comply with the provisions of §§ 38.2-500, 38.2-501, 38.2-502, 38.2-503, 38.2-504, 38.2-506, and 38.2-512 regarding deceptive, false, or fraudulent acts or practices. However, the provisions of this subdivision do not relieve a risk retention group from the requirements of any other state statutes regarding deceptive, false, or fraudulent acts or practices.

6. Any risk retention group must submit to an examination by the Commission to determine its financial condition if the commissioner of the jurisdiction in which the group is chartered has not initiated an examination or does not initiate an examination within sixty days after a request by the Commission. Any such examination shall be coordinated to avoid unjustified repetition and conducted in an expeditious manner and in accordance with the NAIC's Examiner Handbook.

7. Every application form for insurance from a risk retention group and any policy issued by a risk retention group shall contain in ten point type on the front page and the declaration page, the following notice:

NOTICE

This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group.

8. The following acts by a risk retention group are hereby prohibited:

a. The solicitation or sale of insurance by a risk retention group to any person who is not eligible for membership in such group; and

b. The solicitation or sale of insurance by, or operation of, a risk retention group that is in a hazardous financial condition or is financially impaired.

9. No risk retention group shall be allowed to do business in this Commonwealth if an insurance company is directly or indirectly a member or owner of such risk retention group, other than in the case of a risk retention group all of whose members are insurance companies.

10. The terms of any insurance policy provided by a risk retention group shall not provide or be construed to provide insurance policy coverage prohibited generally by the laws of this Commonwealth or declared unlawful by the Supreme Court of Virginia. For the purpose of this subdivision, a risk retention group shall comply with §§ 38.2-227, 38.2-2200, 38.2-2204 and any other applicable laws of this Commonwealth.

11. A risk retention group not chartered in this Commonwealth and doing business in this Commonwealth shall comply with a lawful order issued in a voluntary dissolution proceeding or in a delinquency proceeding commenced by a state insurance commissioner or the Commission if there has been a finding of financial impairment after an examination under this section.

1987, c. 585; 1992, c. 588.

§ 38.2-5104. Associations.

A. The provisions of Chapter 16 of Title 38.2 shall not apply to a risk retention group.

B. A risk retention group shall participate in any mechanisms established pursuant to § 38.2-2015 for the equitable apportionment of liability insurance losses and expenses.

1987, c. 585.

§ 38.2-5105. Repealed.

Repealed by Acts 2001, c. 706, cl. 2, effective September 1, 2002.

§ 38.2-5106. Purchasing groups; exemption from certain laws relating to the group purchase of insurance.

Any purchasing group meeting the criteria established under the provisions of the federal Liability Risk Retention Act of 1986 shall be exempt from any law of this Commonwealth relating to the creation of groups for the purchase of insurance, prohibition of group purchasing, or any law that would discriminate against a purchasing group or its members. A purchasing group shall be subject to all other applicable laws of this Commonwealth.

1987, c. 585.

§ 38.2-5107. Insurers; exemptions from certain laws relating to the group purchase of insurance.

A. An insurer shall be exempt from any law of this Commonwealth which prohibits providing, or offering to provide, to a purchasing group or its members advantages based on their loss and expense experience not afforded to other persons with respect to rates, policy forms, coverages, or other matters.

B. Any insurer who transacts the business of insurance in this Commonwealth with a purchasing group or its members shall comply with the provisions of § 38.2-1024 and all other statutes in Title

38.2 which are applicable to licensed insurers, unless the insurer has received prior approval of the Commission to issue surplus lines insurance pursuant to Chapter 48 of this title.

1987, c. 585.

§ 38.2-5108. Notice and registration requirements of purchasing groups.

A. A purchasing group which intends to do business in this Commonwealth shall furnish notice to the Commission, on forms prescribed by the Commission, which shall:

1. Identify the state in which the group is domiciled;

2. Identify all other states in which the group intends to do business;

3. Specify the lines and classifications of liability insurance which the purchasing group intends to purchase;

4. Identify the insurance company from which the group intends to purchase its insurance, the domicile of such company, and the business address of such company;

5. Specify the method by which, and the person(s), if any, through whom insurance will be offered to its purchasing groups located in this Commonwealth;

6. Identify the principal place of business of the group including the business address of the group; and

7. Provide such other information as may be required by the Commission to verify that the purchasing group is qualified under the definition set forth in this chapter.

B. A purchasing group shall, within ten days, notify the Commission of any changes in any items set forth in subsection A of this section.

C. The purchasing group shall register with and designate the clerk of the Commission as its agent solely for the purpose of receiving service of legal documents or process, except that such requirements shall not apply in the case of a purchasing group:

1. Which (i) was domiciled before April 1, 1986, and (ii) is domiciled on and after October 27, 1986, in any state of the United States;

2. Which (i) before October 27, 1986, purchased insurance from an insurance carrier licensed in any state and (ii) since October 27, 1986, purchases its insurance from an insurance carrier licensed in any state;

3. Which was a purchasing group under the requirements of the Product Liability Risk Retention Act of 1981 before October 27, 1986; and

4. Which does not purchase insurance that was not authorized for purposes of an exemption under that Act, as in effect before October 27, 1986.

D. Each purchasing group that is required to give notice pursuant to subsection A of this section shall also furnish such information as may be required by the Commission to (i) verify that the entity

qualifies as a purchasing group; (ii) determine where the purchasing group is located; and (iii) determine appropriate tax treatment.

E. Any purchasing group which was doing business in Virginia prior to the enactment of this subsection shall, within thirty days after July 1, 1992, furnish notice to the Commission pursuant to the provisions of subsection A of this section and furnish such information as may be required pursuant to subsections B and C of this section.

1987, c. 585; 1992, c. 588.

§ 38.2-5109. Restrictions on insurance purchased by purchasing groups.

A. A purchasing group may not purchase insurance from a risk retention group that is not chartered in a state or from an insurer not admitted in the state in which the purchasing group is located, unless the purchase is effected through a licensed agent or broker acting pursuant to the surplus lines laws and regulations of such state.

B. No purchasing group may purchase insurance providing for a deductible or self-insured retention applicable to the group as a whole; however, coverage may provide for a deductible or self-insured retention applicable to individual members.

1987, c. 585; 1992, c. 588.

§ 38.2-5110. Commission's authority regarding risk retention groups and purchasing groups.

The Commission is authorized to make use of any of the powers established under Titles 12.1 and 38.2 to enforce the laws of this Commonwealth so long as those powers are not specifically preempted by the Product Liability Risk Retention Act of 1981, as amended by the Risk Retention Amendments of 1986. This includes, but is not limited to, the Commission's power to investigate, issue subpoenas, conduct depositions and hearings, issue orders, and impose penalties. The Commission shall be deemed a state court of competent jurisdiction, independent of its Bureau of Insurance, in all judicial proceedings to enforce the provisions of this chapter.

1987, c. 585; 1995, c. 843.

§ 38.2-5111. Penalties.

A risk retention group which violates any provision of this chapter will be subject to fines and penalties applicable to licensed insurers generally, including revocation of its license or the right to do business in this Commonwealth.

1987, c. 585.

§ 38.2-5112. Duty on agents or brokers.

Any person acting, or offering to act, as an agent or surplus lines broker for a risk retention group or purchasing group, which solicits members, sells insurance coverage, purchases coverage for its members located within this Commonwealth or otherwise does business in this Commonwealth shall, before commencing any such activity, comply with the applicable provisions of Chapters 18 and 48 of this title, relating to property and casualty insurance agents and surplus lines brokers.

1987, c. 585.

§ 38.2-5113. Financial responsibility policy form or coverage requirements.

Any risk retention group and any insurer who transacts the business of insurance in this Commonwealth with a purchasing group or its members shall not be exempt from the policy form or coverage requirements of this Commonwealth's motor vehicle financial responsibility insurance law. For the purpose of this section, any risk retention group and any insurer who transacts the business of insurance in this Commonwealth with a purchasing group or its members shall comply with §§ 38.2-2200 through 38.2-2207, §§ 38.2-2209, 38.2-2211, 38.2-2216, and §§ 38.2-2218 through 38.2-2225 and any other applicable law of this Commonwealth.

1987, c. 585.

§ 38.2-5114. Application of other state laws to persons or corporations.

Nothing in this chapter shall be construed to affect the applicability of state laws which are generally applicable to persons or corporations.

1987, c. 585.

§ 38.2-5115. Binding effect of orders issued in U.S. District Court.

An order issued by any district court of the United States enjoining a risk retention group from soliciting or selling insurance, or operating, in any state, or in all states or in any territory or possession of the United States upon a finding that such a group is in a hazardous financial condition shall be enforceable in the courts of the state.

1987, c. 585.

Chapter 52 - LONG-TERM CARE INSURANCE

§ 38.2-5200. Definitions.

As used in this chapter:

"Applicant" means in the case of an individual long-term care insurance policy, the person who seeks to contract for such benefits, or in the case of a group long-term care insurance policy, the proposed certificateholder.

"Certificate" means any certificate or evidence of coverage issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this Commonwealth.

"Group long-term care insurance" means a long-term care insurance policy delivered or issued for delivery in this Commonwealth to any group which complies with § 38.2-3521.1.

"Long-term care insurance" means any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than twelve consecutive months for each covered person on an expense incurred, indemnity, prepaid, or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, personal care, mental health or substance abuse services, provided in a setting other than an acute care unit of a hospital. Such term

includes group and individual annuities and life insurance policies or riders that provide directly or that supplement long-term care insurance. Such term shall also include qualified long-term insurance contracts. Long-term care insurance may be issued by insurers, fraternal benefit societies, health services plans, health maintenance organizations, cooperative nonprofit life benefit companies or mutual assessment life, accident and sickness insurers to the extent they are otherwise authorized to issue life or accident and sickness insurance. Health maintenance organizations, cooperative nonprofit life benefit companies and mutual assessment life, accident and sickness insurers may apply to the Commission for approval to provide long-term care insurance.

"Policy" means any individual or group policy of insurance, contract, subscriber agreement, certificate, rider or endorsement delivered or issued for delivery in this Commonwealth by an insurer, fraternal benefit society, health services plan, health maintenance organization or any similar organization.

"Qualified long-term care insurance policy" or "federally tax-qualified long-term care insurance contract" means an individual or group insurance policy or contract that meets the requirements of § 7702B (b) of the Internal Revenue Code of 1986, as amended. Such term shall also include the portion of a life insurance policy or contract that provides long-term care insurance coverage by rider or as part of the contract and that satisfies the requirements of §§ 7702B (b) and 7702B (e) of the Internal Revenue Code of 1986, as amended.

1987, c. 586; 1990, c. 285; 2000, c. 559.

§ 38.2-5201. What laws applicable.

All policies and certificates shall comply with all of the provisions of this title relating to insurance policies and certificates generally, except Article 2 (§ 38.2-3408 et seq.) of Chapter 34 and Chapter 36 of this title. In the event of conflict between the provisions of this chapter and other provisions of this title, the provisions of this chapter shall be controlling.

1987, c. 586; 1990, c. 285.

§ 38.2-5202. Promulgation of regulations; standards for policy provisions.

A. The Commission may adopt regulations to establish specific standards for policy provisions of long-term care insurance policies. These standards shall be in addition to and in accordance with applicable laws of this Commonwealth. The standards shall address terms of renewability, nonforfeiture provisions if applicable, initial and subsequent conditions of eligibility, continuation or conversion, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, definitions of terms, and disclosure of rating practices to consumers and may address any other standards considered appropriate by the Commission.

B. The Commission shall promulgate such regulations regarding long-term care insurance policies and certificates as it deems appropriate.

C. Regulations issued by the Commission shall:

1. Recognize the unique, developing and experimental nature of long-term care insurance;

2. Recognize the appropriate distinctions necessary between group and individual long-term care insurance policies;

3. Recognize the unique needs of both those individuals who have reached retirement age and those preretirement individuals interested in purchasing long-term care insurance products; and

4. Recognize the appropriate distinctions necessary between long-term care insurance and accident and sickness insurance policies, prepaid health plans, and other health service plans.

1987, c. 586; 1990, c. 285; 2000, c. 559; 2001, c. 114.

§ 38.2-5202.1. Refund of premium for cancellation or termination of policy.

A. Each individual long-term care insurance policy or certificate shall provide for refund of premium in the event of cancellation or termination of coverage. In the event that the policy or certificate is cancelled by the insurer or terminated by the insured, the insurer shall, within thirty days of the effective date of such cancellation or termination, return to the insured the unearned portion of any premium paid. The earned premium shall be computed on a pro rata basis.

B. The requirements of this section shall apply to all individual long-term care insurance policies, contracts, and plans delivered, issued for delivery, reissued, renewed, or extended or at any time when any term of any such policy, contract, or plan is changed or any premium adjustment is made. The requirements of this section shall apply to neither group long-term care insurance nor to any individual long-term care insurance policy, contract or plan providing coverage for the duration of the insured's life if the premium therefor is paid in a single installment payment.

2000, c. 532.

§ 38.2-5203. Prohibited provisions.

No long-term care insurance policy may:

1. Be cancelled, nonrenewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificateholder;

2. Contain a provision establishing any new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder;

3. Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care;

4. Be issued based on medical or health status when the policy is issued by an agent or third-party administrator pursuant to the underwriting authority granted to the agent or third-party administrator by the insurer; or

5. Provide that an insurer who has paid benefits under a long-term care insurance policy or certificate may recover the benefit payments in the event that the policy or certificate is rescinded.

1987, c. 586; 1990, c. 285; 2000, c. 559.

§ 38.2-5204. Preexisting conditions.

A. No long-term care insurance policy or certificate shall use a definition of "preexisting condition" which is more restrictive than the following: "preexisting condition" means the existence of symptoms which would cause an ordinary prudent person to seek diagnosis, care or treatment, or a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six months preceding the effective date of coverage of an insured person.

B. No long-term care insurance policy may exclude coverage for a loss or confinement which is the result of a preexisting condition for a period of confinement longer than six months following the effective date of coverage of an insured person.

C. The Commission may extend the limitation periods set forth in subsections A and B of this section as to specific age group categories or specific policy forms upon findings that the extension is in the best interest of the public.

D. The definition of "preexisting condition" does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, underwriting in accordance with that insurer's established underwriting standards for long-term care insurance policies. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in subsection A or B expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in subsection A or B.

1987, c. 586; 1990, c. 285.

§ 38.2-5205. Prior institutionalization.

A. No long-term care insurance policy may be delivered or issued for delivery in this Commonwealth if such policy conditions eligibility (i) for any benefits provided in an institutional care setting on the receipt of a higher level of institutional care or (ii) for any benefits on a prior hospitalization requirement.

B. A long-term care insurance policy containing any limitations or conditions for eligibility other than those prohibited in subsection A shall clearly label such limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate entitled "Limitations or Conditions on Eligibility for Benefits."

C. A long-term care insurance policy containing a benefit advertised, marketed or offered as a home health care or home care benefit may not condition receipt of benefits on a prior institutionalization requirement.

D. A long-term care insurance policy which conditions eligibility of noninstitutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than thirty days for which benefits are paid.

1987, c. 586; 1990, c. 285.

§ 38.2-5206. Rates.

A. Benefits provided for long-term care shall be reviewed and approved as set forth in regulations issued by the Commission addressing long-term care insurance. The regulations shall provide standards for initial filing requirements and premium rate schedule increases similar to those set forth in the model regulation for long-term care insurance developed by the National Association of Insurance Commissioners.

B. The regulation promulgated under this section shall recognize the unique, developing and experimental nature of long-term care insurance and shall recognize the unique needs of those individuals who have reached retirement age and the needs of those preretirement individuals interested in purchasing long-term care insurance policies.

C. A certificate by a qualified actuary or other qualified professional approved by the Commission as to the adequacy of the rates and reserves shall be filed with the Commission along with adequate supporting information.

1987, c. 586; 1990, c. 286; 2002, c. 334.

§ 38.2-5207. Disclosure.

In order to provide for fair disclosure in the sale of long-term care insurance policies:

1. An outline of coverage shall be delivered to an applicant for an individual long-term care insurance policy at the time of application for an individual policy. In the case of direct response solicitation, the insurer shall deliver the outline of coverage upon the applicant's request, but regardless of request shall make such delivery no later than at the time of policy delivery. The Commission shall prescribe a standard format, including style, arrangement, and overall appearance, and the content of an outline of coverage. In the case of agent solicitations, an agent shall deliver the outline of coverage prior to the presentation of an application or enrollment form. In the case of direct response solicitations, the outline of coverage shall be presented in conjunction with any application or enrollment form.

Such outline of coverage shall include:

a. A description of the principal benefits and coverage provided in the policy;

b. A statement of the exclusions, reductions and limitations contained in the policy;

c. A statement of the renewal provisions, including any reservation in the policy of a right to change premiums. Continuation or conversion provisions of group coverage shall be specifically described;

d. A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions;

e. A description of the terms under which the policy may be returned and premium refunded; and

f. A brief description of the relationship of cost of care and benefits.

2. A certificate delivered or issued for delivery in this Commonwealth shall include:

a. A description of the principal benefits and coverage provided in the policy;

b. A statement of the exclusions, reductions and limitations contained in the policy; and

c. A statement that the group master policy should be consulted to determine governing contractual provisions.

3. The Commission shall adopt and publish a Long-Term Care Insurance Consumer Guide. After adoption and publication by the Commission, a copy of the Consumer Guide shall be provided at the time of delivery of the policy or certificate.

4. No long-term care insurance policy or certificate shall be marketed as a qualified long-term care insurance policy or federally tax-qualified long-term care insurance contract unless the policy or contract contains a statement prominently disclosing that such policy or certificate is a qualified long-term care insurance policy or federally tax-qualified long-term care insurance contract.

1987, c. 586; 1990, c. 285; 2000, c. 559.

§ 38.2-5207.1. Disclosure; life insurance policies.

Whenever an individual life insurance policy which provides long-term care benefits within the policy or by rider is delivered, it shall be accompanied by a policy summary. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make such delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary shall also include:

1. An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

2. An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits, if any, for each covered person; and

3. Any exclusions, reductions, and limitations on benefits of long-term care.

If applicable to the policy type, the summary shall also include (i) a disclosure of the effects of exercising other rights under the policy, (ii) a disclosure of guarantees related to long-term care costs of insurance charges, and (iii) current and projected maximum lifetime benefits.

1990, c. 285.

§ 38.2-5207.2. Long-term care benefits; monthly report.

Whenever long-term care benefits being paid are funded through a life insurance policy by acceleration of the death benefit, a monthly report shall be provided to the policyholder. Such report shall include:

1. Any long-term care benefits paid out during the month;

2. An explanation of any changes in the policy, e.g., death benefits or cash values, due to long-term care benefits being paid out; and

3. The amount of long-term care benefits existing or remaining.

1990, c. 285.

§ 38.2-5208. Right to return; free look provision.

Long-term care insurance policies and certificates shall have a notice prominently printed on the first page or attached thereto stating in substance that the policyholder or insured person has the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the policyholder or insured person is not satisfied for any reason. A policy or certificate returned pursuant to the notice shall be void from its inception upon the mailing or delivery of the policy or certificate to the insurer or its agent.

1987, c. 586; 1990, c. 285.

§ 38.2-5209. Incontestability.

Each long-term care policy or certificate shall include an incontestability provision that includes the following:

1. For a policy or certificate that has been in force for less than six months, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is material to the acceptance of coverage.

2. For a policy or certificate that has been in force for at least six months but less than two years, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is both material to the acceptance of coverage and that pertains to the condition for which benefits are sought.

3. After a policy or certificate has been in force for two years, it is not contestable upon the grounds of misrepresentation alone, and such policy or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

4. In the event of the death of the insured, this section shall not apply to the remaining death benefit of a life insurance policy that accelerates benefits for long-term care. In such event, the contestability of the remaining death benefits under such a life insurance policy shall be governed by the provisions of § 38.2-3305 or § 38.2-3326. In all other situations, this section shall apply to life insurance policies that accelerate benefits for long-term care.

2000, c. 559.

§ 38.2-5210. Nonforfeiture benefit.

A long-term care insurance policy or certificate shall not be delivered or issued for delivery in this Commonwealth unless the policyholder or certificateholder has been offered the option of purchasing a policy including a nonforfeiture benefit, as provided in regulations promulgated by the Commission. The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy or certificate. If the policyholder or certificateholder declines the nonforfeiture benefit, the insurer shall provide a contingent benefit upon lapse that shall be available for a specified period of time following a substantial increase in premium rates.

2000, c. 559.

Chapter 53 - PRIVATE REVIEW AGENTS [Repealed]

§§ 38.2-5300 through 38.2-5309. Repealed.

Repealed by Acts 1998, c. 129.

Chapter 54 - UTILIZATION REVIEW STANDARDS AND APPEALS [Repealed]

§§ 38.2-5400 through 38.2-5409. Repealed.

Repealed by Acts 1998, c. 891.

Chapter 55 - RISK-BASED CAPITAL ACT

§ 38.2-5500. Applicability.

The provisions of this chapter shall be known as The Risk-Based Capital Act and may be referred to herein as "the Act." The Act shall apply to all persons licensed in the Commonwealth to transact an insurance business pursuant to provisions in Chapter 10 (§ 38.2-1000 et seq.), 11 (§ 38.2-1100 et seq.), 12 (§ 38.2-1200 et seq.), 25 (§ 38.2-2500 et seq.), 41 (§ 38.2-4100 et seq.), 42 (§ 38.2-4200 et seq.), 43 (§ 38.2-4300 et seq.), 45 (§ 38.2-4500 et seq.), or 61 (§ 38.2-6100 et seq.).

1995, c. 789; 2000, c. 47; 2012, c. 156; 2014, c. 309.

§ 38.2-5501. Definitions.

As used in this chapter, the following terms shall have the following meanings:

"Adjusted RBC Report" means an RBC report which has been adjusted by the Commission in accordance with subsection F of § 38.2-5502.

"Capital and surplus" or "capital," except when used in the term "risk-based capital" or "adjusted capital," means net worth of a health maintenance organization and, for all other licensees, means surplus to policyholders.

"Corrective Order" means an order issued by the Commission specifying corrective actions which the Commission has determined are required.

"Delinquency proceeding" means any proceeding commenced against a licensee for the purpose of liquidating, rehabilitating, reorganizing or conserving a licensee pursuant to the provisions of Chapter 15 (§ 38.2-1500 et seq.).

"Domestic health organization" means a health organization domiciled in this Commonwealth.

"Domestic insurer" means any domestic company which has obtained a license to engage in insurance transactions in this Commonwealth in accordance with the applicable provisions of Chapter 10 (§ 38.2-1000 et seq.) or Chapter 41 (§ 38.2-4100 et seq.).

"Domestic licensee" means and includes a domestic insurer and a domestic health organization.

"Foreign health organization" means a health organization not domiciled in this Commonwealth which is licensed to do business in this Commonwealth.

"Foreign insurer" means any company not domiciled in this Commonwealth which has obtained a license to engage in insurance transactions in this Commonwealth in accordance with the applicable provisions in Chapter 10 (§ 38.2-1000 et seq.) or Chapter 41 (§ 38.2-4100 et seq.).

"Foreign licensee" means and includes a foreign insurer and a foreign health organization.

"Health organization" means an insurer that is required by the Commission to use the NAIC's Health Annual Statement blank when filing the annual statement prescribed by § 38.2-1300, or a corporation licensed pursuant to Chapter 42 (§ 38.2-4200 et seq.) operating a health or hospital services plan in the Commonwealth, or a health maintenance organization or limited health maintenance organization licensed pursuant to Chapter 43 (§ 38.2-4300 et seq.), or a corporation licensed pursuant to Chapter 45 (§ 38.2-4500 et seq.) and operating a dental or optometric services plan in the Commonwealth, or a dental plan organization licensed pursuant to Chapter 61 (§ 38.2-6100 et seq.).

"Licensee" means and includes a life and health insurer, a property and casualty insurer, and a health organization.

"Life and health insurer" means any domestic insurer or foreign insurer, whether known as a life insurer or a property and casualty insurer or a reciprocal or a fraternal benefit society, which is authorized to write any class of life insurance, annuities, or accident and sickness insurance, and is not writing a class of insurance set forth in §§ 38.2-110 through 38.2-132, provided that "life and health insurer" shall not include any insurer which is required by the Commission to use the NAIC's Health Annual Statement blank when filing the annual statement prescribed by § 38.2-1300.

"NAIC" means the National Association of Insurance Commissioners.

"Negative Trend," with respect to a life and health insurer, means a negative trend over a period of time, as determined in accordance with the "Trend Test Calculation" included in the Life RBC Instructions.

"Property and casualty insurer" means any domestic insurer or foreign insurer which is authorized under any chapter of this title to write any class of insurance except a class of life insurance or annuities, provided that "property and casualty insurer" shall not include monoline mortgage guaranty insurers, financial guaranty insurers and title insurers, nor shall it include any insurer which is required by the Commission to use the NAIC's Health Annual Statement blank when filing the annual statement prescribed by § 38.2-1300.

"RBC" means risk-based capital.

"RBC Instructions" means the RBC Report including risk-based capital instructions adopted by the NAIC, as such RBC Instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

"RBC Level" means a licensee's Company Action Level RBC, Regulatory Action Level RBC, Authorized Control Level RBC, or Mandatory Control Level RBC where:

1. "Company Action Level RBC" means, with respect to any licensee, the product of 2.0 and its Authorized Control Level RBC;

2. "Regulatory Action Level RBC" means the product of 1.5 and its Authorized Control Level RBC;

3. "Authorized Control Level RBC" means the number determined under the risk-based capital formula in accordance with the RBC Instructions;

4. "Mandatory Control Level RBC" means the product of 0.70 and the Authorized Control Level RBC.

"RBC Plan" means a comprehensive financial plan containing the elements specified in subsection B of § 38.2-5503. If the Commission rejects the RBC Plan, and it is revised by the licensee, with or without the Commission's recommendation, the plan shall be called the "Revised RBC Plan."

"RBC Report" means the report required in § 38.2-5502.

"Total Adjusted Capital" means the sum of:

1. A licensee's statutory capital and surplus as determined in accordance with statutory accounting applicable to the annual financial statements required to be filed under § 38.2-1300; and

2. Such other items, if any, as the RBC Instructions may provide.

1995, c. 789; 2000, c. 47; 2007, c. 360; 2012, c. 156; 2014, c. 309.

§ 38.2-5502. RBC Reports.

A. Every domestic licensee shall, on or prior to each March 1, the "filing date," prepare and submit to the Commission a report of its RBC Levels as of the end of the calendar year just ended, in a form and containing such information as is required by the RBC Instructions. In addition, every domestic licensee shall file its RBC Report:

1. With the NAIC in accordance with the RBC Instructions; and

2. With the insurance commissioner in any state in which the licensee is authorized to do business, if the insurance commissioner has notified the licensee of its request in writing, in which case, the licensee shall file its RBC Report not later than the later of:

a. Fifteen days from the receipt of notice to file its RBC Report with that state; or

b. The filing date.

B. A life and health insurer's RBC shall be determined in accordance with the formula set forth in the RBC Instructions. The formula shall take into account, and may adjust for the covariance between, the following risks:

1. The risk with respect to the insurer's assets;

2. The risk of adverse insurance experience with respect to the insurer's liabilities and obligations;

3. The interest rate risk with respect to the insurer's business; and

4. All other business risks and such other relevant risks as are set forth in the RBC Instructions.

Each risk shall be determined in each case by applying the factors in the manner set forth in the RBC Instructions.

C. A property and casualty insurer's RBC shall be determined in accordance with the formula set forth in the RBC Instructions. The formula shall take into account, and may adjust for the covariance between, the following risks:

1. Asset risk;

2. Credit risk;

3. Underwriting risk; and

4. All other business risks and such other relevant risks as are set forth in the RBC Instructions.

Each risk shall be determined in each case by applying the factors in the manner set forth in the RBC Instructions.

D. A health organization's RBC shall be determined in accordance with the formula set forth in the RBC Instructions. The formula shall take into account, and may adjust for the covariance between, the following risks:

1. Asset risk;

2. Credit risk;

3. Underwriting risk; and

4. All other business risks and such other relevant risks as are set forth in the RBC Instructions.

Each risk shall be determined in each case by applying the factors in the manner set forth in the RBC Instructions.

E. An excess of capital over the amount produced by the risk-based capital requirements contained in this Act and the formulas, schedules and instructions referred to in this Act is desirable in the business of insurance. Accordingly, licensees should seek to maintain capital above the RBC levels required by this Act. Additional capital is used and useful in the insurance business and helps to secure a licensee against various risks inherent in, or affecting, the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in this Act.

F. If a domestic licensee files an RBC Report which in the judgment of the Commission is inaccurate, then the Commission shall adjust the RBC Report to correct the inaccuracy and shall notify the licensee of the adjustment. The notice shall contain a statement of the reason for the adjustment. An RBC Report as so adjusted is referred to as an "Adjusted RBC Report."

1995, c. 789; 2000, c. 47.

§ 38.2-5503. Company Action Level Event.

