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SENATE BILL NO. 460

Offered January 14, 2026

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A BILL to amend and reenact § 2.2-2818 of the Code of Virginia, relating to state employee health insurance plan; coverage for prosthetic devices.

Patron—Roem

Referred to Committee on General Laws and Technology

Be it enacted by the General Assembly of Virginia:

1. That § 2.2-2818 of the Code of Virginia is amended and reenacted as follows:

§ 2.2-2818. Health and related insurance for state employees.

A. The Department of Human Resource Management shall establish a plan, subject to the approval of the Governor, for providing health insurance coverage, including chiropractic treatment, hospitalization, medical, surgical, and major medical coverage, for state employees and retired state employees with the Commonwealth paying the cost thereof to the extent of the coverage included in such plan. The same plan shall be offered to all part-time state employees, but the total cost shall be paid by such part-time employees. The Department of Human Resource Management shall administer this section. The plan chosen shall provide means whereby coverage for the families or dependents of state employees may be purchased. Except for part-time employees, the Commonwealth may pay all or a portion of the cost thereof, and for such portion as the Commonwealth does not pay, the employee, including a part-time employee, may purchase the coverage by paying the additional cost over the cost of coverage for an employee.

Such contribution shall be financed through appropriations provided by law.

B. The plan shall:

1. Include coverage for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age 35 through 39, one such mammogram biennially to persons age 40 through 49, and one such mammogram annually to persons age 50 and over and may be limited to a benefit of \$50 per mammogram subject to such dollar limits, deductibles, and coinsurance factors as are no less favorable than for physical illness generally.

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.

In order to be considered a screening mammogram for which coverage shall be made available under this section:

a. The mammogram shall 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 provider; (ii) performed by a registered technologist; (iii) interpreted by a qualified radiologist; and (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. A copy of the mammogram report shall be sent or delivered to the health care practitioner who ordered it;

b. 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

c. 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.

2. Include coverage for postpartum services providing inpatient care and a home visit or visits that 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.

3. Include an appeals process for resolution of complaints that shall provide reasonable procedures for the resolution of such complaints and shall be published and disseminated to all covered state employees. The appeals process shall be compliant with federal rules and regulations governing nonfederal, self-insured governmental health plans. The appeals process shall include a separate expedited emergency appeals procedure that shall provide resolution within time frames established by federal law. For appeals involving adverse decisions as defined in § 32.1-137.7, the Department shall contract with one or more independent

59 review organizations to review such decisions. Independent review organizations are entities that conduct
60 independent external review of adverse benefit determinations. The Department shall adopt regulations to
61 assure that the independent review organization conducting the reviews has adequate standards, credentials
62 and experience for such review. The independent review organization shall examine the final denial of claims
63 to determine whether the decision is objective, clinically valid, and compatible with established principles of
64 health care. The decision of the independent review organization shall (i) be in writing, (ii) contain findings
65 of fact as to the material issues in the case and the basis for those findings, and (iii) be final and binding if
66 consistent with law and policy.

67 Prior to assigning an appeal to an independent review organization, the Department shall verify that the
68 independent review organization conducting the review of a denial of claims has no relationship or
69 association with (i) the covered person or the covered person's authorized representative; (ii) the treating
70 health care provider, or any of its employees or affiliates; (iii) the medical care facility at which the covered
71 service would be provided, or any of its employees or affiliates; or (iv) the development or manufacture of
72