A. "Company Action Level Event" means any of the following events:

1. The filing of an RBC Report by a licensee which indicates that:

a. The licensee's Total Adjusted Capital is greater than or equal to its Regulatory Action Level RBC but less than its Company Action Level RBC;

b. If a life and health insurer, the insurer has Total Adjusted Capital which is greater than or equal to its Company Action Level RBC but less than the product of its Authorized Control Level RBC and 3.0 and has a negative trend;

c. If a property and casualty insurer, the insurer has Total Adjusted Capital that is greater than or equal to its Company Action Level RBC but less than the product of its Authorized Control Level RBC and 3.0 and triggers the trend test determined in accordance with the Trend Test Calculation included in the Property and Casualty RBC instructions; or

d. If a health organization, the health organization has Total Adjusted Capital that is greater than or equal to its Company Action Level RBC but less than the product of its Authorized Control Level RBC and 3.0 and triggers the trend test determined in accordance with the Trend Test Calculation included in the Health RBC instructions;

2. The notification by the Commission to the licensee of an Adjusted RBC Report that indicates the event in subdivision A 1 a, provided the licensee does not challenge the Adjusted RBC Report under § 38.2-5507; or

3. If, pursuant to § 38.2-5507, the licensee challenges an Adjusted RBC Report that indicates the event in subdivision A 1 a, the notification by the Commission to the licensee that the Commission has, after a hearing, rejected the licensee's challenge.

B. In the event of a Company Action Level Event, the licensee shall prepare and submit to the Commission an RBC Plan which shall:

1. Identify the conditions in the licensee which contribute to the Company Action Level Event;

2. Contain proposals of corrective actions which the licensee intends to take and would be expected to result in the elimination of the Company Action Level Event;

3. Provide projections of the licensee's financial results in the current year and for at least the four succeeding years if the licensee is a life and health insurer or a property and casualty insurer, or at least two succeeding years if the licensee is a health organization, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory balance sheets, operating income, net income, capital and surplus, and RBC levels. If appropriate, the projections for both new and renewal business shall include separate projections for each major line of business and separately identify each significant income, expense and benefit component;

4. Identify the key assumptions impacting the licensee's projections and the sensitivity of the projections to the assumptions; and

5. Identify the quality of, and problems associated with, the licensee's business, including but not limited to its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each case.

C. The RBC Plan shall be submitted:

1. Within forty-five days of the Company Action Level Event; or

2. If the licensee challenges an Adjusted RBC Report pursuant to § 38.2-5507, within forty-five days after notification to the licensee that the Commission has, after a hearing, rejected the licensee's challenge.

D. Within sixty days after the submission by a licensee of an RBC Plan to the Commission, the Commission shall notify the licensee whether the RBC Plan shall be implemented or is, in the judgment of the Commission, unsatisfactory. If the Commission determines the RBC Plan is unsatisfactory, the notification to the licensee shall set forth the reasons for the determination, and may set forth proposed revisions which will render the RBC Plan satisfactory, in the judgment of the Commission. Upon notification from the Commission, the licensee shall prepare a Revised RBC Plan, which may incorporate by reference any revisions proposed by the Commission, and shall submit the Revised RBC Plan to the Commission:

1. Within forty-five days after the notification from the Commission; or

2. If the licensee challenges the notification from the Commission under § 38.2-5507, within forty-five days after a notification to the licensee that the Commission has, after a hearing, rejected the licensee's challenge.

E. In the event of a notification by the Commission to a licensee that the licensee's RBC Plan or Revised RBC Plan is unsatisfactory, the Commission may at the Commission's discretion, subject to the licensee's right to a hearing under § 38.2-5507, specify in the notification that the notification constitutes a Regulatory Action Level Event.

F. Every domestic licensee that files an RBC Plan or Revised RBC Plan with the Commission shall file a copy of the RBC Plan or Revised RBC Plan with the insurance commissioner in any state in which the licensee is authorized to do business if:

1. Such state has an RBC provision substantially similar to subsection A of § 38.2-5508; and

2. The insurance commissioner of that state has notified the licensee of its request for the filing in writing, in which case the licensee shall file a copy of the RBC Plan or Revised RBC Plan in that state no later than the later of:

a. Fifteen days after the receipt of notice to file a copy of its RBC Plan or Revised RBC Plan with the state; or

b. The date on which the RBC Plan or Revised RBC Plan is filed under subsection C of § 38.2-5504.

1995, c. 789; 2000, c. 47; 2007, c. 360; 2012, c. 156.

§ 38.2-5504. Regulatory Action Level Event.

A. "Regulatory Action Level Event" means, with respect to any licensee, any of the following events:

1. The filing of an RBC Report by the licensee which indicates that the licensee's Total Adjusted Capital is greater than or equal to its Authorized Control Level RBC but less than its Regulatory Action Level RBC;

2. The notification by the Commission to a licensee of an Adjusted RBC Report that indicates the event in subdivision A 1, provided the licensee does not challenge the Adjusted RBC Report under § 38.2-5507;

3. If, pursuant to § 38.2-5507, the licensee challenges an Adjusted RBC Report that indicates the event in subdivision A 1, the notification by the Commission to the licensee that the Commission has, after a hearing, rejected the licensee's challenge;

4. The failure of the licensee to file an RBC Report by the filing date, unless the licensee has provided an explanation for such failure which is satisfactory to the Commission and has cured the failure within ten days after the filing date;

5. The failure of the licensee to submit an RBC Plan to the Commission within the time period set forth in subsection C of § 38.2-5503;

6. Notification by the Commission to the licensee that:

a. The RBC Plan or Revised RBC Plan submitted by the licensee is, in the judgment of the Commission, unsatisfactory; and

b. Such notification constitutes a Regulatory Action Level Event with respect to the licensee, provided the licensee has not challenged the determination under § 38.2-5507;

7. If, pursuant to § 38.2-5507, the licensee challenges a determination by the Commission under subdivision A 6, the notification by the Commission to the licensee that the Commission has, after a hearing, rejected such challenge;

8. Notification by the Commission to the licensee that the licensee has failed to adhere to its RBC Plan or Revised RBC Plan, but only if such failure has a substantial adverse effect on the ability of the licensee to eliminate the Company Action Level Event in accordance with its RBC Plan or Revised RBC Plan and the Commission has so stated in the notification, provided the licensee has not challenged the determination under § 38.2-5507; or

9. If, pursuant to § 38.2-5507, the licensee challenges a determination by the Commission under subdivision A 8, the notification by the Commission to the licensee that the Commission has, after a hearing, rejected the challenge.

B. In the event of a Regulatory Action Level Event, the Commission shall:

1. Require the licensee to prepare and submit an RBC Plan or, if applicable, a Revised RBC Plan;

2. Perform such examination or analysis as the Commission deems necessary of the assets, liabilities and operations of the licensee including a review of its RBC Plan or Revised RBC Plan; and

3. Subsequent to the examination or analysis, issue a corrective order specifying such corrective actions as the Commission shall determine are required. In determining corrective actions, the Commission may take into account such factors as are deemed relevant with respect to the licensee based upon the Commission's examination or analysis of the assets, liabilities and operations of the licensee, including, but not limited to, the results of any sensitivity tests undertaken pursuant to the RBC Instructions.

C. The RBC Plan or Revised RBC Plan shall be submitted:

1. Within forty-five days after the occurrence of the Regulatory Action Level Event;

2. If the licensee challenges an Adjusted RBC Report pursuant to § 38.2-5507 and the challenge is not frivolous in the judgment of the Commission, within forty-five days after the notification to the licensee that the Commission has, after a hearing, rejected the licensee's challenge; or

3. If the licensee challenges a Revised RBC Plan under § 38.2-5507 and the challenge is not frivolous in the judgment of the Commission, within forty-five days after notification to the licensee that the Commission has, after a hearing, rejected the licensee's challenge.

D. The Commission may retain actuaries and investment experts and other consultants as may be necessary in the judgment of the Commission to review the licensee's RBC Plan or Revised RBC Plan, examine or analyze the assets, liabilities and operations, including contractual relationships, of the licensee and formulate the corrective order with respect to the licensee. The fees, costs and expenses relating to consultants shall be borne by the affected licensee or such other party as directed by the Commission.

1995, c. 789; 2000, c. 47.

§ 38.2-5505. Authorized Control Level Event.

A. "Authorized Control Level Event" means any of the following events:

1. The filing of an RBC Report by the licensee which indicates that the licensee's Total Adjusted Capital is greater than or equal to its Mandatory Control Level RBC but less than its Authorized Control Level RBC;

2. The notification by the Commission to the licensee of an Adjusted RBC Report that indicates the event in subdivision A 1, provided the licensee does not challenge the Adjusted RBC Report under § 38.2-5507;

3. If, pursuant to § 38.2-5507, the licensee challenges an Adjusted RBC Report that indicates the event in subdivision A 1, the notification by the Commission to the licensee that the Commission has, after a hearing, rejected the licensee's challenge;

4. The failure of the licensee to respond, in a manner satisfactory to the Commission, to a corrective order, provided the licensee has not challenged the corrective order under § 38.2-5507; or

5. If the licensee has challenged a corrective order under § 38.2-5507 and the Commission has, after a hearing, rejected the challenge or modified the corrective order, the failure of the licensee to respond, in a manner satisfactory to the Commission, to the corrective order subsequent to rejection or modification by the Commission.

B. In the event of an Authorized Control Level Event with respect to a licensee, the Commission shall:

1. Take such actions as are required under § 38.2-5504 regarding a licensee with respect to which a Regulatory Action Level Event has occurred; or

2. If the Commission deems it to be in the best interests of the policyholders and creditors of the licensee and of the public, take such actions as are necessary to cause the licensee to be placed under regulatory control under the provisions of Chapter 15 (§ 38.2-1500 et seq.). In the event the Commission takes such actions, the Authorized Control Level Event shall be deemed an indication of a hazardous financial condition which serves as sufficient grounds for the Commission to commence delinquency proceedings, and the receiver appointed in conjunction with such proceedings shall have the rights, powers and duties with respect to the licensee as are set forth in Chapter 15 or any order of liquidation, rehabilitation or conservation entered pursuant thereto. In the event the Commission takes actions under this subdivision pursuant to an Adjusted RBC Report, the licensee shall be entitled to such protections as are afforded to licensees under the appropriate provisions of this title pertaining to summary proceedings.

1995, c. 789; 2000, c. 47.

§ 38.2-5506. Mandatory Control Level Event.

A. "Mandatory Control Level Event" means any of the following events:

1. The filing of an RBC Report which indicates that the licensee's Total Adjusted Capital is less than its Mandatory Control Level RBC;

2. The notification by the Commission to the licensee of an Adjusted RBC Report that indicates the event in subdivision A 1, provided the licensee does not challenge the Adjusted RBC Report under § 38.2-5507; or

3. If, pursuant to § 38.2-5507, the licensee challenges an Adjusted RBC Report that indicates the event in subdivision A 1, notification by the Commission to the licensee that the Commission has, after a hearing, rejected the licensee's challenge.

B. In the event of a Mandatory Control Level Event:

1. With respect to a life and health insurer, the Commission shall take actions as are necessary to place the insurer under regulatory control pursuant to the provisions of Chapter 15 (§ 38.2-1500 et seq.). In that event, the Mandatory Control Level Event shall be deemed an indication of a hazardous

financial condition which serves as sufficient grounds for the Commission to commence delinquency proceedings, and the receiver appointed in conjunction with such proceedings, shall have the rights, powers and duties with respect to the insurer as are set forth in Chapter 15 or any order of liquidation, rehabilitation or conservation entered thereunder. If the Commission takes actions pursuant to an Adjusted RBC Report, the insurer shall be entitled to such protections as are afforded to insurers under the appropriate provisions of this title pertaining to summary proceedings. Notwithstanding any of the foregoing, the Commission may forego action for up to ninety days after the Mandatory Control Level Event if the Commission finds there is a reasonable expectation that the Mandatory Control Level Event may be eliminated within the ninety-day period.

2. With respect to a property and casualty insurer, the Commission shall take actions as are necessary to place the insurer under regulatory control pursuant to the provisions of Chapter 15, or, in the case of an insurer which is writing no business and which is running-off its existing business, may allow the insurer to continue to run-off under the supervision of the Commission. In either event, the Mandatory Control Level Event shall be deemed an indication of a hazardous financial condition which serves as sufficient grounds for the Commission to commence delinquency proceedings, and the receiver appointed in conjunction with such proceedings, shall have the rights, powers and duties with respect to the insurer as are set forth in Chapter 15 or any order of liquidation, rehabilitation, or conservation entered thereunder. If the Commission takes actions pursuant to an Adjusted RBC Report, the insurer shall be entitled to such protections as are afforded to insurers under the appropriate provisions of this title pertaining to summary proceedings. Notwithstanding any of the foregoing, the Commission may forego action for up to ninety days after the Mandatory Control Level Event if the Commission finds there is a reasonable expectation that the Mandatory Control Level Event may be eliminated within the ninety-day period.

3. With respect to a health organization, the Commission shall take actions as are necessary to place the health organization under regulatory control pursuant to and in accordance with applicable provisions in Chapter 15 (§ 38.2-1500 et seq.) and § 38.2-4214.1, or § 38.2-4509.1 of this title. In that event, the Mandatory Control Level Event shall be deemed an indication of a hazardous financial condition which serves as sufficient grounds for the Commission to commence delinquency proceedings, and the receiver appointed in conjunction with such proceedings shall have the rights, powers and duties with respect to the licensee as are set forth in Chapter 15, or any order of liquidation, rehabilitation or conservation entered thereunder. If the Commission takes actions pursuant to an adjusted RBC Report, the health organization shall be entitled to such protections as are afforded to the licensee under the appropriate provisions of this title pertaining to summary proceedings. Notwithstanding any of the foregoing, the Commission may forego action for up to ninety days after the Mandatory Control Level Event if the Commission finds there is a reasonable expectation that the Mandatory Control Level Event may be eliminated within the ninety-day period.

1995, c. 789; 2000, c. 47; 2018, c. 706.

§ 38.2-5507. Hearings.

A. A licensee shall have the right to a confidential hearing, on a record before the Commission, at which the licensee may challenge any determination or action by the Commission, upon:

1. Notification to a licensee by the Commission of an Adjusted RBC Report;

2. Notification to a licensee by the Commission that (i) the licensee's RBC Plan or Revised RBC Plan is unsatisfactory and (ii) such notification constitutes a Regulatory Action Level Event with respect to such licensee;

3. Notification to a licensee by the Commission that the licensee has failed to adhere to its RBC Plan or Revised RBC Plan and that such failure has a substantial adverse effect on the ability of the licensee to eliminate the Company Action Level Event with respect to the licensee in accordance with its RBC Plan or Revised RBC Plan; or

4. Notification to a licensee by the Commission of a Corrective Order with respect to the licensee.

B. The licensee shall notify the Commission of its request for a hearing within five days after the notification by the Commission under subdivision 1, 2, 3 or 4 of subsection A. Upon receipt of the licensee's request for a hearing, the Commission shall set a date for the hearing, which date shall be no less than ten nor more than thirty days after the date of the licensee's request.

1995, c. 789; 2000, c. 47.

§ 38.2-5508. Confidentiality; prohibition on announcements; prohibition on use in ratemaking.

A. All RBC Plans and RBC Reports, to the extent the information therein is not required to be set forth in a publicly available annual statement schedule, which are filed with the Commission with respect to any domestic licensee or foreign licensee, constitute information that might be damaging to the licensee if made available to its competitors, and therefore shall be kept confidential by the Commission. This information shall not be made public nor shall it be subject to subpoena, other than by the Commission and then only for the purpose of enforcement actions taken by the Commission pursuant to this Act or any other provision of the insurance laws of this Commonwealth; however, the Commission may at its discretion disclose such confidential information to (i) a regulatory official of any state or country; (ii) the NAIC, its affiliate or its subsidiary; or (iii) a law-enforcement authority of any state or country. Any such disclosure by the Commission shall not constitute a waiver of confidentiality of such plans, reports, and information. As used in this subsection, RBC Reports and RBC Plans shall include the results or report of any examination or analysis of a licensee performed by the Commission pursuant to the provisions of this Act or by the insurance regulatory officials of another state pursuant to the provisions of a substantially similar risk-based capital statute.

B. The comparison of a licensee's Total Adjusted Capital to any of its RBC Levels is a regulatory tool which may indicate the need for possible corrective action with respect to the licensee, and is not intended as a means to rank licensees generally. Therefore, except as otherwise required under the provisions of this Act, the making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly to be made, published, disseminated, circulated or placed before the

public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing an assertion, representation or statement ranking any licensee relative to other licensees solely on the basis of comparisons between Total Adjusted Capital and RBC Levels or any component derived in the calculation of RBC Levels, by any licensee, agent, broker or other person engaged in any manner in the insurance business would be misleading and is therefore prohibited. If any materially false statement comparing a licensee's Total Adjusted Capital to its RBC Levels, or any of them, or a misleading comparison of any other amount to the licensee's RBC Levels is published in any written publication and the licensee is able to demonstrate to the Commission with substantial proof the falsity or misleading nature of such statement, as the case may be, then the licensee may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false or misleading statement.

C. RBC Instructions, RBC Reports, Adjusted RBC Reports, RBC Plans and Revised RBC Plans are intended solely for use by the Commission in monitoring the solvency of licensees and the need for possible corrective action with respect to licensees and shall not be used by the Commission for rate-making nor considered or introduced as evidence in any rate proceeding nor used by the Commission to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance which a licensee or any affiliate is authorized to write.

1995, c. 789; 2000, c. 47; 2001, c. 519.

§ 38.2-5509. Supplemental provisions; rules; exemption.

A. The provisions of this Act are supplemental to any other provisions of the laws of this Commonwealth, and shall not preclude or limit any other powers or duties of the Commission, the Commissioner of Insurance, or any of the Commission's employees or agents under such laws, including, but not limited to, the provisions of §§ 38.2-1038 and 38.2-1040, subdivision A 7 of § 38.2-4316, and Chapter 15 (§ 38.2-1500 et seq.) and any regulations issued thereunder.

B. The Commission may adopt reasonable rules necessary for the implementation of this Act.

C. The Commission may exempt from the application of this Act any domestic property and casualty insurer which:

1. Writes direct business only in this Commonwealth;

2. Writes direct annual premiums of $2 million or less; and

3. Assumes no reinsurance in excess of five percent of direct premium written.

D. The Commission may exempt from the application of this Act an insurer organized and operating under the laws of this Commonwealth and licensed pursuant to the provisions of Chapter 25 (§ 38.2-2500 et seq.).

E. The Commission may exempt from the application of this Act a domestic health organization that writes direct business only in this Commonwealth and assumes no reinsurance in excess of five

percent of direct premium written, and either (i) writes direct annual premiums of two million dollars or less for comprehensive medical coverages or (ii) is licensed pursuant to Chapter 45 (§ 38.2-4500 et seq.) and covers less than 2,000 lives. As used in this subsection, "comprehensive medical coverages" means contracts providing basic health care services and Medicare and Medicaid risk coverages or policies providing hospital, surgical, major medical, Medicare risk and Medicaid risk coverages. Medicare supplement need not be included and premiums for administrative services shall not be included.

1995, c. 789; 2000, c. 47; 2018, c. 706.

§ 38.2-5510. Foreign licensees.

A. Any foreign licensee shall, upon the written request of the Commission, submit to the Commission an RBC Report as of the end of the calendar year just ended not later than the later of:

1. The date an RBC Report would be required to be filed by a domestic licensee under this Act; or

2. Fifteen days after the request is received by the foreign licensee.

Any foreign licensee shall, at the written request of the Commission, promptly submit to the Commission a copy of any RBC Plan that is filed with the insurance commissioner of any other state.

B. In the event of a Company Action Level Event, Regulatory Action Level Event or Authorized Control Level Event with respect to any foreign licensee as determined under the RBC statute applicable in the state of domicile of the licensee, or, if no RBC provision is in force in that state, under the provisions of this Act, if the insurance commissioner of the state of domicile of the foreign licensee fails to require the foreign licensee to file an RBC Plan in the manner specified under the RBC statute, or, if no RBC provision is in force in the state, under § 38.2-5503 hereof, the Commission may require the foreign licensee to file an RBC Plan with the Commission. In such event, the failure of the foreign licensee to file an RBC Plan with the Commission shall be grounds to order the licensee to cease writing new insurance business in this Commonwealth or to suspend, revoke or refuse to issue a license pursuant to § 38.2-1040.

C. In the event of a Mandatory Control Level Event with respect to any foreign licensee, if no domiciliary receiver has been appointed with respect to the foreign licensee under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign licensee, the Commission may deem such licensee in a condition where any further transaction of business will be hazardous to its policyholders, creditors, members, subscribers, stockholders, or to the public, and an action may be instituted and conducted pursuant to the provisions of Chapter 15 (§ 38.2-1500 et seq.) and, if applicable, § 38.2-4214.1 or 38.2-4509.1, and the occurrence of the Mandatory Control Level Event shall be considered adequate grounds for the application for such action.

1995, c. 789; 2000, c. 47; 2018, c. 706.

§ 38.2-5511. Immunity.

There shall be no liability on the part of, and no cause of action shall arise against, the Commission, the Commissioner of Insurance, or any of the Commission's employees or agents, acting in good faith, for any action taken by them in the performance of their powers and duties under this Act.

1995, c. 789.

§ 38.2-5512. Repealed.

Repealed by Acts 2015, c. 709, cl. 2.

§ 38.2-5513. Notices.

All notices by the Commission to a licensee which may result in regulatory action hereunder shall be effective upon dispatch if transmitted by registered or certified mail, or in the case of any other transmission shall be effective upon the licensee's receipt of such notice.

1995, c. 789; 2000, c. 47.

§ 38.2-5514. Phase-in provision.

For RBC Reports required to be filed by insurers with respect to 1994, the following requirements shall apply in lieu of the provisions of §§ 38.2-5503, 38.2-5504, 38.2-5505 and 38.2-5506:

1. In the event of a Company Action Level Event with respect to a domestic insurer, the Commission shall take no regulatory action hereunder.

2. In the event of a Regulatory Action Level Event under subdivision A 1, A 2 or A 3 of § 38.2-5504, the Commission shall take the actions required under § 38.2-5503.

3. In the event of a Regulatory Action Level Event under subdivision 4, 5, 6, 7, 8 or 9 of subsection A of § 38.2-5504 or an Authorized Control Level Event, the Commission shall take the actions required under § 38.2-5504 with respect to the insurer.

4. In the event of a Mandatory Control Level Event with respect to an insurer, the Commission shall take the actions required under § 38.2-5505 with respect to the insurer.

1995, c. 789.

§ 38.2-5515. Expired.

Expired.

Chapter 56 - THE VIRGINIA HEALTH SAVINGS ACCOUNT PLAN

§ 38.2-5600. Repealed.

Repealed by Acts 2005, cc. 503 and 572, cl. 2.

§ 38.2-5601. The Virginia Health Savings Account Plan.

A. The Department of Taxation and the Commission shall amend the Virginia Medical Savings Account Plan prepared pursuant to former § 38.2-5600 in order to address the provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, permitting eligible individuals to establish health savings accounts pursuant to § 223 of the Internal Revenue Code

of 1986, as amended, which amended Plan shall be designated as the Virginia Health Savings Account Plan. The Department of Taxation and the Commission shall present the Virginia Health Savings Account Plan to the Chairs of the House Committees on Appropriations; Finance; Health, Welfare and Institutions; and Labor and Commerce and the Senate Committees on Finance and Appropriations; Education and Health; and Commerce and Labor by January 1, 2006. Thereafter the Department of Taxation and the Commission shall update the Plan annually and provide copies of such updates to the chairs of such committees.

B. The Virginia Health Savings Account Plan shall, consistent with federal law authorizing the establishment and use of health savings accounts, identify measures by private and public entities that will increase the utilization and efficacy of health savings accounts by the Commonwealth's residents, employers, and providers of health care coverage. The Plan shall include recommendations for legislation that would increase the attractiveness of health savings accounts, or eliminate barriers to their use, by providing:

1. Definitions of eligible participants;

2. Criteria for accounts, including, but not limited to, such matters as trustees, maximum amounts, and the rollover of balances in medical savings accounts to health savings accounts;

3. Measures that would encourage public and private employers to offer, as part of a cafeteria menu of insurance plans, high-deductible health plans that would qualify for a health savings account pursuant to § 223 of the Internal Revenue Code of 1986, as amended; and

4. Any other provisions appropriate to maximize the use of health savings accounts within the Commonwealth.

C. The Plan shall include a report by the Commission on the availability of high deductible health plans, as defined in § 223 (c) (2) of the Internal Revenue Code of 1986, as amended, in the Commonwealth.

D. The Plan shall include recommendations by the Department of Taxation for a system of income tax deductions or refundable credits, consistent with federal law and regulation, for (i) employers who voluntarily contribute to their employees' health savings accounts, (ii) health care providers who participate in providing care to health savings account holders at a reduced cost or without compensation, and (iii) eligible individuals, as defined in § 223 (a) of the Internal Revenue Code of 1986, as amended, who qualify under applicable federal or state definitions as members of the working poor.

1995, c. 650; 2002, c. 372; 2005, cc. 503, 572.

§ 38.2-5602. Operation of medical savings accounts.

Medical savings accounts may be established in the Commonwealth, and may be converted to health savings accounts, pursuant to applicable federal law and regulation.

1995, c. 650; 2002, c. 372; 2005, cc. 503, 572.

§ 38.2-5602.1. Operation of health savings accounts; high deductible health plans.

Health savings accounts may be established in the Commonwealth pursuant to applicable federal law and regulation. Unless otherwise prohibited by any provision of this title, any health carrier, as defined in § 38.2-5800, authorized to conduct business in the Commonwealth may offer a high deductible health plan that would qualify for and may be offered in conjunction with a health savings account pursuant to § 223 of the Internal Revenue Code of 1986, as amended.

2005, cc. 503, 572.

§ 38.2-5603. Repealed.

Repealed by Acts 2005, cc. 503 and 572, cl. 2.

§ 38.2-5604. Health savings accounts exempt from claims.

A. As used in this section, "health savings account" means a health savings account or medical savings account authorized under § 220 or 223 of the Internal Revenue Code of 1986, as amended from time to time.

B. Notwithstanding any provision of law to the contrary, the rights of a participant or beneficiary of a health savings account to hold or to receive moneys paid into or out of, the assets of, and the income of the health savings account:

1. Shall be exempt from creditor process;

2. Shall not be liable to attachment, garnishment, or other process; and

3. Shall not be seized, taken, appropriated, or applied by any legal or equitable process or operation of law to pay any debt or liability of the participant or beneficiary of the account.

2010, c. 595.

Chapter 57 - VIATICAL SETTLEMENTS ACT [Repealed]

§§ 38.2-5700 through 38.2-5707. Repealed.

Repealed by Acts 2003, c. 717.

Chapter 58 - MANAGED CARE HEALTH INSURANCE PLANS

§ 38.2-5800. Definitions.

As used in this chapter:

"Accident and sickness insurance company" means a person subject to licensing in accordance with provisions in Chapter 10 (§ 38.2-1000 et seq.) or Chapter 41 (§ 38.2-4100 et seq.) seeking or having authorization (i) to issue accident and sickness insurance as defined in § 38.2-109, (ii) to issue the benefit certificates or policies of accident and sickness insurance described in § 38.2-3801, or (iii) to provide hospital, medical and nursing benefits pursuant to §§ 38.2-4116 and 38.2-4123.

"Affiliated provider" means any provider that is employed by or has entered into a contractual agreement either directly or indirectly with a health carrier to provide health care services to members of a managed care health insurance plan for which the health carrier is responsible under this chapter.

"Basic health care services" means emergency services, inpatient hospital and physician care, outpatient medical services, laboratory and radiological services, mental health and substance use disorder benefits, and preventive health services.

"Copayment" means a payment required of covered persons as a condition of the receipt of specific health services.

"Covered person" means an individual, whether a policyholder, subscriber, enrollee, or member of a managed care health insurance plan (MCHIP) who is entitled to health care services or benefits provided, arranged for, paid for or reimbursed pursuant to an MCHIP.

"Evidence of coverage" includes any certificate, individual or group agreement or contract or related documents issued in conjunction with the certificate, agreement or contract, issued to a subscriber setting out the coverage and other rights to which a covered person is entitled.

"Health care services" means the furnishing of services to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury or physical disability.

"Health carrier" means an entity subject to Title 38.2 that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including an entity providing a plan of health insurance, health benefits or health services, an accident and sickness insurance company, a health maintenance organization, or a nonstock corporation offering or administering a health services plan, a hospital services plan, or a medical or surgical services plan, or operating a plan subject to regulation under Chapter 45 (§ 38.2-4500 et seq.).

"Health maintenance organization" means a person licensed pursuant to Chapter 43 (§ 38.2-4300 et seq.).

"Limited health care services" means dental care services, vision care services, and such other services as may be determined by the Commission to be limited health care services. Limited health care services shall not include hospital, medical, surgical or emergency services except as such services are provided incident to the limited health care services set forth in the preceding sentence.

"Managed care health insurance plan" or "MCHIP" means an arrangement for the delivery of health care in which a health carrier undertakes to provide, arrange for, pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis which (i) contains one or more incentive arrangements, including any credentialing requirements intended to influence the cost or level of health care services between the health carrier and one or more providers with respect to the delivery of health care services and (ii) requires or creates benefit payment differential incentives for covered persons to use providers that are directly or indirectly managed, owned, under contract with or employed by the health carrier. Any health maintenance organization as defined in § 38.2-

4300 or health carrier that offers preferred provider contracts or policies as defined in § 38.2-3407 or preferred provider subscription contracts as defined in § 38.2-4209 shall be deemed to be offering one or more MCHIPs. For the purposes of this definition, the prohibition of balance billing by a provider shall not be deemed a benefit payment differential incentive for covered persons to use providers who are directly or indirectly managed, owned, under contract with or employed by the health carrier. A single managed care health insurance plan may encompass multiple products and multiple types of benefit payment differentials; however, a single managed care health insurance plan shall encompass only one provider network or set of provider networks.

"Medical necessity" or "medically necessary" means appropriate and necessary health care services which are rendered for any condition which, according to generally accepted principles of good medical practice, requires the diagnosis or direct care and treatment of an illness, injury, or pregnancy-related condition, and are not provided only as a convenience.

"Network" means the set of providers directly or indirectly managed, owned, under contract with or employed directly or indirectly by a health carrier for the purpose of delivering health care services to the covered persons of an MCHIP.

"Provider" or "health care provider" means any hospital, physician, or other person authorized by statute, licensed or certified to furnish health care services.

"Service area" means a clearly defined geographic area in which a health carrier has directly or indirectly arranged for the provision of health care services to be generally available and readily accessible to covered persons of an MCHIP.

1998, c. 891; 2006, c. 448; 2015, c. 649.

§ 38.2-5801. General provisions.

A. No person shall operate an MCHIP in this Commonwealth unless the health carrier who directly or indirectly manages, owns, contracts with, or employs the providers for the plan is licensed in accordance with provisions in this title as an insurance company, a health maintenance organization, or a nonstock corporation organized in accordance with provisions in Chapter 42 (§ 38.2-4200 et seq.) or Chapter 45 (§ 38.2-4500 et seq.) of this title. Such health carrier shall be deemed responsible for the MCHIP and its compliance with this chapter and the provisions of Title 32.1 concerning quality assurance of MCHIPs. A health carrier may be responsible for more than one MCHIP; however, no MCHIP shall have more than one responsible health carrier.

B. Except as provided in subsection C, no person shall operate an MCHIP in this Commonwealth unless the health carrier responsible for the MCHIP holds an active or temporarily suspended certificate of quality assurance issued by the Department of Health.

C. 1. A health maintenance organization applying for licensure under this title on or after July 1, 1998, or whose application for such licensure is pending before the Commission on July 1, 1998, shall request its initial certificate of quality assurance prior to licensing and a copy of its request shall be

included with and made a part of the licensing application and material filed with the Commission pursuant to § 38.2-4301 and subsection B of § 38.2-5802. Until July 1, 2000, (i) issuance of a license under § 38.2-4302 shall be contingent upon receipt of notice from the State Health Commissioner that the health maintenance organization's description of its complaint system has been reviewed and approved by the State Health Commissioner and (ii) upon issuance of the license such health maintenance organization shall be deemed in compliance with subsection B provided no certificate of quality assurance has been issued to the health maintenance organization which has been revoked or not renewed by the State Health Commissioner. Effective July 1, 2000, issuance of a license under § 38.2-4302 shall be contingent upon the Department of Health's issuance of a certificate of quality assurance.

2. Until July 1, 2000, a health maintenance organization licensed under this title on and before July 1, 1998, shall be deemed in compliance with the provisions of this section if (i) a request for initial certification has been filed with the Department of Health on or before December 1, 1998, and is pending before the State Health Commissioner and (ii) no certificate has been issued to the health maintenance organization which has been revoked or not renewed by the State Health Commissioner.

3. A health carrier, other than a health maintenance organization, responsible for an MCHIP pursuant to this chapter, shall request its initial certificate of quality assurance from the Department of Health on or before December 1, 1998, or becoming responsible for a MCHIP under this title. Until July 1, 2000, such health carrier shall be deemed in compliance with the provisions of this section if (i) a request for initial certification is pending before the Department of Health and (ii) no certificate has been issued to the health carrier which has been revoked or not renewed by the State Health Commissioner.

D. The provisions of this chapter shall apply to all health carriers and all MCHIPs operating in this Commonwealth unless an exemption is recognized in accordance with § 38.2-3420; and, except as otherwise provided in this chapter, the provisions of this chapter shall be supplemental and in addition to those otherwise applicable under this title or Title 32.1.

1998, c. 891.

§ 38.2-5802. Establishment of an MCHIP.

A. A health carrier, when applying for initial licensing under this title and with each request for renewal that is to be effective on or after July 1, 1999, shall describe and categorize generally its transactions and operations in this Commonwealth that influence the cost or level of health care services between the health carrier and one or more providers with respect to the delivery of health care services through its MCHIPs. Descriptions and categorization shall identify generally the arrangements that the health carrier has with providers with respect to the delivery of health care services. Descriptions of incentive arrangements shall include compensation methodology and incentives. The descriptions of incentive arrangements shall not include amounts of compensation and values of incentives. Renewal filings shall clearly identify new matter and material changes of information disclosed in the preceding filing.

B. A health carrier applying to the Department of Health for initial certification of quality assurance shall simultaneously file a copy of its request for certification with the Commission and shall include the list of providers required by § 38.2-5805. Such filings shall be assessed by the Department of Health.

C. In addition to items specified in subsection B, the initial filing under this chapter by a health carrier subject to subsection B of § 38.2-5801 shall include any forms of contracts, including any amendments thereto, made with health care providers enabling the health carrier to provide health care services through its MCHIPs to covered persons. Individual provider contracts and contracts with persons outside this Commonwealth shall not be filed with the Commission unless requested by the Commission or necessary to explain or fully disclose pursuant to subsection D operational changes that are materially at variance with the information currently on file with the Commission. The health carrier shall maintain a complete file of all contracts made with health care providers which shall be subject to examination by the Commission. The contracts shall be retained in the file for a period of at least five years after their expiration. Notwithstanding the provisions of Chapter 37 (§ 2.2-3700 et seq.) of Title 2.2 of the Code of Virginia, such contracts shall be confidential and shall not be subject to discovery upon subpoena.

D. No MCHIP shall be operated in a manner that is materially at variance with the information submitted pursuant to this section. Any change in such information which would result in operational changes that are materially at variance with the information currently on file with the Commission shall be subject to the Commission's prior approval. If the Commission fails to act on a notice of material change within thirty days of its filing, the proposed changes shall be deemed approved. A material change in the MCHIP's health care delivery system shall be deemed to result in operational changes that are materially at variance with the information on file with the Commission. The Commission may determine that other changes are material and may require disclosure to secure full and accurate knowledge of the affairs and condition of the health carrier.

E. A health carrier shall give notice to the State Health Commissioner of the filings it makes with the Commission pursuant to this section.

F. The provisions of this section are applicable generally for all health carriers subject to licensure under this title. The provisions of this section shall be applied specifically as follows: (i) the provisions of subsection A are applicable for each health carrier requesting renewal of a license on or after July 1, 1998, and also for each health carrier applying for initial licensing on or after July 1, 1998; (ii) the provisions of subsection B shall be applied to any health carrier that files an application with the Department of Health for initial certification of quality assurance; (iii) the provisions of subsection C become applicable as soon as a health carrier makes a filing pursuant to this section; (iv) the filing requirements described in subsection D are applicable for all material filed with the Commission pursuant to this section, and shall be applied also when a health carrier proposes material changes to information of the type described in this section which previously had been filed with the Commission

pursuant to provisions of Chapter 43 (§ 38.2-4300 et seq.) of this title; and (v) the provisions of subsection E are applicable whenever a health carrier makes a filing pursuant to this section.

1998, c. 891; 1999, c. 20.

§ 38.2-5803. Disclosures and representations to enrollees.

A. The following shall be provided to the MCHIP's covered persons at the time of enrollment or at the time the contract or evidence of coverage is issued and shall be made available upon request or at least annually:

1. A list of the names and locations of all affiliated providers. Such list may be made available in a form other than a printed document, provided the purchaser or existing enrollee is given the means to request and receive a printed copy of such list.

2. A description of the service area or areas within which the MCHIP shall provide health care services.

3. A description of the method of resolving complaints of covered persons, including a description of any arbitration procedure if complaints may be resolved through a specified arbitration agreement.

4. Notice that the MCHIP is subject to regulation in the Commonwealth by both the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1.

5. A prominent notice included within the evidence of coverage, providing substantially the following: "If you have any questions regarding an appeal or grievance concerning the health care services that you have been provided that have not been satisfactorily addressed by your plan, you may contact the Office of the Managed Care Ombudsman for assistance." Such notice shall also provide the toll-free telephone number, mailing address, and electronic mail address of the Office of the Managed Care Ombudsman. This section shall not apply to evidences of coverage for enrollees in the plans administered by the Department of Medical Assistance Services that provide benefits pursuant to Title XIX or Title XXI of the Social Security Act, as amended.

B. The following shall apply to MCHIPs that require a covered person to select a primary care physician with respect to the offer of basic health care services by the MCHIP:

1. At the time of enrollment each covered person shall have the right to select a primary care physician from among the health carrier's affiliated primary care physicians for the MCHIP, subject to availability.

2. Any covered person who is dissatisfied with his primary care physician shall have the right to select another primary care physician from among the affiliated primary care physicians, subject to availability. The health carrier may impose a reasonable waiting period for this transfer.

1998, c. 891; 2000, c. 922; 2004, c. 715; 2006, c. 866.

§ 38.2-5804. Complaint system.

A. A health carrier subject to subsection B of § 38.2-5801 shall establish and maintain for each of its MCHIPs a complaint system approved by the Commission and the State Health Commissioner to provide reasonable procedures for the resolution of written complaints in accordance with requirements in or established pursuant to provisions in this title and Title 32.1 and shall include the following:

1. A record of the complaints shall be maintained for no less than five years.

2. Such health carrier shall provide complaint forms and/or written procedures to be given to covered persons who wish to register written complaints. Such forms or procedures shall include the address and telephone number of the managed care licensee to which complaints shall be directed and the mailing address, telephone number, and electronic mail address of the Office of the Managed Care Ombudsman, and shall also specify any required limits imposed by or on behalf of the MCHIP. Such forms and written procedures shall include a clear and understandable description of the covered person's right to appeal adverse decisions pursuant to § 32.1-137.15.

B. The Commission, in cooperation with the State Health Commissioner, shall examine the complaint system. The effectiveness of the complaint system of the managed care health insurance plan licensee in allowing covered persons, or their duly authorized representatives, to have issues regarding quality of care appropriately resolved under this chapter shall be assessed by the State Health Commissioner pursuant to provisions in Title 32.1 and the regulations promulgated thereunder. Compliance by the health carrier and its managed care health insurance plans with the terms and procedures of the complaint system, as well as the provisions of this title, shall be assessed by the Commission.

C. The health carrier for each MCHIP shall submit to the Office of the Managed Care Ombudsman and the State Health Commissioner an annual complaint report in a form prescribed by the Commission and the Board of Health. The complaint report shall include (i) a description of the procedures of the complaint system, (ii) the total number of complaints handled through the grievance or complaint system, (iii) the disposition of the complaints, (iv) a compilation of the nature and causes underlying the complaints filed, (v) the time it took to process and resolve each complaint, and (vi) the number, amount, and disposition of malpractice claims adjudicated during the year with respect to any of the MCHIP's affiliated providers.

D. The provisions of this section shall not apply to plans administered by the Department of Medical Assistance Services that provide benefits pursuant to Title XIX or Title XXI of the Social Security Act, as amended.

E. The provisions of Chapter 5 (§ 38.2-500 et seq.) of this title shall apply to the health carrier, its MCHIPs, and evidence of coverage and representations thereto, except to the extent that the Commission determines that the nature of the health carrier, its MCHIP, and evidences of coverage and representations thereto render any of the provisions clearly inappropriate.

1998, c. 891; 1999, cc. 643, 649; 2000, c. 922; 2006, c. 866.

§ 38.2-5805. Provider contracts.

A. Each health carrier subject to subsection B of § 38.2-5801 shall file with the Commission a list of the current providers who have executed a contract directly with the health carrier or indirectly through an intermediary organization for the purpose of providing health care services pursuant to an MCHIP or for the benefit of a covered person of an MCHIP. The list shall include the names and localities of the providers. The list shall be updated by the health carrier at least annually and more frequently as required by the Commission in accordance with provisions in this title or by the State Health Commissioner in accordance with provisions in Title 32.1.

B. Every contract with a provider of health care services enabling an MCHIP to provide health care services shall be in writing.

C. When the health carrier is a health maintenance organization, the contracts with providers enabling the MCHIP to provide health care services to the covered persons shall contain a "hold harmless" clause setting forth that, in the event such health carrier fails to pay for health care services as set forth in the contract, the covered persons shall not be liable to the provider for any sums owed by the health carrier. The following requirements shall apply to such contracts:

1. Such contracts shall require that if the provider terminates the agreement, the provider shall give the health carrier at least sixty days' advance notice of termination.

2. No provider party to such a contract, or agent, trustee or assignee thereof, may maintain any action at law against a covered person to collect sums owed by the health carrier.

3. If there is an intermediary organization enabling a health carrier subject to subsection B of § 38.2-5801 to provide health care services by means of the intermediary organization's own contracts with health care providers, the contracts between the intermediary organization and its providers shall be in writing.

4. The contracts shall set forth that, in the event either the health carrier or the intermediary organization fails to pay for health care services as set forth in the contracts between the intermediary organization and its providers, or in the contract between the intermediary organization and the health carrier, the covered person shall not be liable to the provider for any sums owed by either the intermediary organization or the health carrier.

5. No provider party to such a contract, or agent, trustee or assignee thereof, may maintain any action at law against a covered person to collect sums owed by the health carrier or the intermediary organization.

6. An agreement to provide health care services between an intermediary organization and a health carrier subject to subsection B of § 38.2-5801 shall require that if the intermediary organization terminates the agreement, the intermediary organization shall give the health carrier at least sixty days' advance notice of termination.

7. An agreement to provide health care services between an intermediary organization and a provider shall require that if the provider terminates the agreement, the provider shall give the intermediary organization at least sixty days' advance notice of termination.

8. Each such health carrier and intermediary organization shall be responsible for maintaining its executed contracts enabling it to provide health care services. These contracts shall be available for the Commission's review and examination for a period of five years after the expiration of any such contract.

9. The "hold harmless" clause required by this section shall read essentially as set forth in this subdivision. The health carrier may use a corresponding provision of different wording approved by the Commission that is not less favorable in any respect to the covered persons.

Hold Harmless Clause

[Provider] hereby agrees that in no event, including, but not limited to nonpayment by the MCHIP or its health carrier, the insolvency of the [health carrier], or breach of this agreement, shall [Provider] bill, charge, collect a deposit from; seek compensation, remuneration or reimbursement from; or have any recourse against subscribers or persons other than the health carrier for services provided pursuant to this Agreement. This provision shall not prohibit collection of any applicable copayments or deductibles billed in accordance with the terms of the subscriber agreement for the MCHIP.

[Provider] further agrees that (i) this provision shall survive the termination of this Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of the plan's subscribers and (ii) this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between [Provider] and the subscriber or persons acting on the subscriber's behalf.

10. If there is an intermediary organization between the health carrier and the health care providers, the hold harmless clause set forth in subdivision 5 shall be amended to include nonpayment by the plan, the health carrier, and the intermediary organization and shall be included in any contract between the intermediary organization and health care providers and in any contract between the health carrier on behalf of the MCHIP and the intermediary organization.

D. The Commission may specify for each type of health carrier other than a health maintenance organization the circumstances, if any, under which a health carrier for an MCHIP shall contract with a provider with the "hold harmless" clause described in subsection C. The Commission may specify also the extent to which certain accounting treatment, reserves, net worth or surplus shall be required for liabilities arising from provider contracts without the "hold harmless" clause.

1998, c. 891.

§ 38.2-5806. Prohibited practices.

A. No MCHIP licensee may cancel or refuse to renew the coverage of a covered person for basic health care services on the basis of the status of the covered person's health.

B. The following provisions shall apply whenever an MCHIP provides a covered person who is also a resident of a continuing care facility with coverage for Medicare benefits and the covered person's primary care physician determines that it is medically necessary for the covered person to be referred to a skilled nursing unit:

1. The health carrier shall not require that the covered person relocate to a skilled nursing unit outside the continuing care facility if (i) the continuing care facility's skilled nursing unit is certified as a Medicare skilled nursing facility and (ii) the continuing care facility agrees, as to such skilled nursing unit, to become a contracting provider in accordance with the health carrier's standard terms and conditions for its participating providers.

2. A continuing care facility that satisfies clauses (i) and (ii) of subdivision 1 shall not be obligated to accept as a skilled nursing unit patient any one other than a resident of the continuing care facility; and neither the health carrier nor the continuing care facility shall be allowed to include the skilled nursing unit or facilities on the list required by § 38.2-5802 or to advertise in any other way that the facility's skilled nursing unit is a participating provider with respect to coverage offered by the MCHIP for Medicare benefits or skilled nursing unit facilities for other than the continuing care facility's residents.

As used in this subsection, "Medicare benefits" means medical and health products, benefits and services offered in accordance with Title XVIII of the United States Social Security Act (42 U.S.C. § 1395 et seq.) and "continuing care facility" means a continuing care retirement community regulated pursuant to Chapter 49 (§ 38.2-4900 et seq.) of this title.

C. The following shall apply in accordance with provisions in Title 32.1 or regulations promulgated thereunder:

1. Where complaints of a covered person may be resolved through a specified arbitration agreement, the covered person shall be advised in writing of his rights and duties under the agreement at the time the complaint is registered.

2. No contract or evidence of coverage that entitles covered persons to resolve complaints through an arbitration agreement shall limit or prohibit such arbitration for any claims asserted having a monetary value of $250 or more.

3. If the covered person agrees to binding arbitration, his written acceptance of the arbitration agreement shall not be executed prior to the time the complaint is registered nor subsequent to the time an initial resolution is made, and the agreement shall be accompanied by a statement setting forth in writing the terms and conditions of binding arbitration.

1998, c. 891.

§ 38.2-5807. Access to care.

Access to care shall be assessed by the Department of Health in accordance with provisions in Article 1.1 (§ 32.1-137.1 et seq.) of Chapter 5 of Title 32.1 concerning quality assurance.

1998, c. 891.

§ 38.2-5808. Examinations.

A. In lieu of or in addition to making its own examination of an MCHIP and its health carrier, the Commission may accept the report of an examination of the health carrier or other person responsible for the MCHIP under the laws of another state certified by the insurance supervisory official, similar regulatory agency, or the state health commissioner of another state.

B. The Commission shall coordinate examinations of an MCHIP and its health carrier with the State Health Commissioner's examination or review of the health carrier to ensure an appropriate level of regulatory oversight and to avoid any undue duplication of effort or regulation.

C. The Commission shall accept a current certificate of quality assurance issued by the Department of Health as evidence of compliance by the certificate holder with any provision in this chapter authorizing or requiring assessment by the Department of Health, by the State Health Commissioner, or pursuant to regulations promulgated by the State Health Commissioner.

1998, c. 891.

§ 38.2-5809. Suspension or revocation of license.

The Commission may suspend or revoke any license issued to a health carrier if it finds that any of the following conditions exist:

1. The State Health Commissioner certifies to the Commission pursuant to § 32.1-137.5 that the health carrier or its MCHIP is unable to fulfill its obligations to furnish quality health care services as set forth in Article 1.1 (§ 32.1-137.1 et seq.) of Chapter 5 of Title 32.1. The suspension of a certificate of quality assurance shall not be deemed such a certification by the State Health Commissioner.

2. The State Health Commissioner notifies the Commission that the health carrier has failed to implement the complaint system required by Title 32.1 and § 38.2-5804 to resolve valid complaints reasonably.

3. The Commission determines that a certificate of quality assurance issued to the health carrier has been revoked by the State Health Commissioner, or a request for renewal of such certificate has been denied or disapproved by the State Health Commissioner.

1998, c. 891.

§ 38.2-5810. Statutory construction and relationship to other laws.

A. Neither the health carrier nor the MCHIP shall be deemed to be engaged in the practice of medicine solely by virtue of its compliance with this chapter. All health care providers associated with an MCHIP shall be subject to all provisions of law.

B. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health carrier providing an MCHIP subject to § 38.2-3431 shall not be required to offer coverage to or accept applications from an employee who does not reside within the MCHIP's service area.

1998, c. 891.

§ 38.2-5811. Controversies involving contracts.

The Commission shall have no jurisdiction to adjudicate controversies between an MCHIP and its covered persons, and a breach of contract shall not be deemed a violation of this chapter.

1998, c. 891.

Chapter 59 - OFFICE OF THE MANAGED CARE OMBUDSMAN

§ 38.2-5900. Definitions.

As used in this chapter:

"Covered person" means an individual, whether a policyholder, subscriber, enrollee, covered dependent, or member of a managed care health insurance plan, who is entitled to health care services or benefits provided, arranged for, paid for or reimbursed pursuant to a managed care health insurance plan as defined in and subject to regulation under Chapter 58, when such coverage is provided under a contract issued in this Commonwealth.

1999, cc. 643, 649; 2000, c. 922; 2011, c. 788.

§§ 38.2-5901 through 38.2-5903. Repealed.

Repealed by Acts 2011, c. 788, cl. 2, effective July 1, 2011.

§ 38.2-5904. Office of the Managed Care Ombudsman established; responsibilities.

A. The Commission shall create within the Bureau of Insurance the Office of the Managed Care Ombudsman. The Office of the Managed Care Ombudsman shall promote and protect the interests of covered persons under managed care health insurance plans in the Commonwealth. All state agencies shall assist and cooperate with the Office of the Managed Care Ombudsman in the performance of its duties under this chapter. The definitions in § 32.1-137.7 shall have the same meanings ascribed to them in § 32.1-137.7 when used in this section.

B. The Office of the Managed Care Ombudsman shall:

1. Assist covered persons in understanding their rights and the processes available to them according to their managed care health insurance plan.

2. Answer inquiries from covered persons and other citizens by telephone, mail, electronic mail and in person.

3. Provide to covered persons and other citizens information concerning managed care health insurance plans and other utilization review entities upon request.

4. Develop information on the types of managed care health insurance plans available in the Commonwealth, including mandated benefits and utilization review procedures and appeals, and receive and analyze the annual complaint data required to be filed by each health carrier providing a managed care health insurance plan, as provided in subsection C of § 38.2-5804.

5. Make available, either separately or through an existing Internet Web site utilized by the Bureau of Insurance, information as set forth in subdivision 4 and such additional information as may be deemed appropriate.

6. In conjunction with complaint and inquiry data maintained by the Bureau of Insurance, maintain data on inquiries received, the types of assistance requested, any actions taken and the disposition of each such matter.

7. Upon request, assist covered persons in using the procedures and processes available to them from their managed care health insurance plan, including all utilization review appeals. Such assistance may require the review of insurance and health care records of a covered person, which shall be done only with that person's express written consent. The confidentiality of any such medical records shall be maintained in accordance with the confidentiality and disclosure laws of the Commonwealth.

8. Ensure that covered persons have access to the services provided through the Office of the Managed Care Ombudsman and that the covered persons receive timely responses from the representatives of the Office of the Managed Care Ombudsman to the inquiries.

9. Upon request to the Commission by any of the standing committees of the General Assembly having jurisdiction over insurance or health or the Joint Commission on Health Care, provide to the Commission for dissemination to the requesting parties assessments of proposed and existing managed care health insurance laws and other studies of managed care health insurance plan issues.

10. Monitor changes in federal and state laws relating to health insurance.

11. Provide information to the Commission that will permit the Commission to report annually on the activities of the Office of the Managed Care Ombudsman to the standing committees of the General Assembly having jurisdiction over insurance and over health and to the Joint Commission on Health Care. The Commission's report shall be filed by December 1 of each year, and shall include a summary of significant new developments in federal and state laws relating to health insurance each year.

12. Carry out activities as the Commission determines to be appropriate.

1999, cc. 643, 649; 2000, c. 922.

§ 38.2-5905. Repealed.

Repealed by Acts 2011, c. 788, cl. 2, effective July 1, 2011.

Chapter 60 - VIATICAL SETTLEMENTS ACT

§ 38.2-6000. Definitions.

As used in this chapter:

"Advertising" means any written, electronic, or printed communication or any communication by means of recorded telephone messages or transmitted on radio, television, the Internet, or similar communications media, including film strips, motion pictures, and videos published, disseminated, cir-

culated or placed before the public, directly or indirectly, for the purpose of creating an interest in or inducing a person to sell a life insurance policy pursuant to a viatical settlement contract.

"Business of viatical settlements" means an activity involved in, but not limited to, the offering, solicitation, negotiation, procurement, effectuation, purchasing, investing, financing, monitoring, tracking, underwriting, selling, transferring, assigning, pledging, or hypothecating in any other manner, of viatical settlement contracts or purchase agreements.

"Chronically ill" means (i) being unable to perform at least two activities of daily living, which shall include eating, toileting, transferring, bathing, dressing or continence, (ii) requiring substantial supervision by another person to protect the individual from threats to health and safety due to severe cognitive impairment, or (iii) having a level of disability similar to that described in clause (i) as determined by the federal Secretary of Health and Human Resources.

"Financing entity" means an underwriter, placement agent, lender, purchaser of securities, purchaser of a policy or certificate from a viatical settlement provider, credit enhancer, or any entity that has a direct ownership in a policy or certificate that is the subject of a viatical settlement contract, but whose principal activity related to the transaction is providing funds to effect the viatical settlement or purchase of one or more viaticated policies and who has an agreement in writing with one or more licensed viatical settlement providers to finance the acquisition of viatical settlement contracts. Financing entity does not include a non-accredited investor or viatical settlement purchaser.

"Fraudulent viatical settlement act" includes:

1. Acts or omissions committed by any person who, knowingly or with intent to defraud, for the purpose of depriving another of property or for pecuniary gain, commits or permits its employees or its agents to engage in acts including:

a. Presenting, causing to be presented or preparing with knowledge or belief that it will be presented to or by a viatical settlement provider, viatical settlement broker, viatical settlement purchaser, financing entity, insurer, insurance producer, or any other person, false material information, or concealing material information, as part of, in support of, or concerning a fact material to one or more of the following: (i) an application for the issuance of a viatical settlement contract or insurance policy; (ii) the underwriting of a viatical settlement contract or insurance policy; (iii) a claim for payment or benefit pursuant to a viatical settlement contract or insurance policy; (iv) premiums paid on an insurance policy; (v) payments and changes in ownership or beneficiary made in accordance with the terms of a viatical settlement contract, or insurance policy; (vi) the reinstatement or conversion of an insurance policy; (vii) in the solicitation, offer, effectuation or sale of a viatical settlement contract or insurance policy; (viii) the issuance of written evidence of a viatical settlement contract or insurance policy; or (ix) a financing transaction;

b. Employing any device, scheme, or artifice to defraud related to viaticated policies;

2. In the furtherance of a fraud or to prevent the detection of a fraud any person commits or permits its employees or its agents to: (i) remove, conceal, alter, destroy, or sequester from the Commission the assets or records of a licensee or other person engaged in the business of viatical settlements; (ii) misrepresent or conceal the financial condition of a licensee, financing entity, insurer, or other person; (iii) transact the business of viatical settlements in violation of laws requiring a license, certificate of authority, or other legal authority for the transaction of the business of viatical settlements; or (iv) file with the Commission or the chief insurance regulatory official of another jurisdiction a document containing false information or otherwise conceals information about a material fact from the Commission;

3. Embezzlement, theft, misappropriation or conversion of moneys, funds, premiums, credits, or other property of a viatical settlement provider, insurer, insured, viator, insurance policyowner, or any other person engaged in the business of viatical settlements or insurance;

4. Recklessly entering into, brokering, or otherwise dealing in a viatical settlement contract, the subject of which is a life insurance policy that was obtained by presenting false information concerning any fact material to the policy or by concealing, for the purpose of misleading another, information concerning any fact material to the policy, where the viator or the viator's agent intended to defraud the policy's issuer. "Recklessly" means engaging in the conduct in conscious and clearly unjustifiable disregard of a substantial likelihood of the existence of the relevant facts or risks, such disregard involving a gross deviation from acceptable standards of conduct; or

5. Attempting to commit, assisting, aiding or abetting in the commission of, or conspiracy to commit the acts or omissions specified in this subsection.

"Licensee under this chapter" means a person licensed by the Commission as a viatical settlement provider or viatical settlement broker.

"NAIC" means National Association of Insurance Commissioners.

"Policy" means an individual or group policy, group certificate, contract or arrangement of life insurance affecting the rights of a resident of this Commonwealth or bearing a reasonable relation to this Commonwealth, regardless of whether delivered or issued for delivery in this Commonwealth.

"Related provider trust" means a titling trust or other trust established by a licensed viatical settlement provider or a financing entity for the sole purpose of holding the ownership or beneficial interest in purchased policies in connection with a financing transaction. The trust shall have a written agreement with the licensed viatical settlement provider under which the licensed viatical settlement provider is responsible for ensuring compliance with all statutory and regulatory requirements and under which the trust agrees to make all records and files related to viatical settlement transactions available to the Commission as if those records and files were maintained directly by the licensed viatical settlement provider.

"Special purpose entity" means a corporation, partnership, trust, limited liability company, or other similar entity formed solely to provide either directly or indirectly access to institutional capital markets for a financing entity or licensed viatical settlement provider.

"Terminally ill" means having an illness or sickness that can reasonably be expected to result in death in 24 months or less.

"Viatical settlement broker" means a person that on behalf of another and for a fee, commission or other valuable consideration introduces viators to viatical settlement providers, or offers or attempts to negotiate viatical settlement contracts between a viator and one or more viatical settlement providers. A viatical settlement broker may act as agent for a viatical settlement provider or on behalf of the viator, provided that a viatical settlement broker shall not be deemed to act exclusively for the viator unless, pursuant to written agreement between the parties, the broker agrees (i) to disclose fully all interests in the viatical settlement contract and relationships with the viatical settlement provider, including its affiliates and appointed or contracted agents, and (ii) that compensation for services as a viatical settlement broker shall be paid directly and only by the viator. The term does not include an attorney, certified public accountant, or a financial planner accredited by a nationally recognized accreditation agency, who is retained to represent the viator and whose compensation is not paid directly or indirectly by the viatical settlement provider or viatical settlement purchaser.

"Viatical settlement contract" means a written agreement establishing the terms under which compensation or anything of value will be paid, which compensation or value is less than the expected death benefit of the insurance policy or certificate, in return for the viator's assignment, transfer, sale, devise or bequest of the death benefit or ownership of any portion of the insurance policy or certificate of insurance. A viatical settlement contract also includes a contract for a loan or other financing transaction with a viator secured primarily by an individual or group life insurance policy, other than a loan by a life insurance company pursuant to the terms of the life insurance contract, or a loan secured by the cash value of a policy. A viatical settlement contract includes an agreement with a viator to transfer ownership or change the beneficiary designation at a later date regardless of the date that compensation is paid to the viator. "Viatical settlement contracts" do not include accelerated benefits provisions contained in life insurance policies, whether issued with the original policy or as a rider, according to the regulations promulgated by the Commission.

"Viatical settlement provider" means a person, other than a viator, that enters into or effectuates a viatical settlement contract. Viatical settlement provider does not include: (i) a bank, savings bank, savings and loan association, credit union, or other licensed lending institution that takes an assignment of a life insurance policy as collateral for a loan; (ii) the issuer of a life insurance policy providing accelerated benefits under § 38.2-3115.1 and pursuant to the contract; (iii) an authorized or eligible insurer that provides stop loss coverage to a viatical settlement provider, viatical settlement purchaser, financing entity, special purpose entity or related provider trust; (iv) a natural person who enters into or effectuates no more than one agreement in a calendar year for the transfer of life insurance policies for any value less than the expected death benefit; (v) a financing entity; (vi) a special purpose entity; (vii)

a related provider trust; (viii) a viatical settlement purchaser; or (ix) an accredited investor or qualified institutional buyer as defined respectively in Regulation D, Rule 501 or Rule 144A of the Federal Securities Act of 1933, as amended, and who purchases a viaticated policy from a viatical settlement provider and does not communicate with the viator or insured who is a resident of this Commonwealth except through a licensee under this chapter.

"Viatical settlement purchaser" means a person who gives a sum of money as consideration for a life insurance policy or an interest in the death benefits of a life insurance policy, or a person who owns or acquires or is entitled to a beneficial interest in a trust that owns a viatical settlement contract or is the beneficiary of a life insurance policy that has been or will be the subject of a viatical settlement contract, for the purpose of deriving an economic benefit. Viatical settlement purchaser does not include (i) a licensee under this chapter; (ii) an accredited investor or qualified institutional buyer as defined respectively in Regulation D, Rule 501 or Rule 144A of the Federal Securities Act of 1933, as amended; (iii) a financing entity; (iv) a special purpose entity; or (v) a related provider trust.

"Viaticated policy" means a life insurance policy or certificate that has been acquired by a viatical settlement provider pursuant to a viatical settlement contract.

"Viator" means the owner of a life insurance policy or a certificate holder under a group policy who enters or seeks to enter into a viatical settlement contract. For the purposes of this chapter and the application of Article 6.1 (§ 38.2-1865.1 et seq.) of Chapter 18 of this title, a viator shall not be limited to an owner of a life insurance policy or a certificate holder under a group policy insuring the life of an individual with a terminal or chronic illness except where specifically addressed. Viator does not include (i) a licensee under this chapter; (ii) an accredited investor or qualified institutional buyer as defined respectively in Regulation D, Rule 501 or Rule 144A of the Federal Securities Act of 1933, as amended; (iii) a financing entity; (iv) a special purpose entity; or (v) a related provider trust.

1997, c. 814, § 38.2-5700; 2003, c. 717.

§ 38.2-6001. Viatical settlement brokers.

No person shall act as a viatical settlement broker with a resident of this Commonwealth without first obtaining a license from the Commission in accordance with Article 6.1 (§ 38.2-1865.1 et seq.) of Chapter 18 of this title. If there is more than one viator on a single policy, and the viators are residents of different states, the viatical settlement broker shall be required to hold a license in the state in which the viator having the largest percentage resides or, if the viators hold equal ownership, the viatical settlement broker shall be required to hold a license in the state of residence of one viator agreed upon in writing by all the viators.

2003, c. 717.

§ 38.2-6002. Viatical settlement providers, license requirements.

A. No person shall act as a viatical settlement provider with a resident of this Commonwealth without first obtaining a license from the Commission.

1. A person seeking to be licensed as a viatical settlement provider in this Commonwealth shall apply for such license in a form acceptable to the Commission and shall pay to the Commission a nonrefundable application fee in an amount prescribed by the Commission. On and after July 1, 2003, such fee shall be not less than $300 and not more than $1,500. The application fee required by this subdivision shall be collected by the Commission, paid directly into the state treasury, and credited to the "Bureau of Insurance Special Fund – State Corporation Commission" for the maintenance of the Bureau of Insurance as provided in subsection B of § 38.2-400.

2. A license issued anytime prior to July 1, 2004, shall expire on June 30, 2004, unless renewed as set forth herein.

3. On or before March 1 of each year commencing March 1, 2004, a licensed viatical settlement provider shall remit a renewal application form and nonrefundable renewal fee in the form and amount prescribed by the Commission. Such fee shall be not less than $300 and not more than $1,500. The renewal fee required by this subdivision shall be collected by the Commission and paid directly into the state treasury and credited to the "Bureau of Insurance Special Fund – State Corporation Commission" for the maintenance of the Bureau of Insurance as provided in subsection B of § 38.2-400.

4. A viatical settlement provider's license expiring on June 30 may be renewed on July 1 for a one-year period ending on June 30 of the following year if the required renewal application and a nonrefundable renewal fee have been received and the license is not terminated, suspended, or revoked at the time of renewal. The renewal fee required by this subdivision shall be collected by the Commission and paid directly into the state treasury and credited to the "Bureau of Insurance Special Fund – State Corporation Commission" for the maintenance of the Bureau of Insurance as provided in subsection B of § 38.2-400.

B. The applicant shall provide information on forms required by the Commission. The Commission shall have authority, at any time, to require the applicant to disclose fully the identity of all stockholders, partners, officers, members, and employees, and the Commission may, in the exercise of the Commission's discretion, refuse to issue a license in the name of a legal entity if not satisfied that any officer, employee, stockholder, partner, or member thereof who may materially influence the applicant's conduct meets the standards of this chapter.

C. A license issued to a legal entity authorizes all partners, officers, members, and designated employees to act as the viatical settlement provider under the license, and all those persons shall be named in the application and any application supplements.

D. Upon the filing of an application and the payment of the nonrefundable application fee, the Commission shall make such investigation of each applicant as the Commission may determine to be appropriate and issue a license if it finds that the applicant: (i) has provided a detailed plan of operation; (ii) is competent and trustworthy; (iii) indicates its intention to act in good faith within the confines of the license; (iv) has a good business reputation; (v) if an individual, has had experience, training or education that qualifies him for licensure; (vi) if a resident partnership, limited liability company, or

corporation, has recorded the existence of the partnership, limited liability company, or corporation pursuant to law; (vii) if a corporation, has specific authority to act as a viatical settlement provider in its charter; (viii) if a nonresident partnership, limited liability company, or corporation, has furnished proof of its authority to transact business in Virginia; and (ix) has provided an anti-fraud plan that meets the requirements of subdivision E 3 b of § 38.2-6011.

E. If the applicant for a viatical settlement provider license is a nonresident, such applicant, as a condition precedent to receiving or holding a license, shall designate a resident of this Commonwealth as the person upon whom any process, notices, or order required or permitted by law to be served upon such nonresident viatical settlement provider may be served; and such licensee shall promptly notify the clerk of the Commission in writing of every change in its designated agent for service of process, and such change shall not become effective until acknowledged by the Commission. Whenever a nonresident viatical settlement provider transacting business in this Commonwealth fails to appoint or maintain a registered agent in this Commonwealth, or whenever its registered agent cannot with reasonable diligence be found at the registered office, the clerk of the Commission shall be an agent of the nonresident upon whom service may be made in accordance with § 12.1-19.1.

F. A licensed insurer shall be prohibited from transacting the business of a viatical settlement provider.

G. The Commission may suspend, revoke, refuse to issue, or refuse to renew the license of a viatical settlement provider if the Commission finds that the applicant or licensee has (i) made any material misrepresentation in the application; (ii) been guilty of fraudulent or dishonest practices; (iii) been subject to a final administrative action or has otherwise been shown to be untrustworthy or incompetent to act as a viatical settlement provider; (iv) demonstrated a pattern of unreasonable payments to viators; (v) been convicted of a felony or any misdemeanor involving fraud or moral turpitude; (vi) entered into any viatical settlement contract that has not been approved pursuant to this chapter; (vii) failed to honor contractual obligations set out in a viatical settlement contract; (viii) demonstrated or represented that it no longer meets the requirements for initial licensure; (ix) has assigned, transferred, or pledged a viaticated policy to a person other than a viatical settlement provider licensed in this Commonwealth, viatical settlement purchaser, an accredited investor, or qualified institutional buyer as defined respectively in Regulation D, Rule 501 or Rule 144A of the Federal Securities Act of 1933, as amended, financing entity, special purpose entity, or related provider trust; (x) violated any provisions of this chapter or other applicable provisions of this title or has in its employ or organization any officer, partner, member, or key management personnel who has violated any provision of this chapter or other applicable provisions of this title; or (xi) has renewed or requested renewal of its license before implementing the anti-fraud initiatives required by subsection E of § 38.2-6011.

H. No applicant to whom a license is refused after a hearing, nor any licensee whose license is revoked, shall apply again for a license under this chapter until after the expiration of a period of five years from the date of the Commission's order, or such other period of time as the Commission prescribes in its order.

I. A viatical settlement provider shall be bonded as required by the Commission. Rules issued pursuant to § 38.2-6014 may identify other mechanisms for financial accountability.

1997, c. 814, § 38.2-5701; 1998, c. 11; 2003, c. 717; 2023, c. 577.

§ 38.2-6003. Approval of viatical settlement contracts and disclosure statements.

A. A person shall not use a viatical settlement contract or provide to a viator a disclosure statement form in this Commonwealth unless filed with and approved by the Commission in accordance with procedures set forth in § 38.2-316. In the absence of more specific regulation or rules promulgated by the Commission for the business of viatical settlements, standards and requirements of general application set forth in § 38.2-316 and rules promulgated thereunder shall be deemed applicable to viatical settlement contracts and disclosure statement forms, required by this chapter.

B. At the Commission's discretion, the Commission may require the submission of advertising material used or intended for use in this Commonwealth.

1997, c. 814, § 38.2-5704; 2003, c. 717.

§ 38.2-6004. Reporting requirements.

A. A viatical settlement provider shall file with the Commission on or before March 1 of each year the certification required by subsection E of § 38.2-6011 and an annual report containing such information as the Commission may prescribe by rule or regulation; however, such information shall be limited to only those transactions where the viator is a resident of this Commonwealth.

B. A viatical settlement provider shall report in writing to the Commission the following:

1. New or revised information about its officers, stockholders owning 10 percent or greater interest in the licensee or an affiliate of the licensee, partners, directors, members, or designated employees within 30 calendar days of the change;

2. Any change in business or residence address or name within 30 calendar days of the change.

C. A licensed viatical settlement provider convicted of a felony shall report within 30 calendar days to the Commission the facts and circumstances regarding the criminal conviction.

1997, c. 814, § 38.2-5703; 1999, c. 59; 2001, c. 706; 2003, c. 717; 2023, c. 577.

§ 38.2-6005. Privacy.

Except as otherwise allowed or required by law, a viatical settlement provider, viatical settlement broker, insurance company, insurance producer, information bureau, rating agency or company, or any other person with actual knowledge of an insured's identity, shall not disclose that identity as an insured, or the insured's financial or medical information to any other person unless the disclosure:

1. Is necessary to effect a viatical settlement between the viator and a viatical settlement provider and the viator and insured have provided prior written consent to the disclosure;

2. Is provided in response to an investigation or examination by the Commission or another governmental agency or officer or pursuant to the requirements of subsection C of § 38.2-6011;

3. Is a term of or condition to the transfer of a policy by one viatical settlement provider to another viatical settlement provider;

4. Is necessary to permit a financing entity, related provider trust, or special purpose entity to finance the purchase of policies by a viatical settlement provider and the viator and insured have provided prior written consent to the disclosure;

5. Is necessary to allow the viatical settlement provider or viatical settlement broker or their authorized representatives to make contacts for the purpose of determining health status; or

6. Is required to purchase stop loss coverage.

2003, c. 717.

§ 38.2-6006. Examinations; record retention; investigations.

A. Viatical settlement providers, viatical settlement brokers, and persons seeking a license under this title to transact the business of viatical settlements in this Commonwealth shall be subject to examination by the Commission pursuant to Article 4 (§ 38.2-1317 et seq.) of Chapter 13 of this title. For purposes of completing such examination, the Commission may examine or investigate any person, or the business of any person, insofar as the examination or investigation is, in the sole discretion of the Commission, necessary or material to the examination of a licensee.

B. A person required to be licensed by this chapter shall for five years retain copies of (i) all proposed, offered or executed contracts, purchase agreements, underwriting documents, policy forms, and applications from the date of the proposal, offer or execution of the contract or purchase agreement, whichever is later; (ii) all checks, drafts or other evidence and documentation related to the payment, transfer, deposit, or release of funds from the date of the transaction; and (iii) all other records and documents related to the requirements of this chapter or Article 6.1 (§ 38.2-1865.1 et seq.) of Chapter 18 of this title. This section does not relieve a person of the obligation to produce these documents to the Commission after the retention period has expired if the person has retained the documents. Records required to be retained by this section must be legible and complete and may be retained in paper, photograph, microprocess, magnetic, mechanical, or electronic media, or by any process that accurately reproduces or forms a durable medium for the reproduction of a record.

C. The Commission may investigate suspected fraudulent viatical settlement acts and persons engaged or alleged to be engaged in the business of viatical settlements.

2003, c. 717.

§ 38.2-6007. Disclosure.

A. Before asking a viator or insured to sign any document, a licensee under this chapter shall provide the respective viator or insured, or both, with a copy of the disclosure document described in this subsection. The viatical settlement provider or viatical settlement broker shall provide the viator with an additional copy of the disclosures, with the application, no later than the time the application for the viatical settlement contract is signed by all parties. The disclosures shall be provided in a separate

document that is signed by the viator and the viatical settlement provider or viatical settlement broker, and shall provide the following information:

1. There are possible alternatives to viatical settlement contracts including any accelerated death benefits or policy loans offered under the viator's life insurance policy.

2. Some or all of the proceeds of the viatical settlement may be taxable under federal income tax and state franchise and income taxes, and assistance should be sought from a professional tax advisor.

3. Proceeds of the viatical settlement could be subject to the claims of creditors.

4. Receipt of the proceeds of a viatical settlement may adversely affect the viator's eligibility for Medicaid or other government benefits or entitlements, and advice should be obtained from the appropriate government agencies.

5. The viator has the right to rescind a viatical settlement contract for 15 calendar days after the receipt of the viatical settlement proceeds by the viator, as provided in subsection C of § 38.2-6008. If the insured dies during the rescission period, the settlement contract shall be deemed to have been rescinded, subject to repayment of all viatical settlement proceeds and any premiums, loans, and loan interest to the viatical settlement provider or viatical settlement purchaser.

6. Funds will be sent to the viator within three business days after the viatical settlement provider has received the insurer's or group administrator's acknowledgment that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated.

7. Entering into a viatical settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy or certificate, to be forfeited by the viator. Assistance should be sought from a financial adviser.

8. Disclosure to a viator shall include distribution of a brochure describing the process of viatical settlements. The NAIC's form for the brochure shall be used unless one is developed by the Commission.

9. The disclosure document shall contain the following language: "All medical, financial, or personal information solicited or obtained by a viatical settlement provider or viatical settlement broker about an insured, including the insured's identity or the identity of family members, a spouse, or a significant other may be disclosed as necessary to effect the viatical settlement between the viator and the viatical settlement provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every two years."

10. The insured may be contacted by either the viatical settlement provider or broker or its authorized representative for the purpose of determining the insured's health status. This contact is limited to once every three months if the insured has a life expectancy of more than one year, and no more than once per month if the insured has a life expectancy of one year or less.

B. A viatical settlement provider shall provide the viator with at least the following disclosures no later than the date the viatical settlement contract is signed by all parties. The disclosures shall be conspicuously displayed in the viatical settlement contract or in a separate document signed by the viator and the viatical settlement provider or viatical settlement broker, and provide the following information:

1. The affiliation, if any, between the viatical settlement provider and the issuer of the insurance policy to be viaticated;

2. The name, address, and telephone number of the viatical settlement provider;

3. The dollar amount of the current death benefit payable to the viatical settlement provider under the policy or certificate. If known, the viatical settlement provider shall also disclose the availability of any additional guaranteed insurance benefits, the dollar amount of any accidental death and dismemberment benefits under the policy or certificate, and the viatical settlement provider's interest in those benefits;

4. State the name, business address, and telephone number of the independent third party escrow agent, and the fact that the viator or owner may inspect or receive copies of the relevant escrow or trust agreements or documents; and

5. If an insurance policy to be viaticated has been issued as a joint policy or involves family riders or any coverage of a life other than the insured under the policy to be viaticated, the viator shall be informed of the possible loss of coverage on the other lives under the policy and shall be advised to consult with his insurance producer or the insurer issuing the policy for advice on the proposed viatical settlement.

C. If the provider transfers ownership or changes the beneficiary of the insurance policy, the provider shall communicate the change in ownership or beneficiary to the insured within 20 days after the change.

1997, c. 814, § 38.2-5705; 2003, c. 717.

§ 38.2-6008. General rules.

A. A viatical settlement provider entering into a viatical settlement contract shall:

1. First obtain:

a. If the viator is the insured, a written statement from a licensed attending physician that the viator is of sound mind and under no constraint or undue influence to enter into a viatical settlement contract; and

b. A document in which the insured consents to the release of his medical records to a viatical settlement provider, viatical settlement broker, and the insurance company that issued the life insurance policy covering the life of the insured. The consent for the release of medical records shall only be obtained for the insurance company if the life insurance policy covering the insured was issued within 48 months of the date of the viator's application for the viatical settlement contract.

2. Within 20 days after a viator executes documents necessary to transfer any rights under an insurance policy or within 20 days of entering any agreement, option, promise or any other form of understanding, expressed or implied, to viaticate the policy, the viatical settlement provider shall give written notice to the insurer that issued that insurance policy that the policy has or will become a viaticated policy. The notice shall be accompanied by the documents required by subdivision 3.

3. The viatical settlement provider shall deliver a copy of the medical release required under subdivision 1 b of this subsection, a copy of the viator's application for the viatical settlement contract, the notice required under subdivision 2, and a request for verification of coverage to the insurer that issued the life policy that is the subject of the viatical transaction. The verification form adopted by the NAIC shall be used unless standards for verification are developed by the Commission.

4. The insurer shall respond to a request for verification of coverage submitted on an approved form by a viatical settlement provider not later than 30 calendar days after the date the request is received. The insurer shall complete and issue the verification of coverage to the viatical settlement provider or, in its response, the insurer shall indicate whether, based on the medical evidence and documents provided, the insurer intends to pursue an investigation regarding possible fraud or the validity of the insurance contract.

5. Prior to or at the time of execution of the viatical settlement contract, the viatical settlement provider shall obtain a witnessed document in which the viator consents to the viatical settlement contract, represents that the viator has a full and complete understanding of the viatical settlement contract, that he has a full and complete understanding of the benefits of the life insurance policy, acknowledges that he is entering into the viatical settlement contract freely and voluntarily and, for persons who are chronically or terminally ill, acknowledges that the insured has a terminal or chronic illness and that the terminal or chronic illness or condition was diagnosed after the life insurance policy was issued.

6. If a viatical settlement broker performs any of these activities required of the viatical settlement provider, the provider is deemed to have fulfilled the requirements of this section.

B. All medical information solicited or obtained by any licensee shall be subject to the applicable provisions of state law relating to privacy or confidentiality of medical information.

C. All viatical settlement contracts entered into in this Commonwealth shall provide the viator with an unconditional right to rescind the contract for at least 15 calendar days from the receipt of the viatical settlement proceeds. If the insured dies during the rescission period, the viatical settlement contract shall be deemed to have been rescinded, subject to repayment to the viatical settlement provider or purchaser of all viatical settlement proceeds, and any premiums, loans, and loan interest that have been paid by the viatical settlement provider or purchaser.

D. The viatical settlement provider shall instruct the viator to send the executed documents required to effect the change in ownership, assignment or change in beneficiary directly to the independent escrow agent. Within three business days after the date the escrow agent receives the documents, or from the date the viatical settlement provider receives the documents, if the viator erroneously

provides the documents directly to the provider, the provider shall pay or transfer the proceeds of the viatical settlement into an escrow or trust account maintained in a state or federally-chartered financial institution whose deposits are insured by the Federal Deposit Insurance Corporation. Upon payment of the settlement proceeds into the escrow account, the escrow agent shall deliver the original change in ownership, assignment, or change in beneficiary forms to the viatical settlement provider or related provider trust. Upon the escrow agent's receipt of the acknowledgment of the properly completed transfer of ownership, assignment, or designation of beneficiary from the insurance company, the escrow agent shall pay the settlement proceeds to the viator.

E. Failure to tender consideration to the viator for the viatical settlement contract within the time disclosed pursuant to subdivision A 6 of § 38.2-6007 renders the viatical settlement contract voidable by the viator for lack of consideration until the time consideration is tendered to and accepted by the viator.

F. Contacts with the insured for the purpose of determining the health status of the insured by the viatical settlement provider or viatical settlement broker after the viatical settlement has occurred shall only be made by the viatical settlement provider or broker licensed in this Commonwealth or its authorized representatives and shall be limited to once every three months for insureds with a life expectancy of more than one year, and to no more than once per month for insureds with a life expectancy of one year or less. The provider or broker shall explain the procedure for these contacts at the time the viatical settlement contract is entered into. The limitations set forth in this subsection shall not apply to any contacts with an insured for reasons other than determining the insured's health status. Viatical settlement providers and viatical settlement brokers shall be responsible for the actions of their authorized representatives.

2003, c. 717.

§ 38.2-6009. Prohibited practices.

A. It is a violation of this chapter for any person to enter into a viatical settlement contract within a two-year period commencing with the date of issuance of the insurance policy or certificate unless the viator certifies to the viatical settlement provider that one or more of the following conditions have been met within the two-year period:

1. The policy was issued upon the viator's exercise of conversion rights arising out of a group or individual policy, provided the total of the time covered under the conversion policy plus the time covered under the prior policy is at least 24 months. The time covered under a group policy shall be calculated without regard to any change in insurance carriers, provided the coverage has been continuous and under the same group sponsorship;

2. The viator submits independent evidence to the viatical settlement provider that one or more of the following conditions have been met within the two-year period:

a. The insured is terminally or chronically ill, or

b. The viator or insured disposes of his ownership interests in a closely held corporation pursuant to terms of a buyout or other similar agreement in effect at the time the insurance policy was initially issued.

B. Copies of the certifications and independent evidence required by this subsection and documents required by subsection A of § 38.2-6008 shall be submitted to the insurer when the viatical settlement provider submits a request to the insurer for verification of coverage. The copies shall be accompanied by a letter of attestation from the viatical settlement provider that the copies are true and correct copies of the documents received by the viatical settlement provider.

2003, c. 717.

§ 38.2-6010. Advertising for viatical settlements.

A. This section shall apply to any advertising of viatical settlement contracts, or related products or services intended for dissemination in this Commonwealth, including Internet advertising viewed by persons located in this Commonwealth. Where disclosure requirements are established pursuant to federal regulation, this section shall be interpreted so as to minimize or eliminate conflict with federal regulation wherever possible.

B. Each licensee under this chapter shall establish and at all times maintain a system of control over the content, form and method of dissemination of all advertisements of its contracts, products, and services. All advertisements, regardless of by whom written, created, designed, or presented, shall be the responsibility of the licensee, as well as the individual who created or presented the advertisement. A system of control shall include regular routine notification, at least once a year, to agents and others authorized by the licensee who disseminates advertisements of the requirements and procedures for approval prior to the use of any advertisements not furnished by the licensee.

C. Advertisements shall be truthful and not misleading in fact or by implication. The form and content of an advertisement of a viatical settlement contract shall be sufficiently complete and clear so as to avoid deception. It shall not have the capacity or tendency to mislead or deceive. Whether an advertisement has the capacity or tendency to mislead or deceive shall be determined by the Commission from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence within the segment of the public to which it is directed.

D. The information required to be disclosed under this section shall not be minimized, rendered obscure, or presented in an ambiguous fashion or intermingled with the text of the advertisement so as to be confusing or misleading.

1. An advertisement shall not omit material information or use words, phrases, statements, references, or illustrations if the omission or use has the capacity, tendency, or effect of misleading or deceiving viators, as to the nature or extent of any benefit, loss covered, premium payable, or state or federal tax consequence. The fact that the viatical settlement contract offered is made available for inspection prior to consummation of the sale, or an offer is made to refund the payment if the viator is not satisfied

or that the viatical settlement contract includes a "free look" period that satisfies or exceeds legal requirements, does not remedy misleading statements.

2. An advertisement shall not use the name or title of a life insurance company or a life insurance policy unless the advertisement has been approved by the insurer.

3. An advertisement shall not state or imply that interest charged on an accelerated death benefit or a policy loan is unfair, inequitable, or in any manner an incorrect or improper practice.

4. The words "free," "no cost," "without cost," "no additional cost," "at no extra cost," or words of similar import shall not be used with respect to any benefit or service unless true. An advertisement may specify the charge for a benefit or a service or may state that a charge is included in the payment or use other appropriate language.

5. Testimonials, appraisals, or analysis used in advertisements must be genuine; represent the current opinion of the author; be applicable to the viatical settlement contract, product, or service advertised, if any; and be accurately reproduced with sufficient completeness to avoid misleading or deceiving prospective viators as to the nature or scope of the testimonials, appraisal, analysis, or endorsement. In using testimonials, appraisals, or analysis, the viatical settlement licensee makes as its own all the statements contained therein, and the statements are subject to all the provisions of this section.

a. If the individual making a testimonial, appraisal, analysis, or an endorsement has a financial interest in the viatical settlement provider, viatical settlement broker, or related entity as a stockholder, director, officer, employee, or otherwise, or receives any benefit directly or indirectly other than required union scale wages, that fact shall be prominently disclosed in the advertisement.

b. An advertisement shall not state or imply that a viatical settlement contract benefit or service has been approved or endorsed by a group of individuals, society, association, or other organization unless that is the fact and unless any relationship between an organization and the viatical settlement licensee is disclosed. If the entity making the endorsement or testimonial is owned, controlled, or managed by the viatical settlement licensee, or receives any payment or other consideration from the viatical settlement licensee for making an endorsement or testimonial, that fact shall be disclosed in the advertisement.

c. When an endorsement refers to benefits received under a viatical settlement contract all pertinent information shall be retained for a period of five years after its use.

E. An advertisement shall not contain statistical information unless it accurately reflects recent and relevant facts. The source of all statistics used in an advertisement shall be identified.

F. An advertisement shall not disparage insurers, viatical settlement providers, viatical settlement brokers, viatical settlement investment agents, insurance producers, policies, services, or methods of marketing.

G. The name of the viatical settlement licensee shall be clearly identified in all advertisements about the licensee or its viatical settlement contracts, products, or services, and if any specific viatical

settlement contract is advertised, the viatical settlement contract shall be identified either by form number or some other appropriate description. If an application is part of the advertisement, the name of the viatical settlement provider shall be shown on the application.

H. An advertisement shall not use a trade name, group designation, name of the parent company of a viatical settlement licensee, name of a particular division of the viatical settlement licensee, service mark, slogan, symbol, or other device or reference without disclosing the name of the viatical settlement licensee, if the advertisement would have the capacity or tendency to mislead or deceive as to the true identity of the viatical settlement licensee, or to create the impression that a company other than the viatical settlement licensee would have any responsibility for the financial obligation under a viatical settlement contract.

I. An advertisement shall not use any combination of words, symbols, or physical materials that by their content, phraseology, shape, color, or other characteristics are so similar to a combination of words, symbols, or physical materials used by a government program or agency or otherwise appear to be of such a nature that they tend to mislead prospective viators into believing that the solicitation is in some manner connected with a government program or agency.

J. An advertisement may state that a viatical settlement licensee is licensed in the state where the advertisement appears, provided it does not exaggerate that fact or suggest or imply that a competing viatical settlement licensee may not be so licensed. The advertisement may ask the audience to consult the licensee's website or contact the Bureau of Insurance to find out if this Commonwealth requires licensing and, if so, whether the viatical settlement provider or viatical settlement broker is licensed.

K. An advertisement shall not create the impression that the viatical settlement provider, its financial condition or status, the payment of its claims or the merits, desirability, or advisability of its viatical settlement contracts are recommended or endorsed by any government entity.

L. The name of the actual licensee shall be stated in all of its advertisements. An advertisement shall not use a trade name, any group designation, name of any affiliate, or controlling entity of the licensee, service mark, slogan, symbol, or other device in a manner that would have the capacity or tendency to mislead or deceive as to the true identity of the actual licensee or create the false impression that an affiliate or controlling entity would have any responsibility for the financial obligation of the licensee.

M. An advertisement shall not directly or indirectly create the impression that any division or agency of the state or of the U.S. government endorses, approves, or favors:

1. Any viatical settlement licensee or its business practices or methods of operation;

2. The merits, desirability, or advisability of any viatical settlement contract;

3. Any viatical settlement contract; or

4. Any life insurance policy or life insurance company.

N. If the advertiser emphasizes the speed with which the viatication will occur, the advertising must disclose the average time frame from completed application to the date of offer and from acceptance of the offer to receipt of the funds by the viator.

O. If the advertising emphasizes the dollar amounts available to viators, the advertising shall disclose the average purchase price as a percent of face value obtained by viators contracting with the licensee during the past six months.

2003, c. 717.

§ 38.2-6011. Fraud prevention and control.

A. A person shall not commit a fraudulent viatical settlement act. A person shall not knowingly or intentionally interfere with the enforcement of the provisions of this chapter or Article 6.1 (§ 38.2-1865.1 et seq.) of Chapter 18 of this title or investigations of suspected or actual violations of this chapter or Article 6.1 (§ 38.2-1865.1 et seq.) of Chapter 18 of this title. A person in the business of viatical settlements shall not knowingly or intentionally permit any person convicted of a felony involving dishonesty or breach of trust to participate in the business of viatical settlements.

B. Viatical settlement contracts and applications for viatical settlements, regardless of the form of transmission, shall contain the following statement or a substantially similar statement: "Any person who knowingly presents false information in an application for insurance or viatical settlement contract may be guilty of a crime and subject to prosecution." The lack of the required statement does not constitute a defense in any prosecution for a fraudulent viatical settlement act.

C. Any person engaged in the business of viatical settlements having knowledge or a reasonable belief that a fraudulent viatical settlement act is being, will be, or has been committed shall provide to the Commission the information required by, and in a manner prescribed by, the Commission. Any other person having knowledge or a reasonable belief that a fraudulent viatical settlement act is being, will be, or has been committed may provide to the Commission the information required by, and in a manner prescribed by, the Commission.

D. This chapter shall not:

1. Preempt the authority or relieve the duty of other law enforcement or regulatory agencies to investigate, examine, and prosecute suspected violations of law;

2. Prevent or prohibit a person from disclosing voluntarily information concerning viatical settlement fraud to a law enforcement or regulatory agency other than the insurance department; or

3. Limit the powers granted elsewhere by the laws of this Commonwealth to the Commission or an insurance fraud unit to investigate and examine possible violations of law and to take appropriate action against wrongdoers.

E. 1. A viatical settlement provider shall within 60 days of licensure and annually thereafter by March 1 of each year certify to the Commission implementation of anti-fraud initiatives reasonably calculated to detect, prosecute, and prevent fraudulent viatical settlement acts.

2. A viatical settlement broker shall within 60 days of licensure affirm to the Commission implementation of fraud initiatives reasonably calculated to detect, prosecute, and prevent fraudulent viatical settlement acts. Upon renewal of such license, a viatical settlement broker shall affirm to the Commission that such fraud initiatives remain in place. A viatical settlement broker shall make its anti-fraud plan available to the Commission upon request.

3. Anti-fraud initiatives shall include:

a. Fraud investigators, who may be viatical settlement providers or viatical settlement broker employees or independent contractors; and

b. An anti-fraud plan that includes all of the following:

(1) A description of the procedures for detecting and investigating possible fraudulent viatical settlement acts and procedures for resolving material inconsistencies between medical records and insurance applications;

(2) A description of the procedures for reporting possible fraudulent viatical settlement acts to the Commission;

(3) A description of the plan for anti-fraud education and training of underwriters and other personnel; and

(4) A description or chart outlining the organizational arrangement of the anti-fraud personnel who are responsible for the investigation and reporting of possible fraudulent viatical settlement acts and investigating unresolved material inconsistencies between medical records and insurance applications.

F. Anti-fraud plans submitted to or obtained by the Commission and in the control or possession of the Commission shall be privileged and confidential, shall not be subject to inspection or review by the general public, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil or criminal action. However, the Commission is authorized to use the anti-fraud plans in the furtherance of any regulatory or legal action brought as a part of the Commission's duties.

2003, c. 717; 2023, c. 577.

§ 38.2-6012. Civil remedies.

A. Any person damaged by the acts of a person in violation of this chapter may bring a civil action against the person committing the violation in a court of competent jurisdiction.

B. The Commission shall have no jurisdiction to adjudicate controversies between licensees, or between a licensee under this chapter and a viator or an insured.

C. If there is more than one viator on a single policy and the viators are residents of different states, contractual disputes arising from the viatical settlement shall be governed by the law of the state in which the viator having the largest percentage ownership resides or, if the viators hold equal

ownership, the state of residence of one viator agreed upon in writing by all viators, provided that the application of another state's laws shall not impair or limit the ability of the Commission to apply and enforce the provisions of this chapter or Article 6.1 (§ 38.2-1865.1 et seq.) of Chapter 18 of this title in its regulation of transactions with a resident of this Commonwealth.

2003, c. 717.

§ 38.2-6013. Unfair trade practices.

A violation of this chapter shall be considered an unfair trade practice under Chapter 5 (§ 38.2-500 et seq.) of this title and subject to the penalties contained in that chapter.

1997, c. 814, § 38.2-5707; 2003, c. 717.

§ 38.2-6014. Commission authority.

Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such rules and regulations as it may deem necessary to implement this chapter, including, but not limited to:

1. Establishing standards for evaluating reasonableness of payments under viatical settlement contracts for insureds who are terminally or chronically ill. This authority includes, but is not limited to, regulation of discount rates used to determine the amount paid in exchange for assignment, transfer, sale, devise, or bequest of a benefit under a life insurance policy. Viatical settlement providers, where the insured is not terminally ill or chronically ill, shall pay an amount greater than the cash surrender value or accelerated death benefit then available;

2. Establish appropriate licensing requirements, fees, and standards for continued licensure for viatical settlement providers and viatical settlement brokers;

3. Requiring and setting the amount of any bond or other mechanism for financial accountability for viatical settlement providers and viatical settlement brokers; and

4. Adopting rules governing the relationship and responsibilities of both insurers and viatical settlement providers and viatical settlement brokers during the viatication of a life insurance policy or certificate.

1997, c. 814, § 38.2-5706; 2003, c. 717.

§ 38.2-6015. Immunity from liability.

A. No cause of action shall arise nor shall any liability be imposed against the Commission, the Commissioner of Insurance, or any of the Commission's employees or agents, for any statements made or conduct performed in good faith while carrying out the provisions of this chapter or Article 6.1 (§ 38.2-1865.1 et seq.) of Chapter 18 of this title.

B. No cause of action shall arise, nor shall any liability be imposed against any person for the act of communicating or delivering information or data to the Commission, if the act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive.

C. No civil liability shall be imposed on and no cause of action shall arise from a person's furnishing information concerning suspected, anticipated, or completed fraudulent viatical settlement acts or suspected or completed fraudulent insurance acts, if the information is provided to or received from:

1. The Commission, the Commissioner of Insurance, or any of the Commission's employees or agents;

2. Federal, state, or local law enforcement or regulatory officials or their employees, agents or representatives;

3. A person involved in the prevention and detection of fraudulent viatical settlement acts or that person's agents, employees, or representatives;

4. The NAIC, National Association of Securities Dealers, the North American Securities Administrators Association, or their employees, agents or representatives, or other regulatory body overseeing life insurance, viatical settlements, securities, or investment fraud;

5. The life insurer that issued the life insurance policy covering the life of the insured; or

6. Any licensee under this chapter, provided the information furnished shall not be utilized as grounds to excuse the direct actions of such licensee.

D. Immunity provided by subsection C shall not apply to statements made with actual malice. In an action brought against a person for filing a report or furnishing other information concerning a fraudulent viatical settlement act or a fraudulent insurance act, the party bringing the action shall plead specifically any allegation that subsection C does not apply because the person filing the report or furnishing the information did so with actual malice.

E. This section does not abrogate or modify common law or statutory privileges or immunities enjoyed by a person described in subsections A or C.

F. The documents and evidence provided pursuant to this section or obtained by the Commission in an investigation of suspected or actual fraudulent viatical settlement acts shall be privileged and confidential and shall not be a public record and shall not be subject to discovery or subpoena in a private civil or criminal action.

G. Subsection F does not prohibit release by the Commission of documents and evidence obtained in an investigation of suspected or actual fraudulent viatical settlement acts:

1. In administrative or judicial proceedings to enforce laws administered by the Commission;

2. To federal, state, or local law enforcement or regulatory agencies, to an organization established for the purpose of detecting and preventing fraudulent viatical settlement acts or to the NAIC; or

3. At the discretion of the Commission, to a person in the business of viatical settlements that is aggrieved by a fraudulent viatical settlement act.

H. Release of documents and evidence under subsection G does not abrogate or modify the privilege granted in subsection F.

2003, c. 717.

§ 38.2-6016. Applicability of securities laws.

Nothing in this chapter shall preempt or otherwise limit the provisions of the Virginia Securities Act (§ 13.1-501 et seq.), or any regulations, notices, bulletins or other interpretations issued by or through the Commission acting pursuant to the Virginia Securities Act. Compliance with the provisions of this chapter shall not constitute compliance with any applicable provision of the Virginia Securities Act and any amendments thereto or any regulations, notices, bulletins, or other interpretations issued by or through the Commission acting pursuant to the Virginia Securities Act.

2003, c. 717.

Chapter 61 - DENTAL PLAN ORGANIZATIONS

§ 38.2-6100. Applicability of chapter.

A. Except as otherwise provided by law, no dental plan organization shall be organized, conducted, or offered in the Commonwealth other than in the manner set forth in this chapter.

B. This chapter shall not apply to a prepaid dental services plan organized under Chapter 45 (§ 38.2-4500 et seq.) of this title, a health maintenance organization or limited health care services plan licensed to provide dental services under Chapter 43 (§ 38.2-4300 et seq.) of this title, any health service plan licensed under Chapter 42 (§ 38.2-4200 et seq.) of this title, or any insurer whose activities are regulated under other provisions of this title.

C. Nothing contained in this chapter prohibits any dentist individually, in partnership with other dentists, or as part of a professional corporation of dentists from entering into agreements directly with his own patients, or with a parent, guardian, conservator, spouse, or other family member acting on such patient's behalf, involving payment for professional services to be rendered or made available in the future.

2004, c. 668.

§ 38.2-6101. Definitions.

As used in this chapter:

"Contract holder" means (i) with respect to group contracts, the organization or entity to which the dental benefit contract is issued, and (ii) with respect to individual contracts, the individual who enters into a dental benefit contract covering the individual or the individual and dependents of the individual.

"Copayment" means the amount payable for a particular service by an enrollee in accordance with the patient charge schedule or for which the enrollee is responsible as a condition for receiving benefits

under a dental benefit contract. A copayment may be expressed as a specific dollar amount or as a percentage of the allowable charge for a service.

"Dental benefit contract" means a contract that provides benefits for dental services entered into between the dental plan organization and a contract holder.

"Dental plan" means a contractual arrangement for dental services provided or arranged for, that pays benefits or is administered on an individual or group basis. A dental plan includes, but is not limited to, an arrangement where fixed indemnity benefits are paid to an individual or provider for dental services.

"Dental plan organization" means a company that provides directly or arranges for a dental plan.

"Dental service" means a service included in the current Dental Terminology Manual issued by the American Dental Association.

"Dependent" means an individual who is the spouse or child of a subscriber.

"Enrollee" means an individual or a dependent of an individual who is enrolled in a dental plan.

"Evidence of coverage" means any certificate, agreement, or contract issued to a subscriber of a group that sets out the dental services to which the enrollees are entitled.

"Fixed indemnity benefits" means the payment amount or amounts stated in the reimbursement schedule of a dental plan organization that will be paid to a subscriber, or to the subscriber's dentist, for dental services.

"Plan dentist" means any dentist, licensed by the Virginia Board of Dentistry, who has contracted with the dental plan organization or with an entity acting on behalf of the dental plan organization to provide dental services to the enrollees. A dental plan organization may, but is not required to, utilize plan dentists.

"Plan dentist contract" means a contract between the dental plan organization or an entity acting on behalf of the dental plan organization and a plan dentist.

"Subscriber" means (i) with respect to group dental benefit contracts, the person who is covered by the contract, other than as a dependent, by satisfying the eligibility requirements of the group, and (ii) with respect to individual dental benefit contracts, the individual who obtains coverage of the individual only or the individual and dependents of the individual.

2004, c. 668.

§ 38.2-6102. License application.

A. No person shall establish or operate a dental plan organization in the Commonwealth without first obtaining a license from the Commission. Any business entity, which is neither an individual nor a sole proprietorship, may apply to the Commission for a license to establish and operate a dental plan organization in compliance with this chapter.

B. Each application for a license shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the Commission, and shall set forth or be accompanied by the following:

1. A copy of the basic organizational documents of the applicant including, but not limited to, the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments to those documents;

2. A copy of the bylaws, rules, and regulations, or any similar document regulating the conduct of the internal affairs of the applicant;

3. A list of the name, address, official position, and biographical information on forms acceptable to the Commission of each member of the governing body and any person with authority to manage or establish policy; and a full disclosure in the application of (i) any financial interest between such person or any dentist, organization, or corporation owned or controlled by such person and the dental plan organization and (ii) the extent and nature of the financial arrangements between such person and the dental plan organization;

4. A copy of any contract made or to be made between any dentist, sponsor, or organizer of the dental plan organization, or persons listed in subdivision 3 and the applicant;

5. A copy of the evidence of coverage form to be issued to subscribers and the dental benefit contract to be issued to contract holders;

6. A copy of any group contract form that is to be issued to employers, unions, trustees, or other organizations. All group contracts shall set forth the right of subscribers to convert their coverages to an individual contract issued by the dental plan organization;

7. A financial statement or statements and any reports, certificates, or other documents the Commission considers necessary to secure a full and accurate knowledge of the applicant's affairs and financial condition;

8. A complete description of the dental plan organization and its method of operation, including (i) the method of marketing the plan, (ii) a statement regarding the sources of working capital as well as any other sources of funding, and (iii) a description of any insurance, reinsurance, or alternative coverage arrangements proposed, including excess insurance or stop loss insurance;

9. A financial feasibility plan that includes, but is not limited to, (i) detailed enrollment projections, (ii) the methodology for determining premium rates to be charged during at least the first three years of operations and extending one year beyond the anticipated break-even point certified by an actuary, and (iii) a projection, along with material assumptions, of balance sheets, cash flow statements showing capital expenditures and purchase and sale of investments, and income statements on a quarterly basis for at least three years and extending one year beyond the anticipated break-even point; and

10. Any other information the Commission may require to make the determinations required pursuant to § 38.2-6103.

2004, c. 668.

§ 38.2-6103. Issuance of license; capital and surplus; impairment.

A. The Commission shall issue a license to a dental plan organization after the filing of a complete application and payment of a $500 nonrefundable application fee, if the Commission is satisfied that:

1. The persons who are responsible for conducting the affairs of the dental plan organization are trustworthy and capable of providing, arranging for, or paying benefits for the services offered by its dental plan;

2. The dental plan organization is financially responsible and may reasonably be expected to meet its obligations to enrollees. In making this determination, the Commission shall consider, among other things, the following:

a. The financial statements of the dental plan organization;

b. The adequacy of working capital;

c. Any contracts with plan dentists;

d. The deposit of acceptable securities, which shall be in an amount of no less than $50,000; and

e. The applicant's minimum capital and surplus, which shall be the greater of $750,000 or 45 days of anticipated operating expenses and incurred claims expenses.

3. Nothing in the method of operation is contrary to the public interest, as shown in the information submitted pursuant to § 38.2-6102 or Chapter 58 (§ 38.2-5800 et seq.) of this title or by independent investigation.

B. A licensed dental plan organization shall have and maintain at all times the minimum capital and surplus described in subdivision A 2 e. The licensee's capital and surplus shall be subject also to the risk-based capital requirements of Chapter 55 (§ 38.2-5500 et seq.) of this title.

1. If the Commission finds that the minimum capital and surplus of a domestic dental plan organization is impaired, the Commission shall issue an order requiring the dental plan organization to eliminate the impairment within a period not exceeding 90 days. The Commission may by order served upon the dental plan organization prohibit the dental plan organization from issuing any new dental benefit contracts while the impairment exists. If at the expiration of the designated period the dental plan organization has not satisfied the Commission that the impairment has been eliminated, an order for the rehabilitation or liquidation of the dental plan organization may be entered as provided in Chapter 15 (§ 38.2-1500 et seq.) of this title.

2. If the Commission finds an impairment of the minimum capital and surplus of any foreign dental plan organization, the Commission may order the dental plan organization to eliminate the impairment. The Commission may, by order served upon the dental plan organization, prohibit the dental plan organization from issuing any new dental benefit contracts while the impairment exists. If the dental plan organization fails to comply with the Commission's order within a period of not more than 90 days, the Commission may suspend or revoke the license of the dental plan organization.

2004, c. 668.

§ 38.2-6104. License renewals.

A. Each dental plan organization organized under this chapter shall obtain an annual renewal of its license from the Commission by July 1 of each year. The Commission may refuse to renew the license of any dental plan organization or may renew the license, subject to any restrictions considered appropriate by the Commission, if it finds an impairment of the minimum capital and surplus or that the dental plan organization has not satisfied all of the conditions set forth in subsection A of § 38.2-6103.

B. The Commission shall not fail or refuse to renew the license of any dental plan organization without first giving the dental plan organization 10 days' notice of its intention not to renew the license and giving it an opportunity to be heard and to introduce evidence on its behalf. The hearing may be informal and the required notice may be waived by the Commission and the dental plan organization.

2004, c. 668.

§ 38.2-6105. Required dental benefit contract provisions.

A. Each dental benefit contract shall contain the following provisions:

1. An effective date of the contract;

2. A provision describing the payment of required subscription fees or premiums;

3. A grace period provision that complies with § 38.2-6107;

4. For group dental benefit contracts, the eligibility requirements and effective date of coverage for subscribers of the group and their dependents;

5. A provision describing the benefits available under the dental benefit contract;

6. A provision describing the copayments and deductibles for which the enrollee is responsible or the fixed indemnity benefits, if any;

7. A provision describing the service area, if applicable;

8. If a dental plan organization provides benefits only within a stated service area, a provision providing for emergency dental services outside the service area, with the term "emergency" including care to alleviate acute pain;

9. A provision indicating that if a plan dentist refers the enrollee to a specialist who is not a plan dentist for dental services that are covered under the dental benefit contract, the dental plan organization shall be responsible for payment of the specialist's charges to the extent the charges exceed the copayment specified in the dental benefit contract;

10. A provision that reads substantially as follows, if the contract requires use of a plan dentist:

"If during the term of this contract none of the plan dentists can render necessary care and treatment to the enrollee due to circumstances not reasonably within the control of the dental plan organization, such as complete or partial destruction of facilities, war, riot, civil insurrection, labor disputes, or the disability of a significant number of the plan dentists, then the enrollee may seek treatment from an independent licensed dentist of his own choosing. The dental plan organization will pay the enrollee for the expenses incurred for the dental services with the following limitations: The dental plan organization will pay the enrollee for services that are listed in the patient charge schedule as "No Charge," to the extent that such fees are reasonable and customary for dentists in the same geographic area; the dental plan organization will also pay the enrollee for those services listed in the contract for which there is a copayment, to the extent that the reasonable and customary fees for such services exceed the copayment for such services as set forth in the contract. The enrollee may be required to give written proof of loss.";

11. A provision setting out the terms under which coverage will terminate; and

12. A provision setting out a grievance procedure that specifies the time period in which the dental plan organization shall initially respond to an enrollee's grievance, with the time period not exceeding 20 days from the date the grievance is filed with the dental plan organization.

B. Each dental benefit contract shall also have provisions related to extension of benefits that specify:

1. If an enrollee's coverage terminates, an extension of benefits shall be provided for any treatment in progress at the time of termination, provided the treatment requires two or more visits to the dentist's office on separate days as certified by the treating dentist.

2. The extension of benefits shall be, at a minimum, for all types of dental care other than orthodontics, until the completion of the procedure.

3. For orthodontics, the extension of benefits will be at least 60 days if the orthodontist has agreed to or is receiving monthly payments when coverage terminates, or if the orthodontist has agreed to

accept or is receiving payments on a quarterly basis, to the end of the quarter in progress or 60 days, whichever is longer.

4. An extension of benefits is not required if termination is due solely to the failure of the enrollee to pay the subscription fee or premium when the enrollee is otherwise eligible to continue coverage under the dental benefit contract.

2004, c. 668.

§ 38.2-6106. Optional provisions.

Dental benefit contracts may contain the following provisions:

1. A provision including the dental plan organization's intention to charge a specified missed appointment fee. The fee shall be reasonable in relation to the nature of the procedure for which the missed appointment had been made. Neither the plan dentist nor the dental plan organization may charge a missed appointment fee unless this provision appears in the dental benefit contract. For purposes of this section, the term "missed appointment" means an appointment for which advance cancellation of at least 24 hours was not provided.

2. A provision including the dental plan organization's ability to increase premiums or subscription fees, with this provision indicating that these fees may not be increased unless:

a. The contract holder has been given written notice at least 60 days before the effective date of the increase; and

b. In the case of:

(1) An individual contract, present rates under the contract have not been changed for at least 12 months, or

(2) A group contract, present rates under the contract have been in effect for at least 12 months.

3. A provision including the dental plan organization's intention to impose a financial penalty on an enrollee for voluntarily withdrawing from the dental plan during the first year of coverage, which penalty may not:

a. Be charged if the enrollee withdraws from the dental plan after being covered for at least 12 months; or

b. Exceed the usual, customary, and reasonable charge for services received reduced by the sum of the subscription fees paid by or for the enrollee and any copayments paid by or for the enrollee.

4. A provision including the dental plan organization's ability to increase the patient charge schedule, with the provision indicating that the increase may not be effective unless the:

a. Present schedule under the contract has been in effect for at least 12 months; and

b. Contract holder has been given written notice of the increase at least 60 days before the effective date of the increase.

5. A provision including the dental plan organization's rights if an enrollee refuses to follow a particular course of treatment. The dental plan organization may not terminate the membership of an enrollee for refusal to follow a recommended course of treatment for a particular condition. The provision may indicate that the dental plan organization may refuse to provide any further benefits for the particular condition if the enrollee refuses to accept a recommended course of treatment.

6. A provision including the dental plan organization's rights if an enrollee fraudulently uses his membership card or knowingly permits his membership card to be used by others. The dental plan organization may terminate an enrollee's coverage if the enrollee fraudulently uses his membership card or knowingly permits his membership card to be used by others. The dental plan organization may not terminate coverage for an entire family because a dependent fraudulently uses the membership card. In this instance, only the dependent's coverage may terminate.

7. A provision specifying that the dental plan organization may terminate an enrollee's coverage if the enrollee is unable to maintain a satisfactory dentist-patient relationship with a plan dentist, provided, however:

a. Before terminating the enrollee's coverage, the dental plan organization shall permit the enrollee to change primary dentists at least once;

b. The enrollee shall be given written notice of the termination at least 30 days before the termination of the enrollee's membership.

8. If the contract provides coverage for dependent children, the contract shall also contain the following provision:

"Notwithstanding any limiting age stated in the contract, any unmarried child covered under the contract as a dependent of an enrollee who is chiefly dependent for support upon the enrollee, and who, at the time of reaching the limiting age, is incapable of self-support because of mental or physical incapacity that commenced prior to the child's attaining the limiting age, shall continue to be covered under the contract while remaining so dependent, unmarried, and mentally or physically incapacitated, until the coverage on the enrollee upon whom the child is dependent terminates."

2004, c. 668.

§ 38.2-6107. Grace period requirements.

The contract holder shall be given a 31-day grace period for the payment of any premium falling due after the first premium during which coverage remains in effect. If payment is not received within the 31 days, coverage may be cancelled after the thirty-first day and the contract holder may be held liable for the payment of the premium for the period of time coverage remained in effect during the grace period.

2004, c. 668.

§ 38.2-6108. Plan dentist contracts; preferred providers; assignment of benefits.

A. Each contract with a plan dentist shall contain the following provisions:

1. A hold harmless clause that satisfies the requirements of subdivision C 9 of § 38.2-5805.

2. A provision specifying when the contract becomes effective.

3. A provision specifying the date the contract terminates.

4. A provision specifying the renewal terms.

5. Provisions incorporating the rights, remedies and obligations applicable to providers and dental plan organizations set forth in §§ 38.2-3407.1, 38.2-3407.10, 38.2-3407.15, and 38.2-5805.

B. A dental plan organization that offers or administers a plan under which preferred provider policies or contracts are issued shall comply with the requirements of § 38.2-3407 in contracting with dentists for services in connection with the preferred provider policies or contracts.

C. All dental plan organizations shall comply with the provisions of § 38.2-3407.13 relating to assignments of benefits by subscribers and enrollees.

2004, c. 668.

§ 38.2-6109. Delivery of contract forms.

The dental plan organization:

1. Shall provide a written dental benefit contract to each group contract holder within 15 days of acceptance of the group's application by the dental plan organization;

2. Shall provide a written evidence of coverage to each individual covered under a group dental benefit contract within 15 days of acceptance of the group's application by the dental plan organization; and

3. Shall provide a written dental benefit contract to each individual who applies for individual dental coverage within 15 days of acceptance of the individual's application by the dental plan organization.

2004, c. 668.

§ 38.2-6110. Filing requirements for premium rates and subscription fees.

A. The filing with the Commission of any dental benefit contract or rider or endorsement by a dental plan organization shall be accompanied by the filing of premium rates or subscription fees.

B. A subsequent change in premium rates or subscription fees shall be filed with supporting data at least 30 days before the change is proposed to become effective.

2004, c. 668.

§ 38.2-6111. Examinations.

A. The Commission shall examine the affairs of each dental plan organization as provided for in § 38.2-1317.

B. Instead of making its own examination, the Commission may accept the report of an examination of a foreign dental plan organization certified by the insurance supervisory official, similar regulatory agency, or the state health commissioner of another state.

C. The Commission may coordinate its examinations with the State Health Commissioner to ensure an appropriate level of regulatory oversight and to avoid any undue duplication of effort or regulation.

2004, c. 668.

§ 38.2-6112. Licensing of agents.

Dental benefit contracts may be solicited only through health insurance agents and limited lines life and health agents licensed in accordance with Chapter 18 (§ 38.2-1800 et seq.) of this title. Home office salaried officers whose principal duties and responsibilities do not include the negotiation or solicitation of dental benefit contracts shall not be required to be licensed.

2004, c. 668.

§ 38.2-6113. Application of other laws.

A. Except to the extent that such application would be inconsistent with any provision of this chapter, the provisions of Chapter 5 (§ 32.1-123 et seq.) of Title 32.1 and of other chapters of this title, and regulations promulgated thereunder, that are applicable to (i) an insurer licensed pursuant to § 38.2-1024, (ii) a carrier as defined in § 38.2-3407.10, (iii) a health plan as defined in § 38.2-3407.15, or (iv) a health carrier or managed care health insurance plan as defined in § 38.2-5800, shall apply to dental plan organizations and the provision of dental services on behalf of dental plan organizations, as if such provisions specifically stated that they apply to dental plan organizations and the provision of dental services on behalf of dental plan organizations, notwithstanding that such other provisions do not refer to dental plan organizations or the provision of dental services on behalf of dental plan organizations.

B. Any reference in this chapter to specific provisions of any other chapter of this title or of any other title shall not limit the applicability of subsection A.

2004, c. 668.

Chapter 62 - INTERSTATE INSURANCE PRODUCT REGULATION COMPACT

§ 38.2-6200. Form of Compact.

The General Assembly hereby enacts, and the Commonwealth of Virginia hereby enters into, the Interstate Insurance Product Regulation Compact with any and all states legally joining therein according to its terms, in the form substantially as follows:

Article I.

Purposes.

The purposes of this Compact are, through means of joint and cooperative action among the Compacting States:

1. To promote and protect the interest of consumers of individual and group annuity, life insurance, disability income and long-term care insurance products;

2. To develop uniform standards for insurance products covered under the Compact;

3. To establish a central clearinghouse to receive and provide prompt review of insurance products covered under the Compact and, in certain cases, advertisements related thereto, submitted by insurers authorized to do business in one or more Compacting States;

4. To give appropriate regulatory approval to those product filings and advertisements satisfying the applicable uniform standard;

5. To improve coordination of regulatory resources and expertise between state insurance departments regarding the setting of uniform standards and review of insurance products covered under the Compact;

6. To create the Interstate Insurance Product Regulation Commission; and

7. To perform these and such other related functions as may be consistent with the state regulation of the business of insurance.

Article II.

Definitions.

For purposes of this Compact:

1. "Advertisement" means any material designed to create public interest in a Product, or induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace, or retain a policy, as more specifically defined in the Rules and Operating Procedures of the Commission.

2. "Bylaws" mean those bylaws established by the Commission for its governance, or for directing or controlling the Commission's actions or conduct.

3. "Compacting State" means any State which has enacted this Compact legislation and which has not withdrawn pursuant to Article XIV, Section 1, or been terminated pursuant to Article XIV, Section 2.

4. "Commission" means the "Interstate Insurance Product Regulation Commission" established by this Compact.

5. "Commissioner" means the chief insurance regulatory official of a State including, but not limited to, commissioner, superintendent, director, or administrator.

6. "Domiciliary State" means the state in which an Insurer is incorporated or organized; or, in the case of an alien Insurer, its state of entry.

7. "Insurer" means any entity licensed by a State to issue contracts of insurance for any of the lines of insurance covered by this Act.

8. "Member" means the person chosen by a Compacting State as its representative to the Commission, or his or her designee.

9. "Non-compacting State" means any State which is not at the time a Compacting State.

10. "Operating Procedures" mean procedures promulgated by the Commission implementing a Rule, Uniform Standard or a provision of this Compact.

11. "Product" means the form of a policy or contract, including any application, endorsement, or related form which is attached to and made a part of the policy or contract, and any evidence of coverage or certificate, for an individual or group annuity, life insurance, disability income or long-term care insurance product that an Insurer is authorized to issue.

12. "Rule" means a statement of general or particular applicability and future effect promulgated by the Commission, including a Uniform Standard developed pursuant to Article VII of this Compact, designed to implement, interpret, or prescribe law or policy or describing the organization, procedure, or practice requirements of the Commission, which shall have the force and effect of law in the Compacting States.

13. "State" means any state, district or territory of the United States of America.

14. "Third-Party Filer" means an entity that submits a Product filing to the Commission on behalf of an Insurer.

15. "Uniform Standard" means a standard adopted by the Commission for a Product line, pursuant to Article VII of this Compact, and shall include all of the Product requirements in aggregate; provided, that each Uniform Standard shall be construed, whether express or implied, to prohibit the use of any inconsistent, misleading or ambiguous provisions in a Product and the form of the Product made available to the public shall not be unfair, inequitable or against public policy as determined by the Commission.

Article III.

Establishment of the Commission and Venue.

1. The Compacting States hereby create and establish a joint public agency known as the "Interstate Insurance Product Regulation Commission." Pursuant to Article IV, the Commission will have the power to develop Uniform Standards for Product lines, receive and provide prompt review of Products filed therewith, and give approval to those Product filings satisfying applicable Uniform Standards; provided, it is not intended for the Commission to be the exclusive entity for receipt and review of insurance product filings. Nothing herein shall prohibit any Insurer from filing its product in any State wherein the Insurer is licensed to conduct the business of insurance; and any such filing shall be subject to the laws of the State where filed.

2. The Commission is a body corporate and politic, and an instrumentality of the Compacting States.

3. The Commission is solely responsible for its liabilities except as otherwise specifically provided in this Compact.

4. Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the Commission is located.

Article IV.

Powers of the Commission.

The Commission shall have the following powers:

1. To promulgate Rules, pursuant to Article VII of this Compact, which shall have the force and effect of law and shall be binding in the Compacting States to the extent and in the manner provided in this Compact;

2. To exercise its rule-making authority and establish reasonable Uniform Standards for Products covered under the Compact, and Advertisement related thereto, which shall have the force and effect of law and shall be binding in the Compacting States, but only for those Products filed with the Commission, provided, that a Compacting State shall have the right to opt out of such Uniform Standard pursuant to Article VII, to the extent and in the manner provided in this Compact, and, provided further, that any Uniform Standard established by the Commission for long-term care insurance products may provide the same or greater protections for consumers as, but shall not provide less than, those protections set forth in the National Association of Insurance Commissioners' Long-Term Care Insurance Model Act and Long-Term Care Insurance Model Regulation, respectively, adopted as of 2001. The Commission shall consider whether any subsequent amendments to the NAIC Long-Term Care Insurance Model Act or Long-Term Care Insurance Model Regulation adopted by the NAIC require amending of the Uniform Standards established by the Commission for long-term care insurance products;

3. To receive and review in an expeditious manner Products filed with the Commission, and rate filings for disability income and long-term care insurance Products, and give approval of those Products and rate filings that satisfy the applicable Uniform Standard, where such approval shall have the force and effect of law and be binding on the Compacting States to the extent and in the manner provided in the Compact;

4. To receive and review in an expeditious manner Advertisement relating to long-term care insurance products for which Uniform Standards have been adopted by the Commission, and give approval to all Advertisement that satisfies the applicable Uniform Standard. For any product covered under this Compact, other than long-term care insurance products, the Commission shall have the authority to require an insurer to submit all or any part of its Advertisement with respect to that product for review or approval prior to use, if the Commission determines that the nature of the product is such that an Advertisement of the product could have the capacity or tendency to mislead the public. The actions of Commission as provided in this section shall have the force and effect of law and shall be binding in the Compacting States to the extent and in the manner provided in the Compact;

5. To exercise its rule-making authority and designate Products and Advertisement that may be subject to a self-certification process without the need for prior approval by the Commission;

6. To promulgate Operating Procedures, pursuant to Article VII of this Compact, which shall be binding in the Compacting States to the extent and in the manner provided in this Compact;

7. To bring and prosecute legal proceedings or actions in its name as the Commission; provided, that the standing of any state insurance department to sue or be sued under applicable law shall not be affected;

8. To issue subpoenas requiring the attendance and testimony of witnesses and the production of evidence;

9. To establish and maintain offices;

10. To purchase and maintain insurance and bonds;

11. To borrow, accept or contract for services of personnel, including, but not limited to, employees of a Compacting State;

12. To hire employees, professionals or specialists, and elect or appoint officers, and to fix their compensation, define their duties and give them appropriate authority to carry out the purposes of the Compact, and determine their qualifications; and to establish the Commission's personnel policies and programs relating to, among other things, conflicts of interest, rates of compensation and qualifications of personnel;

13. To accept any and all appropriate donations and grants of money, equipment, supplies, materials and services, and to receive, utilize and dispose of the same; provided that at all times the Commission shall strive to avoid any appearance of impropriety;

14. To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve or use, any property, real, personal or mixed; provided that at all times the Commission shall strive to avoid any appearance of impropriety;

15. To sell, convey, mortgage, pledge, lease, exchange, abandon or otherwise dispose of any property, real, personal or mixed;

16. To remit filing fees to Compacting States as may be set forth in the Bylaws, Rules or Operating Procedures;

17. To enforce compliance by Compacting States with Rules, Uniform Standards, Operating Procedures and Bylaws;

18. To provide for dispute resolution among Compacting States;

19. To advise Compacting States on issues relating to Insurers domiciled or doing business in Non-compacting jurisdictions, consistent with the purposes of this Compact;

20. To provide advice and training to those personnel in state insurance departments responsible for product review, and to be a resource for state insurance departments;

21. To establish a budget and make expenditures;

22. To borrow money;

23. To appoint committees, including advisory committees comprising Members, state insurance regulators, state legislators or their representatives, insurance industry and consumer representatives, and such other interested persons as may be designated in the Bylaws;

24. To provide and receive information from, and to cooperate with, law-enforcement agencies;

25. To adopt and use a corporate seal; and

26. To perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of the business of insurance.

Article V.

Organization of the Commission.

1. Membership, Voting and Bylaws.

a. Each Compacting State shall have and be limited to one Member. Each Member shall be qualified to serve in that capacity pursuant to applicable law of the Compacting State. Any Member may be removed or suspended from office as provided by the law of the State from which he or she shall be appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the Compacting State wherein the vacancy exists. Nothing herein shall be construed to affect the manner in which a Compacting State determines the election or appointment and qualification of its own Commissioner.

b. Each Member shall be entitled to one vote and shall have an opportunity to participate in the governance of the Commission in accordance with the Bylaws. Notwithstanding any provision herein to the contrary, no action of the Commission with respect to the promulgation of a Uniform Standard shall be effective unless two-thirds of the Members vote in favor thereof.

c. The Commission shall, by a majority of the Members, prescribe Bylaws to govern its conduct as may be necessary or appropriate to carry out the purposes, and exercise the powers, of the Compact, including, but not limited to:

i. Establishing the fiscal year of the Commission;

ii. Providing reasonable procedures for appointing and electing members, as well as holding meetings, of the Management Committee;

iii. Providing reasonable standards and procedures: (i) for the establishment and meetings of other committees, and (ii) governing any general or specific delegation of any authority or function of the Commission;

iv. Providing reasonable procedures for calling and conducting meetings of the Commission that consists of a majority of Commission members, ensuring reasonable advance notice of each such meeting, and providing for the right of citizens to attend each such meeting with enumerated exceptions designed to protect the public's interest, the privacy of individuals, and insurers' proprietary information, including trade secrets. The Commission may meet in camera only after a majority of the entire

membership votes to close a meeting en toto or in part. As soon as practicable, the Commission must make public (i) a copy of the vote to close the meeting revealing the vote of each Member with no proxy votes allowed, and (ii) votes taken during such meeting;

v. Establishing the titles, duties and authority and reasonable procedures for the election of the officers of the Commission;

vi. Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar laws of any Compacting State, the Bylaws shall exclusively govern the personnel policies and programs of the Commission;

vii. Promulgating a code of ethics to address permissible and prohibited activities of Commission members and employees; and

viii. Providing a mechanism for winding up the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of the Compact after the payment and/or reserving of all of its debts and obligations.

d. The Commission shall publish its Bylaws in a convenient form and file a copy thereof and a copy of any amendment thereto, with the appropriate agency or officer in each of the Compacting States.

2. Management Committee, Officers and Personnel.

a. A Management Committee comprising no more than 14 members shall be established as follows:

i. One member from each of the six Compacting States with the largest premium volume for individual and group annuities, life, disability income, and long-term care insurance products, determined from the records of the NAIC for the prior year;

ii. Four members from those Compacting States with at least two percent of the market based on the premium volume described above, other than the six Compacting States with the largest premium volume, selected on a rotating basis as provided in the Bylaws; and

iii. Four members from those Compacting States with less than two percent of the market, based on the premium volume described above, with one selected from each of the four zone regions of the NAIC as provided in the Bylaws.

b. The Management Committee shall have such authority and duties as may be set forth in the Bylaws, including but not limited to:

i. Managing the affairs of the Commission in a manner consistent with the Bylaws and purposes of the Commission;

ii. Establishing and overseeing an organizational structure within, and appropriate procedures for, the Commission to provide for the creation of Uniform Standards and other Rules, receipt and review of product filings, administrative and technical support functions, review of decisions regarding the disapproval of a product filing, and the review of elections made by a Compacting State to opt out of a

Uniform Standard; provided that a Uniform Standard shall not be submitted to the Compacting States for adoption unless approved by two-thirds of the members of the Management Committee;

iii. Overseeing the offices of the Commission; and

iv. Planning, implementing, and coordinating communications and activities with other state, federal and local government organizations in order to advance the goals of the Commission.

c. The Commission shall elect annually officers from the Management Committee, with each having such authority and duties as may be specified in the Bylaws.

d. The Management Committee may, subject to the approval of the Commission, appoint or retain an executive director for such period, upon such terms and conditions and for such compensation as the Commission may deem appropriate. The executive director shall serve as secretary to the Commission, but shall not be a Member of the Commission. The executive director shall hire and supervise such other staff as may be authorized by the Commission.

3. Legislative and Advisory Committees.

a. A legislative committee comprising state legislators or their designees shall be established to monitor the operations of, and make recommendations to, the Commission, including the Management Committee; provided that the manner of selection and term of any legislative committee member shall be as set forth in the Bylaws. Prior to the adoption by the Commission of any Uniform Standard, revision to the Bylaws, annual budget, or other significant matter as may be provided in the Bylaws, the Management Committee shall consult with and report to the legislative committee.

b. The Commission shall establish two advisory committees, one of which shall comprise consumer representatives independent of the insurance industry, and the other comprising insurance industry representatives.

c. The Commission may establish additional advisory committees as its Bylaws may provide for the carrying out of its functions.

4. Corporate Records of the Commission.

The Commission shall maintain its corporate books and records in accordance with the Bylaws.

5. Qualified Immunity, Defense and Indemnification.

a. The Members, officers, executive director, employees and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided, that nothing in this paragraph shall be construed to protect any such person from suit and/or liability for any damage, loss, injury or liability caused by the intentional or willful and wanton misconduct of that person.

b. The Commission shall defend any Member, officer, executive director, employee or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided, that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further, that the actual or alleged act, error or omission did not result from that person's intentional or willful and wanton misconduct.

c. The Commission shall indemnify and hold harmless any Member, officer, executive director, employee or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities; or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities, provided, that the actual or alleged act, error or omission did not result from the intentional or willful and wanton misconduct of that person.

Article VI.

Meetings and Acts of the Commission.

1. The Commission shall meet and take such actions as are consistent with the provisions of this Compact and the Bylaws.

2. Each Member of the Commission shall have the right and power to cast a vote to which that Compacting State is entitled and to participate in the business and affairs of the Commission. A Member shall vote in person or by such other means as provided in the Bylaws. The Bylaws may provide for Members' participation in meetings by telephone or other means of communication.

3. The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the Bylaws.

Article VII.

Rules and Operating Procedures: Rulemaking Functions of the Commission and Opting Out of Uniform Standards.

1. Rulemaking Authority. The Commission shall promulgate reasonable Rules, including Uniform Standards, and Operating Procedures in order to effectively and efficiently achieve the purposes of this Compact. Notwithstanding the foregoing, in the event the Commission exercises its rulemaking authority in a manner that is beyond the scope of the purposes of this Act, or the powers granted hereunder, then such an action by the Commission shall be invalid and have no force and effect.

2. Rulemaking Procedure. Rules and Operating Procedures shall be made pursuant to a rulemaking process that conforms to the Model State Administrative Procedure Act of 1981, as amended, as may be appropriate to the operations of the Commission. Before the Commission adopts a Uniform

Standard, the Commission shall give written notice to the relevant state legislative committee(s) in each Compacting State responsible for insurance issues of its intention to adopt the Uniform Standard. The Commission in adopting a Uniform Standard shall consider fully all submitted materials and issue a concise explanation of its decision.

3. Effective Date and Opt Out of a Uniform Standard. A Uniform Standard shall become effective 90 days after its promulgation by the Commission or such later date as the Commission may determine; provided, however, that a Compacting State may opt out of a Uniform Standard as provided in this Article. "Opt out" shall be defined as any action by a Compacting State to decline to adopt or participate in a promulgated Uniform Standard. All other Rules and Operating Procedures, and amendments thereto, shall become effective as of the date specified in each Rule, Operating Procedure or amendment.

4. Opt Out Procedure. A Compacting State may opt out of a Uniform Standard, either by legislation or regulation duly promulgated by the Insurance Department under the Compacting State's Administrative Procedure Act or duly promulgated pursuant to the Compacting State's law. If a Compacting State elects to opt out of a Uniform Standard by regulation, it must (a) give written notice to the Commission no later than 10 business days after the Uniform Standard is promulgated, or at the time the State becomes a Compacting State and (b) find that the Uniform Standard does not provide reasonable protections to the citizens of the State, given the conditions in the State. The Commissioner or tribunal shall make specific findings of fact and conclusions of law, based on a preponderance of the evidence, detailing the conditions in the State which warrant a departure from the Uniform Standard and determining that the Uniform Standard would not reasonably protect the citizens of the State. The Commissioner or tribunal must consider and balance the following factors and find that the conditions in the State and needs of the citizens of the State outweigh: (i) the intent of the legislature to participate in, and the benefits of, an interstate agreement to establish national uniform consumer protections for the Products subject to this Act; and (ii) the presumption that a Uniform Standard adopted by the Commission provides reasonable protections to consumers of the relevant Product.

Notwithstanding the foregoing, a Compacting State may, at the time of its enactment of this Compact, prospectively opt out of all Uniform Standards involving long-term care insurance products by expressly providing for such opt out in the enacted Compact, and such an opt out shall not be treated as a material variance in the offer or acceptance of any State to participate in this Compact. Such an opt out shall be effective at the time of enactment of this Compact by the Compacting State and shall apply to all existing Uniform Standards involving long-term care insurance products and those subsequently promulgated.

5. Effect of Opt Out. If a Compacting State elects to opt out of a Uniform Standard, the Uniform Standard shall remain applicable in the Compacting State electing to opt out until such time the opt out legislation is enacted into law or the regulation opting out becomes effective.

Once the opt out of a Uniform Standard by a Compacting State becomes effective as provided under the laws of that State, the Uniform Standard shall have no further force and effect in that State unless and until the legislation or regulation implementing the opt out is repealed or otherwise becomes ineffective under the laws of the State. If a Compacting State opts out of a Uniform Standard after the Uniform Standard has been made effective in that State, the opt out shall have the same prospective effect as provided under Article XIV for withdrawals.

6. Stay of Uniform Standard. If a Compacting State has formally initiated the process of opting out of a Uniform Standard by regulation, and while the regulatory opt out is pending, the Compacting State may petition the Commission, at least 15 days before the effective date of the Uniform Standard, to stay the effectiveness of the Uniform Standard in that State. The Commission may grant a stay if it determines the regulatory opt out is being pursued in a reasonable manner and there is a likelihood of success. If a stay is granted or extended by the Commission, the stay or extension thereof may postpone the effective date by up to 90 days, unless affirmatively extended by the Commission; provided, a stay may not be permitted to remain in effect for more than one year unless the Compacting State can show extraordinary circumstances which warrant a continuance of the stay, including, but not limited to, the existence of a legal challenge which prevents the Compacting State from opting out. A stay may be terminated by the Commission upon notice that the rulemaking process has been terminated.

7. Not later than 30 days after a Rule or Operating Procedure is promulgated, any person may file a petition for judicial review of the Rule or Operating Procedure; provided, that the filing of such a petition shall not stay or otherwise prevent the Rule or Operating Procedure from becoming effective unless the court finds that the petitioner has a substantial likelihood of success. The court shall give deference to the actions of the Commission consistent with applicable law and shall not find the Rule or Operating Procedure to be unlawful if the Rule or Operating Procedure represents a reasonable exercise of the Commission's authority.

Article VIII.

Commission Records and Enforcement.

1. The Commission shall promulgate Rules establishing conditions and procedures for public inspection and copying of its information and official records, except such information and records involving the privacy of individuals and insurers' trade secrets. The Commission may promulgate additional Rules under which it may make available to federal and state agencies, including law-enforcement agencies, records and information otherwise exempt from disclosure, and may enter into agreements with such agencies to receive or exchange information or records subject to nondisclosure and confidentiality provisions.

2. Except as to privileged records, data and information, the laws of any Compacting State pertaining to confidentiality or nondisclosure shall not relieve any Compacting State Commissioner of the duty to disclose any relevant records, data, or information to the Commission; provided, that disclosure to the Commission shall not be deemed to waive or otherwise affect any confidentiality requirement; and

further provided, that, except as otherwise expressly provided in this Act, the Commission shall not be subject to the Compacting State's laws pertaining to confidentiality and nondisclosure with respect to records, data, and information in its possession. Confidential information of the Commission shall remain confidential after such information is provided to any Commissioner.

3. The Commission shall monitor Compacting States for compliance with duly adopted Bylaws, Rules, including Uniform Standards, and Operating Procedures. The Commission shall notify any non-complying Compacting State in writing of its noncompliance with Commission Bylaws, Rules or Operating Procedures. If a noncomplying Compacting State fails to remedy its noncompliance within the time specified in the notice of noncompliance, the Compacting State shall be deemed to be in default as set forth in Article XIV.

4. The Commissioner of any State in which an Insurer is authorized to do business, or is conducting the business of insurance, shall continue to exercise his or her authority to oversee the market regulation of the activities of the Insurer in accordance with the provisions of the State's law. The Commissioner's enforcement of compliance with the Compact is governed by the following provisions:

a. With respect to the Commissioner's market regulation of a Product or Advertisement that is approved or certified to the Commission, the content of the Product or Advertisement shall not constitute a violation of the provisions, standards or requirements of the Compact except upon a final order of the Commission, issued at the request of a Commissioner after prior notice to the Insurer and an opportunity for hearing before the Commission.

b. Before a Commissioner may bring an action for violation of any provision, standard or requirement of the Compact relating to the content of an Advertisement not approved or certified to the Commission, the Commission, or an authorized Commission officer or employee, must authorize the action. However, authorization pursuant to this paragraph does not require notice to the Insurer, opportunity for hearing or disclosure of requests for authorization or records of the Commission's action on such requests.

Article IX.

Dispute Resolution.

The Commission shall attempt, upon the request of a Member, to resolve any disputes or other issues that are subject to this Compact and which may arise between two or more Compacting States, or between Compacting States and Non-compacting States, and the Commission shall promulgate an Operating Procedure providing for resolution of such disputes.

Article X.

Product Filing and Approval.

1. Insurers and Third-Party Filers seeking to have a Product approved by the Commission shall file the Product with, and pay applicable filing fees to, the Commission. Nothing in this Act shall be construed to restrict or otherwise prevent an insurer from filing its Product with the insurance department

in any State wherein the insurer is licensed to conduct the business of insurance, and such filing shall be subject to the laws of the States where filed.

2. The Commission shall establish appropriate filing and review processes and procedures pursuant to Commission Rules and Operating Procedures. Notwithstanding any provision herein to the contrary, the Commission shall promulgate Rules to establish conditions and procedures under which the Commission will provide public access to Product filing information. In establishing such Rules, the Commission shall consider the interests of the public in having access to such information, as well as protection of personal medical and financial information and trade secrets, that may be contained in a Product filing or supporting information.

3. Any Product approved by the Commission may be sold or otherwise issued in those Compacting States for which the Insurer is legally authorized to do business.

Article XI.

Review of Commission Decisions Regarding Filings.

1. Not later than 30 days after the Commission has given notice of a disapproved Product or Advertisement filed with the Commission, the Insurer or Third Party Filer whose filing was disapproved may appeal the determination to a review panel appointed by the Commission. The Commission shall promulgate Rules to establish procedures for appointing such review panels and provide for notice and hearing. An allegation that the Commission, in disapproving a Product or Advertisement filed with the Commission, acted arbitrarily, capriciously, or in a manner that is an abuse of discretion or otherwise not in accordance with the law, is subject to judicial review in accordance with Article III, section 4.

2. The Commission shall have authority to monitor, review and reconsider Products and Advertisement subsequent to their filing or approval upon a finding that the Product does not meet the relevant Uniform Standard. Where appropriate, the Commission may withdraw or modify its approval after proper notice and hearing, subject to the appeal process in section 1 above.

Article XII.

Finance.

1. The Commission shall pay or provide for the payment of the reasonable expenses of its establishment and organization. To fund the cost of its initial operations, the Commission may accept contributions and other forms of funding from the National Association of Insurance Commissioners, Compacting States and other sources. Contributions and other forms of funding from other sources shall be of such a nature that the independence of the Commission concerning the performance of its duties shall not be compromised.

2. The Commission shall collect a filing fee from each Insurer and Third Party Filer filing a Product with the Commission to cover the cost of the operations and activities of the Commission and its staff in a total amount sufficient to cover the Commission's annual budget.

3. The Commission's budget for a fiscal year shall not be approved until it has been subject to notice and comment as set forth in Article VII of this Compact.

4. The Commission shall be exempt from all taxation in and by the Compacting States.

5. The Commission shall not pledge the credit of any Compacting State, except by and with the appropriate legal authority of that Compacting State.

6. The Commission shall keep complete and accurate accounts of all its internal receipts, including grants and donations, and disbursements of all funds under its control. The internal financial accounts of the Commission shall be subject to the accounting procedures established under its Bylaws. The financial accounts and reports including the system of internal controls and procedures of the Commission shall be audited annually by an independent certified public accountant. Upon the determination of the Commission, but no less frequently than every three years, the review of the independent auditor shall include a management and performance audit of the Commission. The Commission shall make an Annual Report to the Governor and legislature of the Compacting States, which shall include a report of the independent audit. The Commission's internal accounts shall not be confidential and such materials may be shared with the Commissioner of any Compacting State upon request; provided, however, that any work papers related to any internal or independent audit and any information regarding the privacy of individuals and insurers' proprietary information, including trade secrets, shall remain confidential.

7. No Compacting State shall have any claim to or ownership of any property held by or vested in the Commission or to any Commission funds held pursuant to the provisions of this Compact.

Article XIII.

Compacting States, Effective Date and Amendment.

1. Any State is eligible to become a Compacting State.

2. The Compact shall become effective and binding upon legislative enactment of the Compact into law by two Compacting States; provided, the Commission shall become effective for purposes of adopting Uniform Standards for, reviewing, and giving approval or disapproval of, Products filed with the Commission that satisfy applicable Uniform Standards only after 26 States are Compacting States or, alternatively, by States representing greater than 40 percent of the premium volume for life insurance, annuity, disability income, and long-term care insurance products, based on records of the NAIC for the prior year. Thereafter, it shall become effective and binding as to any other Compacting State upon enactment of the Compact into law by that State.

3. Amendments to the Compact may be proposed by the Commission for enactment by the Compacting States. No amendment shall become effective and binding upon the Commission and the Compacting States unless and until all Compacting States enact the amendment into law.

Article XIV.

Withdrawal, Default and Termination.

1. Withdrawal.

a. Once effective, the Compact shall continue in force and remain binding upon each and every Compacting State; provided, that a Compacting State may withdraw from the Compact (Withdrawing State) by enacting a statute specifically repealing the statute which enacted the Compact into law.

b. The effective date of withdrawal is the effective date of the repealing statute. However, the withdrawal shall not apply to any Product filings approved or self-certified, or any Advertisement of such Products, on the date the repealing statute becomes effective, except by mutual agreement of the Commission and the Withdrawing State unless the approval is rescinded by the Withdrawing State as provided in subsection e of this section.

c. The Commissioner of the Withdrawing State shall immediately notify the Management Committee in writing upon the introduction of legislation repealing this Compact in the Withdrawing State.

d. The Commission shall notify the other Compacting States of the introduction of such legislation within 10 days after its receipt of notice thereof.

e. The Withdrawing State is responsible for all obligations, duties and liabilities incurred through the effective date of withdrawal, including any obligations, the performance of which extend beyond the effective date of withdrawal, except to the extent those obligations may have been released or relinquished by mutual agreement of the Commission and the Withdrawing State. The Commission's approval of Products and Advertisement prior to the effective date of withdrawal shall continue to be effective and be given full force and effect in the Withdrawing State, unless formally rescinded by the Withdrawing State in the same manner as provided by the laws of the Withdrawing State for the prospective disapproval of Products or Advertisement previously approved under State law.

f. Reinstatement following withdrawal of any Compacting State shall occur upon the effective date of the Withdrawing State reenacting the Compact.

2. Default.

a. If the Commission determines that any Compacting State has at any time defaulted (Defaulting State) in the performance of any of its obligations or responsibilities under this Compact, the Bylaws or duly promulgated Rules or Operating Procedures, then, after notice and hearing as set forth in the Bylaws, all rights, privileges and benefits conferred by this Compact on the Defaulting State shall be suspended from the effective date of default as fixed by the Commission. The grounds for default include, but are not limited to, failure of a Compacting State to perform its obligations or responsibilities, and any other grounds designated in Commission Rules. The Commission shall immediately notify the Defaulting State in writing of the Defaulting State's suspension pending a cure of the default. The Commission shall stipulate the conditions and the time period within which the Defaulting State must cure its default. If the Defaulting State fails to cure the default within the time period specified by the Commission, the Defaulting State shall be terminated from the Compact and all rights, privileges and benefits conferred by this Compact shall be terminated from the effective date of termination.

b. Product approvals by the Commission or Product self-certifications, or any Advertisement in connection with such Product, that are in force on the effective date of termination shall remain in force in the Defaulting State in the same manner as if the Defaulting State had withdrawn voluntarily pursuant to paragraph 1 of this Article.

c. Reinstatement following termination of any Compacting State requires a reenactment of the Compact.

3. Dissolution of Compact.

a. The Compact dissolves effective upon the date of the withdrawal or default of the Compacting State which reduces membership in the Compact to one Compacting State.

b. Upon the dissolution of this Compact, the Compact becomes null and void and shall be of no further force or effect, and the business and affairs of the Commission shall be wound up and any surplus funds shall be distributed in accordance with the Bylaws.

Article XV.

Severability and Construction.

1. The provisions of this Compact shall be severable; and if any phrase, clause, sentence, or provision is deemed unenforceable, the remaining provisions of the Compact shall be enforceable.

2. The provisions of this Compact shall be liberally construed to effectuate its purposes.

Article XVI.

Binding Effect of Compact and Other Laws.

1. Other Laws.

a. Nothing herein prevents the enforcement of any other law of a Compacting State, except as provided in paragraph b of this Article.

b. For any Product approved or certified to the Commission, the Rules, Uniform Standards, and any other requirements of the Commission shall constitute the exclusive provisions applicable to the content, approval and certification of such Products. For Advertisement that is subject to the Commission's authority, any Rule, Uniform Standard or other requirement of the Commission which governs the content of the Advertisement shall constitute the exclusive provision that a Commissioner may apply to the content of the Advertisement. Notwithstanding the foregoing, no action taken by the Commission shall abrogate or restrict: (i) the access of any person to State courts; (ii) remedies available under State law related to breach of contract, tort, or other laws not specifically directed to the content of the Product; (iii) State law relating to the construction of insurance contracts; or (iv) the authority of the attorney general of the State, including but not limited to maintaining any actions or proceedings, as authorized by law.

c. All insurance Products filed with individual States shall be subject to the laws of those States.

2. Binding Effect of this Compact.

a. All lawful actions of the Commission, including all Rules and Operating Procedures promulgated by the Commission, are binding upon the Compacting States.

b. All agreements between the Commission and the Compacting States are binding in accordance with their terms.

c. Upon the request of a party to a conflict over the meaning or interpretation of Commission actions, and upon a majority vote of the Compacting States, the Commission may issue advisory opinions regarding the meaning or interpretation in dispute.

d. In the event any provision of this Compact exceeds the constitutional limits imposed on the legislature of any Compacting State, the obligations, duties, powers or jurisdiction sought to be conferred by that provision upon the Commission shall be ineffective as to that Compacting State, and those obligations, duties, powers or jurisdiction shall remain in the Compacting State and shall be exercised by the agency thereof to which those obligations, duties, powers or jurisdiction are delegated by law in effect at the time this Compact becomes effective.

2004, c. 761.

§ 38.2-6201. Appointment of representative.

The Commissioner of Insurance is hereby appointed as the Commonwealth's representative to the Interstate Insurance Product Regulation Commission.

2004, c. 761.

Chapter 63 - HEALTH CARE SHARING MINISTRIES

§ 38.2-6300. Definition.

As used in this chapter, "health care sharing ministry" means a health care cost sharing arrangement among individuals of the same religion based on their sincerely held religious beliefs, which arrangement is administered by a non-profit organization that has been granted an exemption from federal income taxation pursuant to § 501(c)(3) of the Internal Revenue Code of 1986 and that:

1. Limits its membership to individuals who are of a similar faith;

2. Acts as an organizational clearinghouse for information about members who have financial or medical needs and matches them with members with the present ability to assist those with financial or medical needs, all in accordance with the organization's criteria;

3. Provides for the financial or medical needs of a member through payments directly from one member to another. The requirements of this subdivision 3 may be satisfied by a trust established solely for the benefit of members, which trust is audited annually by an independent auditing firm;

4. Provides amounts that members/subscribers may contribute with (i) no assumption of risk or promise to pay among the members and (ii) no assumption of risk or promise to pay by the organization to the members;

5. Provides written monthly statements to all members that list the total dollar amount of qualified needs submitted to the organization by members for their contribution; and

6. Provides in substance the following written disclaimer on or accompanying all promotional documents distributed by or on behalf of the organization, including applications and guideline materials:

"Notice:

This publication is not insurance, and is not offered through an insurance company. Whether anyone chooses to assist you with your medical bills will be totally voluntary, as no other member will be compelled by law to contribute toward your medical bills. As such, this publication should never be considered to be insurance. Whether you receive any payments for medical expenses and whether or not this publication continues to operate, you are always personally responsible for the payment of your own medical bills."

2008, c. 232.

§ 38.2-6301. Health care sharing ministry not providing insurance.

The provisions of this title shall not apply to a health care sharing ministry. A health care sharing ministry that, through its publication to members, solicits funds for the payment of medical expenses of other members, shall not be considered to be engaging in the business of insurance for purposes of this title and shall not be subject to the jurisdiction of the Commission.

2008, c. 232.

Chapter 64 - Guaranteed Asset Protection Waivers

§ 38.2-6400. Definitions.

As used in this chapter, unless the context requires another meaning:

"Administrator" means a person, other than an insurer or creditor, that performs administrative or operational functions pursuant to a guaranteed asset protection waiver program.

"Borrower" means a debtor, retail buyer, or lessee, under a finance agreement.

"Commercial transaction" means a transaction entered into primarily for a purpose other than personal, family, or household purposes.

"Creditor" means:

1. The lender in a loan or credit transaction;

2. The lessor in a lease transaction;

3. The seller in a commercial retail installment transaction; or

4. The assignees of any person described in subdivision 1, 2, or 3 to whom the credit obligation is payable.

"Finance agreement" means (i) a loan secured by a lien on a motor vehicle or (ii) a lease or retail installment sales contract for the lease or purchase of a motor vehicle.

"Free look period" means the period of time from the effective date of the guaranteed asset protection waiver until the date the borrower may cancel the borrower's finance agreement without penalty, fees, or costs to the borrower. This period of time shall not be shorter than 30 days.

"Guaranteed asset protection waiver" or "GAP waiver" means a contractual agreement wherein a creditor agrees for a separate charge to cancel or waive all or part of amounts due on a borrower's finance agreement in the event of a total physical damage loss or unrecovered theft of a motor vehicle, which agreement is part of, or a separate addendum to, the finance agreement.

"Insurer" means an insurance company licensed, registered, or otherwise authorized to do business under the laws of the Commonwealth.

"Motor vehicle" means any self-propelled or towed vehicle designed for personal or commercial use, including any automobile, truck, motorcycle, off-road vehicle, all-terrain vehicle, recreational vehicle, snowmobile, camper, boat, personal watercraft, and motorcycle, boat, camper, or personal watercraft trailer.

"Retail buyer" means a person who buys motor vehicles not principally for the purpose of resale.

"Retail seller" means person that is regularly engaged in the selling of motor vehicles to retail buyers and that holds any necessary license to sell a motor vehicle to a retail buyer.

2019, cc. 799, 800.

§ 38.2-6401. Requirements for offering guaranteed asset protection waivers.

A. Guaranteed asset protection waivers may be offered, sold, or provided to borrowers in the Commonwealth in compliance with this chapter.

B. GAP waivers may, at the option of the creditor, be sold for a single payment or may be offered with a monthly or periodic payment option.

C. Notwithstanding any other provision of law, any cost to the borrower for a GAP waiver entered into in compliance with the federal Truth in Lending Act, 15 U.S.C. § 1601 et seq., and its implementing regulations, as they may be amended from time to time, shall be separately stated and shall not be considered a finance charge or interest.

D. A retail seller shall insure its GAP waiver obligations under a contractual liability or other insurance policy issued by an insurer. A creditor, other than a retail seller, may insure its GAP waiver obligations under a contractual liability policy or other policy issued by an insurer as provided in § 38.2-6402. Any such insurance policy may be directly obtained by a creditor or retail seller or may be procured by an administrator to cover a creditor's or retail seller's obligations. However, retail sellers that are lessors on motor vehicles are not required to insure obligations related to GAP waivers on the leased vehicles.

E. The GAP waiver shall remain a part of the finance agreement upon the assignment, sale, or transfer of the finance agreement by the creditor.

F. Neither the extension of credit, the term of credit, nor the term of the related motor vehicle sale or lease may be conditioned upon the purchase of a GAP waiver.

G. Any creditor that offers a GAP waiver shall report the sale of GAP waivers and shall forward funds received on all GAP waivers to the designated party, if any, as prescribed in any applicable administrative services agreement, contractual liability policy, other insurance policy, or other specified program documents.

H. Funds received or held by a creditor or administrator and belonging to an insurer, creditor, or administrator pursuant to the terms of a written agreement shall be held by the creditor or administrator in a fiduciary capacity.

2019, cc. 799, 800.

§ 38.2-6402. Contractual liability or other insurance policies.

A. Contractual liability or other insurance policies insuring GAP waivers shall state the obligation of the insurer to reimburse or pay to the creditor any sums the creditor is legally obligated to waive under the GAP waivers issued by the creditor and purchased or held by the borrower.

B. Coverage under a contractual liability or other insurance policy insuring a GAP waiver shall also cover any subsequent assignee upon the assignment, sale, or transfer of the finance agreement.

C. Coverage under a contractual liability or other insurance policy insuring a GAP waiver shall remain in effect unless canceled or terminated in compliance with applicable insurance laws of the Commonwealth.

D. The cancellation or termination of a contractual liability or other insurance policy shall not reduce the insurer's responsibility for GAP waivers issued by the creditor prior to the date of cancellation or termination and for which a premium has been received by the insurer.

2019, cc. 799, 800.

§ 38.2-6403. Disclosures.

Guaranteed asset protection waivers shall disclose, as applicable, in writing and in clear, understandable language that is easy to read the following:

1. The name and address of the initial creditor and the borrower at the time of sale;

2. The identity of any administrator if different from the creditor;

3. The purchase price and the terms of the GAP waiver, including the requirements for protection, conditions, or exclusions associated with the GAP waiver;

4. That the borrower may cancel the GAP waiver within a free look period as specified in the waiver and that the borrower is entitled to a full refund of the purchase price if no benefits have been provided;

5. The procedure the borrower is required to follow, if any, to obtain GAP waiver benefits under the terms and conditions of the waiver, including a telephone number and address where the borrower may apply for waiver benefits;

6. Whether or not the GAP waiver is cancelable after the free look period and the conditions under which it may be canceled or terminated, including the procedures for requesting any refund due;

7. That in order to receive any refund due in the event of a borrower's cancellation of the GAP waiver agreement or early termination of the finance agreement after the free look period of the GAP waiver, the borrower, in accordance with terms of the waiver, is required to provide a written request to cancel to the creditor, administrator, or such other party. If the GAP waiver is canceled as a result of the early termination of the finance agreement, the borrower shall provide the request within 90 days of the occurrence of the event terminating the finance agreement;

8. The methodology for calculating any refund of the unearned purchase price of the GAP waiver due, in the event of cancellation of the GAP waiver or early termination of the finance agreement; and

9. That neither the extension of credit, the terms of the credit, nor the terms of the related motor vehicle sale or lease may be conditioned upon the purchase of the GAP waiver.

2019, cc. 799, 800.

§ 38.2-6404. Cancellation.

A. Guaranteed asset protection waiver agreements may be cancelable or non-cancelable after the free look period. GAP waivers shall provide that if a borrower cancels a waiver within the free look period, the borrower will be entitled to a full refund of the purchase price, if no benefits have been provided.

B. In the event of a borrower's cancellation of the GAP waiver or early termination of the finance agreement, after the agreement has been in effect beyond the free look period, the borrower may be entitled to a refund of any unearned portion of the purchase price of the waiver unless the waiver provides otherwise. In order to receive any refund due in the event of a borrower's cancellation of the GAP waiver agreement or early termination of the finance agreement after the free look period of the GAP waiver, the borrower, in accordance with the terms of the waiver, is required to provide a written request to cancel to the creditor, administrator, or such other party. If the GAP waiver is canceled as a result of the early termination of the finance agreement, the borrower shall provide the request within 90 days of the occurrence of the event terminating the finance agreement.

C. If the cancellation of a GAP waiver occurs as a result of a default under the finance agreement or the repossession of the motor vehicle associated with the finance agreement, or any other termination of the finance agreement, any refund due may be paid directly to the creditor or administrator and applied as set forth in subsection D.

D. Any cancellation refund under subsection A, B, or C may be applied by the creditor as a reduction of the amount owed under the finance agreement unless the borrower can show that the finance agreement has been paid in full.

2019, cc. 799, 800.

§ 38.2-6405. Commercial transactions.

Subsection C of § 38.2-6401 and § 38.2-6403 do not apply to a guaranteed asset protection waiver offered in connection with a lease or retail installment sale associated with a commercial transaction.

2019, cc. 799, 800.

§ 38.2-6406. GAP waivers not insurance.

GAP waivers governed under this chapter are not insurance and are exempt from the insurance laws of the Commonwealth. Persons marketing, soliciting, negotiating, selling, or offering to sell GAP waivers that comply with this chapter are exempt from the Commonwealth's licensing requirements.

2019, cc. 799, 800.

§ 38.2-6407. Exemptions from chapter.

This chapter does not apply to:

1. Any insurance policy offered by an insurer under the insurance laws of the Commonwealth; or

2. A debt cancellation or debt suspension contract offered (i) by a bank or credit union regulated pursuant to Title 6.2 or (ii) in compliance with 12 C.F.R. Part 37, 12 C.F.R. Part 721, or other federal law.

2019, cc. 799, 800.

Chapter 65 - Virginia Health Benefit Exchange

§ 38.2-6500. Definitions.

As used in this chapter, unless the context requires a different meaning:

"American Health Benefit Exchange" means the program established as a component of the Exchange pursuant to this chapter that is designed to facilitate the purchase of qualified health plans or qualified dental plans by qualified individuals.

"Bureau" means the Bureau of Insurance, a division within the Commission through which it administers insurance law.

"Certified application counselor" means individuals certified by the Exchange to perform the duties described in 45 C.F.R. § 155.255(c).

"Commission" means the State Corporation Commission.

"Committee" means the Advisory Committee established pursuant to § 38.2-6503.

"Director" means the Director of the Division appointed by the Commission pursuant to § 38.2-6502.

"Division" means the Health Benefit Exchange Division, a division within the Commission through which it administers the Exchange.

"Eligible employee" means an individual employed by a qualified employer who has been offered health insurance coverage by such qualified employer through the SHOP exchange.

"Eligible entity" means the Bureau, the Department of Medical Assistance Services, or a qualified vendor that has demonstrated experience on a statewide or regional basis in individual and small group health insurance markets and in benefits coverage; however, a health carrier or an affiliate of a health carrier is not an eligible entity.

"Essential health benefits package" means the scope of covered benefits and associated limits of a health benefit plan that (i) provides benefits pursuant to § 38.2-3451; (ii) provides the benefits in the manner described in 45 C.F.R. § 156.115; (iii) limits cost-sharing for such coverage as described in 45 C.F.R. § 156.130; and (iv) subject to offering catastrophic plans as described in § 1302(e) of the Federal Act, provides distinct levels of coverage as described in 45 C.F.R. § 156.140.

"Exchange" means, as the context requires, either (i) the Division or (ii) the Virginia Health Benefit Exchange established pursuant to the provisions of this chapter and in accordance with § 1311(b) of the Federal Act, through which qualified health plans and qualified dental plans are made available to qualified individuals through the American Health Benefit Exchange and to qualified employers through the SHOP exchange. "Exchange," when referring to the Virginia Health Benefit Exchange, collectively refers to both the American Health Benefit Exchange and the SHOP exchange.

"FAMIS" means the Family Access to Medical Insurance Security Plan, including the FAMIS Plus program, established pursuant to Chapter 13 (§ 32.1-351 et seq.) of Title 32.1.

"Federal Act" means the federal Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, P.L. 111-152, and as it may further be amended, and regulations issued thereunder.

"Health benefit plan" or "plan" means a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. The term does not include coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for onsite medical clinics; or other similar insurance coverage, specified in federal regulations issued pursuant to the Federal Act, under which benefits for medical care are secondary or incidental to other insurance benefits. The term does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or other similar limited benefits specified in federal regulations issued pursuant to the Federal Act. The term does not include the following benefits if the

benefits are provided under a separate policy, certificate, or contract of insurance; there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor; and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor: coverage only for a specified disease or illness, for hospital indemnity, or other fixed indemnity insurance. The term does not include the following if offered as a separate policy, certificate, or contract of insurance: Medicare supplemental health insurance as defined under § 1882(g)(1) of the U.S. Social Security Act; coverage supplemental to the coverage provided under 10 U.S.C. § 1071 et seq. (TRICARE); or similar supplemental coverage provided under a group health plan.

"Health carrier" or "carrier" means an entity subject to the insurance laws and regulations of the Commonwealth and subject to the jurisdiction of the Commission that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an insurer licensed to sell accident and sickness insurance, a health maintenance organization, a health services plan, a dental plan organization, a dental services plan, or any other entity providing a plan of health insurance, health benefits, or health care services.

"Insurance agent" has the same meaning as provided in § 38.2-1800.

"Minimum essential coverage" means coverage defined in 45 C.F.R. § 156.600.

"Navigator" means an individual or entity that is registered pursuant to § 38.2-3457.

"PHSA" means the federal Public Health Service Act, Chapter 6A of Title 42 of the United States Code, as amended.

"Qualified dental plan" means a limited scope dental plan that has been certified in accordance with § 38.2-6506.

"Qualified employer" means a small employer that elects to make all of its full-time employees eligible for one or more qualified health plans or qualified dental plans in the small group market offered through the SHOP exchange and, at the employer's option, some or all of its part-time employees, provided that the employer (i) has its principal place of business in the Commonwealth and elects to provide coverage through the SHOP exchange to all of its eligible employees, wherever employed, or (ii) elects to provide coverage through the SHOP exchange to all of its eligible employees who are principally employed in the Commonwealth.

"Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in § 1311(c) of the Federal Act and § 38.2-6506.

"Qualified individual" means an individual, including a minor, who (i) is seeking to enroll in a qualified health plan or qualified dental plan offered to individuals through the Exchange; (ii) resides in the Commonwealth; (iii) is not incarcerated at the time of enrollment, other than incarceration pending the disposition of charges; and (iv) is, and is reasonably expected to be, for the entire period for which

enrollment is sought, a citizen or a national of the United States or an alien lawfully present in the United States.

"Secretary" means the Secretary of the U.S. Department of Health and Human Services.

"SHOP exchange" means the Small Business Health Options Program, established as a component of the Exchange pursuant to this chapter, through which a qualified employer can provide its eligible employees and their dependents with access to one or more qualified health plans or qualified dental plans.

"Small employer" means an employer that employed an average of not more than 50 employees during the preceding calendar year. For the purposes of this definition: (a) all persons treated as a single employer under subsection (b), (c), (m), or (o) of 26 U.S.C. § 414 shall be treated as a single employer; (b) an employer and any predecessor employer shall be treated as a single employer; and (c) all employees shall be counted, including part-time employees and employees who are not eligible for health insurance coverage through the employer. If an employer was not in existence throughout the preceding calendar year, the determination of whether the employer is a small employer shall be based on the average number of employees reasonably expected to be employed by the employer on business days in the current calendar year. An employer that makes enrollment in qualified health plans or qualified dental plans available to its eligible employees through the SHOP exchange and that no longer meets the definition of a small employer because of an increase in the number of its employees shall continue to be treated as a small employer for purposes of this chapter as long as that employer continuously makes enrollment through the SHOP exchange available to its eligible employees.

"Small group market" means the health insurance market under which individuals obtain health insurance coverage, directly or through any arrangement, on behalf of themselves and their dependents through a group health plan maintained by a small employer.

"State-mandated health benefit" means coverage required under this title or other laws of the Commonwealth to be provided in a policy of accident and sickness insurance, an accident and sickness subscription contract, or a health maintenance organization health care plan that includes coverage for specific health care services or benefits.

"State Medicaid Program" means the Commonwealth's Medicaid program under Title XIX of the Social Security Act, as amended from time to time.

2020, cc. 916, 917.

§ 38.2-6501. Exchange objectives.

The Virginia Health Benefit Exchange shall make qualified health plans and qualified dental plans available to qualified individuals in the Commonwealth and provide for the establishment of a Small Business Health Options Program to assist qualified small employers in the Commonwealth in facilitating the enrollment of their eligible employees in qualified health plans and qualified dental plans

offered in the small group market. The Exchange shall promote a transparent and competitive marketplace, promote consumer choice and education, and assist individuals with access to programs, policies and procedures, premium assistance tax credits, and cost-sharing reductions to support the continuity of coverage and reduce the number of uninsured.

2020, cc. 916, 917.

§ 38.2-6502. Division established; Exchange created.

A. The Commission shall establish the Health Benefit Exchange Division as a separate division within the Commission. The Virginia Health Benefit Exchange shall be established and administered by the Commission, through the Division, in compliance with the requirements of this chapter and the Federal Act. The Exchange shall facilitate the purchase and sale of qualified health plans and qualified dental plans to qualified individuals and qualified employers. The Commission shall ensure that the Exchange and Bureau Divisions work in agreement to administer consistent regulation of Exchange plans.

B. The Commission shall appoint a Director of the Division, who shall have overall management responsibility for the Exchange.

C. The Commission, through the Division, shall have governing power and authority in any matter pertaining to the Exchange. The Commission may delegate as it may deem proper such powers and duties to the Director.

D. The Commission shall carry out its duties and responsibilities under this chapter in accordance with its rules of practice and procedure and shall decide all matters related to the Exchange in the same manner as it does when performing its other regulatory, judicial, and administrative duties and responsibilities under this Code.

E. The Commission may adopt rules and regulations pursuant to § 38.2-223 as may be necessary or appropriate for the administration of the Exchange.

2020, cc. 916, 917.

§ 38.2-6503. Advisory Committee.

A. There is hereby established an Advisory Committee in accordance with § 1311 (d) of the Federal Act and 45 C.F.R. § 155.110 to advise and provide recommendations to the Commission and the Director in carrying out the purposes and duties of the Exchange. The Committee shall consist of up to 15 members. Members shall be appointed as follows: five nonlegislative citizen members to be appointed by the Governor, each of whom shall have demonstrated and acknowledged expertise in individual health coverage, small employer health coverage, health benefits plan administration, health care finance and economics, actuarial science, or with expertise in eligibility and enrollment in health care affordability programs and public health insurance; at least three nonlegislative citizen members appointed by the Commission, including an individual representing an organization that represents the Virginia insurance industry, an individual representing insurance agents, and a consumer representative; and any other members determined by the Commission. The Commissioner of Insurance,

the Director of the Department of Medical Assistance Services, the State Health Commissioner, the Commissioner of the Department of Social Services, and the Secretary of Health and Human Resources, or their designees, shall serve as ex officio nonvoting members of the Committee.

B. No member of the Committee shall be a legislator or hold any elective office in state government.

C. A majority of the members appointed by the Governor and a majority of the members appointed by the Commission shall have no conflict of interest as set forth in the Federal Act.

D. After the initial staggering of terms, nonlegislative citizen members shall be appointed for a term of four years. No nonlegislative citizen member shall serve more than two consecutive four-year terms. The remainder of any term to which a member is appointed to fill a vacancy shall not constitute a term in determining the member's eligibility for reappointment.

E. The Committee shall elect a chairman and vice-chairman from among its membership. A majority of the appointed members shall constitute a quorum.

F. All meetings of the Committee shall be announced at least one week in advance on the Exchange website and shall be open to the public. The Committee shall permit reasonable public comment concerning matters on a meeting's agenda at meetings not less frequently than biennially. The Committee shall announce prior to its meetings whether public comment will be accepted. The Committee shall accept written comment from the public on an ongoing basis.

G. Minutes of meetings of the Committee, which shall include the Committee's recommendations and responses to its recommendations, shall be available to the public and posted on the Exchange's website.

2020, cc. 916, 917.

§ 38.2-6504. Exchange requirements.

A. The Exchange shall make qualified health plans and qualified dental plans available to qualified individuals and qualified employers, beginning on a date set by the Commission, which date shall not be later than January 1, 2023, unless the Commission determines that postponement of such date is necessary to complete the establishment of the Exchange. The Exchange shall not make available any health benefit plan that is not a qualified health plan. The Exchange shall allow a health carrier to offer a qualified dental plan either to supplement a qualified health plan or separately, as practicable.

B. The Exchange shall provide for the establishment of a SHOP exchange that will permit enrollment of eligible employees of qualified small employers in the Commonwealth directly through qualified health plan issuers, qualified dental plan issuers, or licensed agents that meet established Exchange standards.

C. The Exchange shall allow a health carrier to offer a plan that provides limited scope dental benefits meeting the requirements of § 9832(c)(2)(A) of the Internal Revenue Code of 1986 through the Exchange, if the plan provides pediatric dental benefits meeting the requirements of § 1302(b)(1)(J) of the Federal Act.

D. Neither the Exchange nor a carrier offering qualified health benefit plans through the Exchange may charge an individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because the individual has become newly eligible for that coverage or because the individual's employer-sponsored coverage has become affordable under the standards of § 36B(c)(2)(C) of the Internal Revenue Code of 1986.

E. The Exchange and any associated programs shall be established and operated and offer plans in compliance with § 1321 (b) of the Federal Act.

2020, cc. 916, 917.

§ 38.2-6505. Duties of Exchange.

The Exchange shall:

1. Implement procedures for the certification, recertification, and decertification of qualified health plans and qualified dental plans consistent with guidelines developed by the Secretary under § 1311 (c) of the Federal Act and § 38.2-6506;

2. Provide for enrollment periods under § 1311(c)(6) of the Federal Act;

3. Provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

4. Utilize a website on which enrollees and prospective enrollees of qualified health plans and qualified dental plans may obtain standardized comparative information. Information on qualified health plans shall include, at a minimum, (i) premium and cost-sharing information; (ii) the summary of benefits and coverage offered; (iii) identification of a qualified health plan as a bronze-level, silver-level, gold-level, or platinum-level plan as defined by § 1302(d) of the Federal Act or a catastrophic plan as defined by § 1302(e) of the Federal Act; (iv) the results of enrollee satisfaction surveys, described in § 1311(c)(4) of the Federal Act; (v) quality ratings assigned pursuant to § 1311(c)(3) of the Federal Act; (vi) medical loss ratio information as reported to the Secretary in accordance with 45 C.F.R. Part 158; (vii) transparency of coverage measures reported to the Exchange during certification processes; and (viii) the provider directory made available to the Exchange. The website shall be accessible to persons with disabilities, shall provide meaningful access for persons with limited English proficiency, and shall contain the information described in clauses (i) through (viii) without diversion to a website of a carrier;

5. Assign a rating to each qualified health plan offered through the Exchange in accordance with the criteria developed by the Secretary under § 1311(c)(3) of the Federal Act;

6. Determine each qualified health plan's level of coverage in accordance with regulations issued by the Secretary under § 1302(d)(2)(A) of the Federal Act;

7. Use a standardized format for presenting health benefit options in the Exchange, including the use of the uniform outline of coverage as established under § 2715 of the PHSA, 42 U.S.C. § 300gg-15;

8. Inform individuals, in accordance with § 1413 of the Federal Act, of eligibility requirements for (i) the State Medicaid Program; (ii) the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act, including FAMIS, as amended from time to time; or (iii) any applicable state or local public health subsidy program, and enroll an individual in such program if it is determined, through screening of the application, that such individual is eligible for any such program;

9. Make available by electronic means through the website described in subdivision 4 a calculator to determine the actual cost of coverage after application of any premium assistance tax credit under 26 U.S.C. § 36B and any cost-sharing reduction under § 1402 of the Federal Act;

10. Establish an American Health Benefit Exchange through which qualified individuals may enroll in any qualified health plan or qualified dental plan offered through the American Health Benefit Exchange for which they are eligible and establish a SHOP exchange through which qualified employers may make their eligible employees eligible for one or more qualified health plans or qualified dental plans offered through the SHOP exchange or specify a level of coverage so that any of their eligible employees may enroll in any qualified health plan or qualified dental plan offered through the SHOP exchange at the specified level of coverage;

11. Subject to § 1411 of the Federal Act, grant a certification attesting that, for purposes of the individual responsibility penalty under § 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual responsibility requirement or from the penalty imposed by that section because there is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual or the individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

12. Transfer to the U.S. Secretary of the Treasury the following:

a. A list of the individuals who are issued a certification under subdivision 11, including the name and taxpayer identification number of each individual;

b. The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium assistance tax credit under 26 U.S.C. § 36B because (i) the employer did not provide minimum essential coverage or (ii) the employer provided minimum essential coverage but a determination under 26 U.S.C. § 36B(c)(2)(C) found that either the coverage was unaffordable for the employee or did not provide the required minimum actuarial value; and

c. The name and taxpayer identification number of (i) each individual who notifies the Exchange under 42 U.S.C. § 18081 that the individual has changed employers and (ii) each individual who ceases coverage under a qualified health plan and the effective date of the cessation;

13. Provide to each employer the name of each of the employer's employees described in subdivision 12 b who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

14. Perform duties required of the Exchange by the Secretary or the U.S. Secretary of the Treasury related to determining eligibility for premium assistance tax credits, reduced cost-sharing, or individual responsibility requirement exemptions;

15. Certify entities qualified to serve as Navigators in accordance with § 1311(i) of the Federal Act and § 38.2-6513;

16. Consult with stakeholders relevant to carrying out the activities required under this chapter, including:

a. Health care consumers who are enrollees in qualified health plans and qualified dental plans;

b. Individuals and entities with experience in facilitating enrollment in qualified health plans and qualified dental plans;

c. Advocates for enrolling hard-to-reach populations, which include individuals with mental health or substance use disorders;

d. Representatives of small businesses and self-employed individuals;

e. The Department of Medical Assistance Services;

f. Federally recognized tribes, as defined in the Federally Recognized Indian Tribe List Act of 1994 (25 U.S.C. § 479a), that are located within the Exchange's geographic area;

g. Public health experts;

h. Health care providers;

i. Large employers;

j. Health carriers; and

k. Insurance agents;

17. Meet the following financial integrity requirements:

a. Keep an accurate accounting of all activities, receipts, and expenditures and annually submit to the Secretary, the Governor, and the Commission a report concerning such accountings;

b. Fully cooperate with any investigation conducted by the Secretary pursuant to the Secretary's authority under the Federal Act and allow the Secretary, in coordination with the Inspector General of the U.S. Department of Health and Human Services, to:

(1) Investigate the affairs of the Exchange;

(2) Examine the properties and records of the Exchange; and

(3) Require periodic reports in relation to the activities undertaken by the Exchange; and

c. Not use any funds in carrying out its activities under this chapter that are intended for the administrative and operational expenses of the Exchange for staff retreats, promotional giveaways,

excessive executive compensation, or promotion of federal or state legislative and regulatory modifications;

18. In collaboration with the Department of Medical Assistance Services, coordinate the operations of the Exchange with the operations of the state plan for medical assistance to determine initial and ongoing eligibility for those programs in a streamlined fashion;

19. Identify systems, policies, and practices to achieve the requirements of subdivisions 8 and 18 and in doing so, consult with stakeholders, including the Department of Taxation, the Department of Medical Assistance Services, the Department of Social Services, consumer groups, insurers, health care providers, navigators or other consumer assisters, insurance brokers or agents, and other relevant stakeholders selected by the Exchange;

20. Prepare an annual marketing plan that includes consumer outreach, licensed health insurance agents, and navigator programs; and

21. Take any other actions necessary and appropriate to ensure that the Exchange complies with the requirements of the Federal Act.

2020, cc. 916, 917; 2021, Sp. Sess. I, c. 162; 2022, cc. 250, 251.

§ 38.2-6506. Certification of health benefit plans as qualified health plans.

A. The Exchange, in consultation with the Bureau, shall certify a health benefit plan as a qualified health plan, unless the Exchange determines that making the plan available through the Exchange is not in the interest of qualified individuals and qualified employers in the Commonwealth, if:

1. The plan provides health benefits in the essential health benefits package. The plan may provide any state-mandated health benefit that is not provided in the essential health benefits package. The plan is not required to provide benefits that duplicate the minimum benefits of qualified dental plans, as set forth in subsection F, if (i) the Exchange has determined that at least one qualified dental plan is available to supplement the plan's coverage and (ii) the health carrier makes prominent disclosure at the time it offers the plan, in a form approved by the Bureau, that such plan does not provide the full range of pediatric dental benefits included in the essential health benefits package and that qualified dental plans providing those benefits and other dental benefits not covered by such plan are offered through the Exchange;

2. The premium rates and policy forms have been approved by or filed with the Commission, in accordance with §§ 38.2-316 and 38.2-316.1;

3. The plan provides at least a bronze level of coverage unless the plan is certified as a qualified catastrophic plan, meets the requirements of the Federal Act for catastrophic plans, and will only be offered to individuals eligible for catastrophic coverage;

4. The plan's cost-sharing requirements do not exceed the limits established under § 1302(c)(1) of the Federal Act;

5. The health carrier offering the plan:

a. Is licensed and in good standing to offer health insurance coverage in the Commonwealth;

b. Offers (i) at least one qualified health plan in the silver level of coverage and one qualified health plan at a gold level of coverage throughout each service area in which it offers coverage through the Exchange and (ii) a child-only plan at the same level of coverage as any qualified health plan offered through the Exchange to individuals who, as of the beginning of the plan year, are less than 21 years of age;

c. Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the Exchange or directly by the health carrier or through an agent;

d. Does not charge any cancellation fees or penalties in violation of subsection D of § 38.2-6504; and

e. Complies with the regulations developed by the Secretary under § 1311(d) of the Federal Act and such other requirements as the Exchange may establish; and

6. The plan meets the requirements of certification as adopted by regulation pursuant to § 38.2-6514 or promulgated by the Secretary under § 1311(c) of the Federal Act, which include minimum standards in the areas of marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms, and descriptions of coverage and information on quality measures for health benefit plan performance.

B. The Exchange shall not refuse to certify a health benefit plan as a qualified health plan (i) on the basis that the plan is a fee-for-service plan, (ii) through the imposition of premium price controls by the Exchange, or (iii) on the basis that the health benefit plan provides treatments necessary to prevent patients' deaths in circumstances that the Exchange determines are inappropriate or too costly.

C. In order to foster a competitive marketplace and consumer choice, the Exchange shall certify all health benefit plans recommended by the Bureau meeting the requirements of § 1311(c) of the Federal Act for participation in the Exchange unless it is not in the interest of qualified individuals and qualified employers. The Exchange shall establish and publish a transparent, objective process for decertifying qualified health plans if it is determined that it is not in the public interest to permit such plans to be offered through the Exchange.

D. The Exchange shall require each health carrier seeking certification of a health benefit plan as a qualified health plan to permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, copayments, and coinsurance, under the individual's plan or coverage that such individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through the Exchange's website and through other means for individuals without access to the Internet.

E. The Exchange shall apply the criteria of this section in a manner that assures a level playing field between or among health carriers participating in the Exchange.

F. The provisions of this chapter that are applicable to qualified health plans shall also apply to the extent applicable to qualified dental plans, except as modified (i) by regulations adopted by the Commission or (ii) in accordance with the following:

1. A health carrier seeking certification of a dental benefit plan as a qualified dental plan shall be licensed in the Commonwealth to offer dental coverage but need not be licensed to offer other health benefits;

2. Qualified dental plans shall be limited to dental and oral health benefits, without substantial duplication of the benefits typically offered by health benefit plans without dental coverage, and shall include, at a minimum, the pediatric dental benefits prescribed by the Secretary pursuant to § 1302(b)(1)(J) of the Federal Act and such other dental benefits as the Exchange may specify or the Secretary may specify by regulation; and

3. Participants in the Exchange shall have the option to purchase at least the pediatric dental benefit component of the essential health benefits package either through a separate qualified dental plan or as a part of a combined offer by a qualified health plan, provided that, with respect to a combined offer, the health and dental benefits are priced separately and also made available for purchase separately at the same price.

2020, cc. 916, 917; 2022, cc. 556, 560.

§ 38.2-6507. Appeal of decertification or denial of certification.

A. The Exchange shall give each health carrier the opportunity to appeal a decertification decision or the denial of certification as a qualified health plan or qualified dental plan.

B. The Exchange shall give each health carrier that appeals a decertification decision or the denial of certification the opportunity for:

1. The submission and consideration of facts, arguments, or proposals of adjustment of the plan or plans at issue; and

2. A hearing and a decision on the record, to the extent that the Exchange and the health carrier are unable to reach agreement following the submission of the information in subdivision 1.

C. Any hearing held pursuant to subsection B shall be conducted by the Commission in accordance with its rules of practice and procedure.

D. Any final action or order of the Commission shall be subject to judicial review in accordance with the provisions of §§ 12.1-39, 12.1-40, and 12.1-41.

2020, cc. 916, 917.

§ 38.2-6508. Open enrollment periods.

Health carriers shall be permitted to utilize open enrollment periods outside of an Exchange as permitted inside of an Exchange pursuant to § 1311(c)(6) of the Federal Act.

2020, cc. 916, 917.

§ 38.2-6509. Choice.

A. In accordance with § 1312(f)(2)(A) of the Federal Act, a qualified employer may either designate one or more qualified health plans from which its eligible employees may choose or designate any level of coverage to be made available to eligible employees through an Exchange.

B. In accordance with § 1312(b) of the Federal Act, a qualified individual enrolled in any qualified health plan may pay any applicable premium owed by such individual to the health carrier issuing such qualified health plan.

C. In accordance with § 1312(d) of the Federal Act:

1. This section shall not prohibit:

a. A health carrier from offering outside of an Exchange a health benefit plan to a qualified individual or qualified employer; or

b. A qualified individual from enrolling in, or a qualified employer from selecting for its eligible employees, a health benefit plan offered outside of an Exchange; and

2. This section shall not limit the operation of any requirement under state law or regulation with respect to any policy or plan that is offered outside of the Exchange with respect to any requirement to offer benefits.

D. Nothing in this section shall restrict the choice of a qualified individual to enroll or not to enroll in a qualified health plan or to participate in an Exchange.

E. Nothing in this section shall compel an individual to enroll in a qualified health plan or to participate in an Exchange.

F. A qualified individual may enroll in any qualified health plan, except that in the case of a catastrophic plan described in § 1302(e) of the Federal Act, a qualified individual may enroll in the plan only if the individual is eligible to enroll in the plan under § 1302(e)(2) of the Federal Act.

G. In accordance with § 1312(e) of the Federal Act, the Exchange may, for a licensed agent who agrees to comply with regulatory requirements, including advance registration with the Exchange, completion of training, and adherence to privacy and security standards set by the Exchange, allow such licensed agents:

1. To enroll qualified individuals and qualified employers in any qualified health plan or any qualified dental plan offered through the Exchange for which the individual or employer is eligible; and

2. To assist qualified individuals in applying for premium tax credits and cost-sharing reductions for qualified health plans purchased through the Exchange.

2020, cc. 916, 917.

§ 38.2-6510. Health Insurance Exchange Fund; assessment.

A. The Exchange shall be authorized to fund its operations through (i) special fund revenues generated by assessment fees on health carriers offering plans through the Exchange, (ii) funds described

in subsection H, or (iii) such funds as the General Assembly may from time to time appropriate. All such funds received under this section and paid into the state treasury shall be deposited to a special fund designated "Health Insurance Exchange Special Fund State Corporation Commission." Interest earned on moneys in the Fund shall remain in the Fund and be credited to it. Any moneys remaining in the Fund, including interest thereon, at the end of each fiscal year shall not revert to the general fund but shall remain in the Fund. Moneys in the Fund shall be used solely for the purposes of supporting the Exchange through initial start-up costs associated with establishment of the Exchange, Exchange operations, outreach, and enrollment, a Navigator program, and other means of supporting the Exchange.

B. The Exchange shall have funding from the sources described in subsection A in an amount sufficient to support its ongoing operations.

C. Assessments on health carriers shall be reasonable and necessary to support the development, operations, and prudent cash management of the Exchange. Assessments shall be approved by the Commission prior to implementation and shall not exceed three percent of the carrier's total monthly premium as described in this subsection, except that the Commission may, after notice and opportunity to be heard, adjust the assessment rate if necessary to ensure that the Exchange is fully funded. The assessment shall be based on the premium charged by a carrier for health benefits plans issued on the American Health Benefits Exchange and each qualified dental plan offered on the American Health Benefits Exchange during any period in which qualified health plans and qualified dental plans are effective on the American Health Benefits Exchange.

D. Taxes, fees, or assessments used to finance the Exchange shall be clearly disclosed by the Exchange as such.

E. Taxes, fees, or assessments used to finance the Exchange shall be considered a state tax or assessment, as defined in § 2718(a) of the PHSA and its implementing regulations, and shall be excluded from health carrier administrative costs for the purpose of calculating medical loss ratios or rebates.

F. Assessments and fees shall not affect the requirement under § 1301 of the Federal Act that carriers charge the same premium rate for each qualified health plan whether offered inside or outside the Exchange.

G. A written report on the implementation and performance of the Exchange functions during the preceding fiscal year, including, at a minimum, the manner in which funds were expended, shall be made available to the public on the website of the Exchange.

H. The Exchange is authorized to apply for and accept federal grants, other federal funds, and grants from nongovernmental organizations for the purposes of developing, implementing, and administering the Exchange.

I. The Commission shall not use any special fund revenues dedicated to its other functions and duties, including revenues from utility consumer taxes or fees from licensees regulated by the Commission, or fees paid to the office of the clerk of the Commission, to fund any of the activities or operating expenses of the Exchange.

2020, cc. 916, 917.

§ 38.2-6511. Procurement, contracting, and personnel.

A. The Commission may contract with other eligible entities and enter into memoranda of understanding with other agencies of the Commonwealth to carry out any of the functions of the Exchange, including agreements with other states or federal agencies to perform joint administrative functions. Such contracts are not subject to the Virginia Public Procurement Act (§ 2.2-4300 et seq.).

B. The Exchange shall not enter into contracts with any health carrier or an affiliate of a health carrier.

C. Employees of the Exchange shall be (i) exempt from application of the Virginia Personnel Act (§ 2.2-2900 et seq.) and Chapter 30 (§ 2.2-3000 et seq.) of Title 2.2, as hereinafter amended or recodified, to the same extent as other employees of the Commission; (ii) eligible for participation in the Virginia Retirement System to the same extent as other similarly situated employees of the Commission; and (iii) compensated and managed in accordance with the Commission's practices and policies applicable to all Commission employees.

2020, cc. 916, 917.

§ 38.2-6512. Confidentiality.

A. Notwithstanding any other provision of law, the records of the Exchange shall be open to public inspection, except that the following information shall not be subject to disclosure: (i) the names and applications of individuals and employers seeking coverage through the Exchange, (ii) individuals' health information, (iii) information exchanged between the Exchange and any other state agency that is subject to confidentiality agreements under contracts entered into with the Exchange, and (iv) communications covered by an applicable legal or other privilege or such internal communications related to the Exchange that are designated confidential in regulations promulgated by the Commission to implement the provisions of this chapter.

B. The Exchange may enter into information-sharing agreements with federal and state agencies and other states' health benefit exchanges to carry out its responsibilities under this chapter, provided that such agreements include adequate protections with respect to the confidentiality of the information to be shared and comply with all state and federal laws and regulations.

2020, cc. 916, 917.

§ 38.2-6513. Navigators.

A. No person shall act as a Navigator unless the person is registered pursuant to Article 7 (§ 38.2-3455 et seq.) of Chapter 34 and is certified by either the U.S. Department of Health and Human Services or the Exchange.

B. The Exchange shall establish a program under which it shall award grants to Navigators to carry out the following duties:

1. Conduct public education activities to raise awareness of the availability of qualified health plans, qualified dental plans, the State Medicaid Program, and FAMIS;

2. Distribute fair and impartial information concerning enrollment in qualified health plans, qualified dental plans, the State Medicaid Program, and FAMIS and the availability of premium tax credits under § 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under § 1402 of the Federal Act;

3. Provide in-person assistance to facilitate enrollment in qualified health plans, qualified dental plans, the State Medicaid Program, and FAMIS;

4. Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under § 2793 of the PHSA, or any other appropriate state agency or agencies, for any enrollee with a grievance, complaint, or question regarding his health benefit plan, coverage, or a determination under that plan or coverage;

5. Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange and ensure accessibility and usability of Navigator tools and functions for individuals with disabilities in accordance with the Americans with Disabilities Act (P.L. 101-336) and § 504 of the Rehabilitation Act as required by 45 C.F.R. § 155.210; and

6. Assist consumers with post-enrollment activities, including completing verification requests, accessing Special Enrollment Periods, accessing health insurance related tax forms, and assisting with complex cases and appeals.

C. To be eligible to receive a grant under subsection B, a Navigator shall demonstrate to the Exchange involved that it has existing relationships, or could readily establish relationships, with employers and employees, consumers, including uninsured and underinsured consumers, or self-employed individuals likely to be qualified to enroll in a qualified health plan.

D. The Exchange shall develop standards, consistent with any standards developed by the Secretary, to ensure that information made available by Navigators is fair, accurate, and impartial.

E. Navigators shall comply with all requirements of Article 7 (§ 38.2-3455 et seq.) of Chapter 34, including successful completion of training programs established by the Exchange for individual Navigators.

2020, cc. 916, 917.

§ 38.2-6514. Certified application counselors.

A. The Exchange shall establish a Certified Application Counselor program pursuant to 45 C.F.R. § 155.225 and shall (i) certify individuals as certified application counselors to perform specified duties,

(ii) designate an organization to certify individuals as certified application counselors to perform specified duties, or (iii) implement a combination both clause (i) and (ii).

B. The Exchange shall ensure, either directly or through designated organizations, that certified application counselors complete required Virginia-specific training on topics including qualified health plan options, insurance affordability programs, eligibility and enrollment rules, and all other regulatory requirements.

C. The Exchange shall ensure certified application counselors adhere to all terms and conditions of privacy and security pursuant to 45 C.F.R. § 155.260(b).

D. The Exchange may decertify a certified application counselor or designated organization for failure to comply with the requirements of this section or of the Exchange.

2020, cc. 916, 917.

§ 38.2-6515. Regulations.

The Commission shall promulgate regulations to implement the provisions of this chapter in accordance with the Commission's rules of practice and procedure. Regulations promulgated under this section shall be consistent with applicable provisions of federal and state law.

2020, cc. 916, 917.

§ 38.2-6516. Reports.

The Exchange, in collaboration with the Secretary of Health and Human Resources, shall submit a report by November 1 of each year to the Chairs of the Senate Committees on Commerce and Labor and Finance and Appropriations and the House Committees on Labor and Commerce and Appropriations that shall include information on (i) Exchange operations and responsibilities, (ii) an accounting of the Exchange's finances, (iii) the effectiveness of the outreach and implementation activities of the Exchange in reducing the number of individuals without health insurance coverage, and (iv) other relevant information.

2020, cc. 916, 917.

§ 38.2-6517. Relation to other laws.

Nothing in this chapter, and no action taken by the Exchange pursuant to this chapter, shall be construed to preempt or supersede the authority of the Commission to regulate the business of insurance within the Commonwealth. Except as expressly provided to the contrary in this chapter, all health carriers offering qualified health plans or qualified dental plans in the Commonwealth shall comply fully with all applicable health insurance laws of the Commonwealth and regulations adopted and orders issued by the Commission.

2020, cc. 916, 917.

Chapter 66 - Commonwealth Health Reinsurance Program

§ 38.2-6600. Definitions.

As used in this chapter, unless the context requires a different meaning:

"Affordable Care Act" means the Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, P.L. 111-152, and as it may be further amended.

"Allowed amount" has the same meaning as provided in § 38.2-3438.

"Attachment point" means the amount set by the Commission for claims costs incurred by an eligible carrier for a covered person's covered benefits in a benefit year, above which the claims costs for benefits are eligible for reinsurance payments under the Program.

"Benefit year" means the calendar year for which an eligible carrier provides coverage through an individual health benefit plan.

"Coinsurance rate" means the rate set by the Commission at which the Program will reimburse an eligible carrier for claims incurred for a covered person's covered benefits in a benefit year, which claims exceed the attachment point but are below the reinsurance cap.

"Covered benefits" has the same meaning as provided in § 38.2-3438.

"Covered person" means an individual covered under individual health insurance coverage that (i) is delivered or issued for delivery in the Commonwealth and (ii) is neither a grandfathered plan, student health insurance coverage, nor transitional coverage that the federal government allows under a nonenforcement policy.

"Eligible carrier" means a carrier that (i) offers individual health insurance coverage other than a grandfathered plan, student health insurance coverage, or transitional coverage that the federal government allows under a nonenforcement policy and (ii) incurs claims costs for a covered person's covered benefits in the applicable benefit year.

"Fund" means the Commonwealth Health Reinsurance Program Special Fund established by the Commission pursuant to § 38.2-6604.

"Grandfathered plan" has the same meaning as provided in § 38.2-3438.

"Group health insurance coverage" has the same meaning as provided in § 38.2-3438.

"Individual health insurance coverage" has the same meaning as provided in § 38.2-3438.

"Net written premiums" means premiums earned on individual and group health insurance coverage, including grandfathered plans, in the Commonwealth, less return premiums and dividends paid or credited to policy or contract holders on the health benefits plan business.

"Payment parameters" means the attachment point, reinsurance cap, and coinsurance rate for the Program.

"Program" means the Commonwealth Health Reinsurance Program established pursuant to this chapter.

"Reinsurance cap" means the amount set by the Commission for claims costs incurred by an eligible carrier for a covered person's covered benefits in a benefit year, above which the claims costs for benefits are no longer eligible for reinsurance payments under the Program.

"Reinsurance payment" means an amount paid to an eligible carrier under the Program.

"State Innovation Waiver" means a waiver of one or more requirements of the Affordable Care Act authorized by § 1332 of the Affordable Care Act, 42 U.S.C. § 18052, and applicable federal regulations.

"Total amount paid by the eligible carrier for any eligible claim" means the amount paid by the eligible carrier based on the allowed amount less any deductible, coinsurance, or copayment, as of the time applicable data is submitted or made accessible under subdivision C 1 of § 38.2-6602.

2021, Sp. Sess. I, c. 480; 2022, cc. 547, 548.

§ 38.2-6601. Commission powers and duties; rules; report.

A. The Commission shall have all the powers necessary to implement the provisions of this chapter and is specifically authorized to:

1. Enter into contracts as necessary or proper to carry out the provisions and purposes of this chapter, including contracts for the administration of the Program, as well as other approved initiatives under the State Innovation Waiver, and with appropriate administrative staff, consultants, and legal counsel;

2. Take action as necessary to avoid the payment of improper claims under the Program;

3. Establish administrative and accounting procedures for the operation of the Program and other approved initiatives under the State Innovation Waiver;

4. Establish procedures and standards for eligible carriers to submit claims under the Program;

5. Establish or adjust the payment parameters in accordance with subdivision B 2 of § 38.2-6602 for each benefit year;

6. Apply for a State Innovation Waiver, federal funds, or both, in accordance with § 38.2-6606, for the implementation and operation of the Program, as well as other initiatives designated by the established work group convened by the Secretary of Health and Human Resources;

7. Apply for, accept, administer, and expend gifts, grants, and donations and any federal funds that become available for the operation of the Program, as well as other initiatives designated by the established work group convened by the Secretary of Health and Human Resources; and

8. Adopt rules as necessary to implement, administer, and enforce this chapter, including rules necessary to align state law with any federal program.

B. If the State Innovation Waiver is granted pursuant to § 38.2-6606, the Commission, during implementation of the Program, shall evaluate the effect of the Program on access to affordable, high-value

health insurance for consumers who are eligible for premium tax credit subsidies and cost-sharing reductions.

2021, Sp. Sess. I, c. 480.

§ 38.2-6602. Commonwealth Health Reinsurance Program; established.

A. The Commission shall implement a reinsurance program, known as the Commonwealth Health Reinsurance Program. Implementation and operation of the Program is contingent upon approval of the State Innovation Waiver submitted by the Commission in accordance with § 38.2-6606. If the State Innovation Waiver and federal funding request submitted by the Commission pursuant to § 38.2-6606 are approved, the Commission shall implement and operate the Program in accordance with this section.

B. The Commission or its designee shall collect or access data from an eligible carrier as necessary to determine reinsurance payments, according to the data requirements under subdivision C 1.

1. Unless an eligible carrier is notified otherwise by the Commission, on a quarterly basis during the applicable benefit year, each eligible carrier shall report to the Commission its claims costs that exceed the attachment point for that benefit year. For each applicable benefit year, the Commission shall notify eligible carriers of reinsurance payments to be made for the applicable benefit year no later than September 30 of the year following the applicable benefit year. By November 15 of the year following the applicable benefit year, the Commission shall disburse all applicable reinsurance payments to an eligible carrier.

2. For the 2023 benefit year and each benefit year thereafter, the Commission shall establish and publish the payment parameters for the applicable benefit year by May 1 of the year immediately preceding the applicable benefit year. In setting the payment parameters under this subsection, the Commission shall consider the following factors: (i) stabilized or reduced premium rates in the individual market, (ii) increased participation in the individual market, (iii) improved access to health care services and their providers for enrolled individuals, (iv) mitigation of the impact high-risk individuals have on premium rates in the individual market, (v) the availability of any federal funding available for the Program, and (vi) the total amount available to fund the Program.

3. If the Commission determines that all reinsurance payments for a covered person's covered benefits requested under the Program by eligible carriers for a benefit year will not be equal to the amount of funding allocated to the Program, the Commission shall determine a uniform pro rata adjustment to be applied to all such requests for reinsurance payments.

C. A carrier that meets the requirement of this subsection and subsection D shall be eligible to request reinsurance payments from the Program. An eligible carrier shall make requests for reinsurance payments in accordance with the requirements established by the Commission.

1. To receive reinsurance payments through the Program, an eligible carrier shall, by April 30 of the year following the benefit year for which reinsurance payments are requested, (i) provide the

Commission with access to the data within the dedicated data environment established by the eligible carrier under the federal risk adjustment program under 42 U.S.C. § 18063 or access to other carrier-specific data if and where necessary and (ii) submit to the Commission an attestation that the carrier has complied with the dedicated data environments, data requirements, establishment and usage of masked enrollee identification numbers, and data submission deadlines.

2. An eligible carrier shall maintain documents and records sufficient to substantiate the requests for reinsurance payments made pursuant to this section for at least five years. An eligible carrier shall also make those documents and records available upon request from the Commission for purposes of verification, investigation, audit, or other review of reinsurance payment requests. The Commission may audit an eligible carrier to assess the carrier's compliance with this section. The eligible carrier shall ensure that its contractors, subcontractors, and agents cooperate with any audit under this section.

D. The Commission or its designee shall calculate each reinsurance payment based on an eligible carrier's incurred claims costs for a covered person's covered benefits in the applicable benefit year. If the claims costs for a covered person's covered benefits in the applicable benefit year do not exceed the attachment point for the applicable benefit year, the carrier shall not be eligible for a reinsurance payment. If the claims costs exceed the attachment point for the applicable benefit year, the Commission shall calculate the reinsurance payment as the product of the coinsurance rate and the eligible carrier's claims costs up to the reinsurance cap. A carrier shall be ineligible for reinsurance payments for claims costs for a covered person's covered benefits in the applicable benefit year that exceed the reinsurance cap. The Commission shall ensure that reinsurance payments made to eligible carriers do not exceed the total amount paid by the eligible carrier for any eligible claim. An eligible carrier may request that the Commission reconsider a decision on the carrier's request for reinsurance payments within 21 days after notice of the Commission's decision.

E. The Commission shall require each eligible carrier that participates in the Program to file with the Commission, by a date and in a form and manner specified by the Commission by rule, the care management protocols the eligible carrier will use to manage claims within the payment parameters.

2021, Sp. Sess. I, c. 480; 2022, cc. 547, 548.

§ 38.2-6603. Accounting; reports.

A. The Commission shall keep an accounting for each benefit year of all:

1. Funds appropriated for reinsurance payments and administrative and operational expenses;

2. Requests for reinsurance payments received from eligible carriers;

3. Reinsurance payments made to eligible carriers; and

4. Administrative and operational expenses incurred for the Program.

B. By November 1 of each year, the Commission shall report to the House Committees on Labor and Commerce and Appropriations, the Senate Committees on Commerce and Labor and Finance and

Appropriations, and the Governor on the operation of the Program. Such report shall be posted on the Commission's website and shall include, at a minimum, the following information for the relevant benefit year:

1. Amounts deposited into the Fund;

2. Requests for reinsurance payments received by eligible carriers;

3. Reinsurance payments made to eligible carriers;

4. Administrative and operational expenses incurred for the Program; and

5. Quantifiable impact of the Program on individual health insurance coverage rates.

2021, Sp. Sess. I, c. 480.

§ 38.2-6604. Commonwealth Health Reinsurance Program Special Fund.

A. The Commission shall be authorized to fund the operations of the Program and to fund other purposes to implement the approved State Innovation Waiver through funds provided to the Commonwealth pursuant to the State Innovation Waiver requested pursuant to § 38.2-6606 and all funds appropriated for such purpose. All funds received under this section and paid into the state treasury shall be deposited to a special fund designated the "Commonwealth Health Reinsurance Program Special Fund State Corporation Commission." Interest earned on moneys in the Fund shall remain in the Fund and be credited to it. Any moneys remaining in the Fund, including interest thereon, at the end of each fiscal year shall not revert to the general fund but shall remain in the Fund. Moneys in the Fund shall be used for (i) the purposes of increasing affordability in the individual market through the Program with a goal of decreasing premiums by up to 20 percent, depending on available revenue and (ii) the establishment, operation, and administration of the Program in carrying out the purposes authorized under this chapter, to include additional purposes to implement an approved State Innovation Waiver with funds that remain following the payment of all applicable reinsurance requests for a benefit year.

B. The Commission shall not use any special fund revenues dedicated to its other functions and duties, including revenues from utility consumer taxes or fees from licensees regulated by the Commission, or fees paid to the office of the Clerk of the Commission, to fund any of the activities or operating expenses of the Program. The Commission shall not pay any funds beyond the moneys in the Fund for the establishment, administration, or operation of the Program.

C. The provision of reinsurance payments shall not constitute an entitlement derived from the Commonwealth or a claim on any other money of the Commonwealth.

D. The Commission shall have no responsibility to make reinsurance payments that would be payable out of federal pass-through funding if such federal pass-through funding is insufficient to fully make such payments.

2021, Sp. Sess. I, c. 480.

§ 38.2-6605. Confidentiality of data.

Data and information that an eligible carrier considers confidential proprietary information that is provided to the Commission pursuant to the provisions of this chapter shall be excluded from, and the Commission shall not be subject to, subpoena or public inspection with respect to such information.

2021, Sp. Sess. I, c. 480.

§ 38.2-6606. State Innovation Waiver request.

A. The Commission shall apply to the appropriate federal agencies under 42 U.S.C. § 18052 for a State Innovation Waiver for benefit years beginning January 1, 2023, and future years, (i) to establish a reinsurance program, in accordance with the provisions of this chapter; (ii) to maximize federal pass-through funding for the reinsurance program; (iii) to be able to use remaining funds for other uses as recommended by a work group established by the Secretary of Health and Human Resources; and (iv) to waive any applicable provisions of the Affordable Care Act. An application for a State Innovation Waiver or for federal funds shall clearly state that operation of the Program is contingent on approval of the waiver or funding request. The Commission shall include in the application a request for pass-through of federal funding in accordance with § 1332(a)(3) of 42 U.S.C § 18052 to allow the Commonwealth to obtain and use, for purposes of helping finance the Program, any federal funds that would, absent the waiver, be used to pay advance payment tax credits and cost-sharing reductions authorized under the federal act. The Commission is authorized to apply for, accept, administer, and expend gifts, grants, and donations, and any federal funds that become available for the implementation of the Program, including the use of amounts necessary to develop and submit the State Innovation Waiver and request for federal funding.

B. The Commission shall submit the waiver application to the appropriate federal agencies by January 1, 2022. The Commission shall make a draft application available for public review and comment by October 1, 2021. The Commission may amend the waiver application as necessary to carry out the provisions of this chapter. The Commission shall promptly notify the Chairmen of the House Committees on Labor and Commerce and Appropriations and the Senate Committees on Commerce and Labor and Finance and Appropriations of any federal actions regarding the waiver request and of any amendment to the waiver application.

2021, Sp. Sess. I, c. 480.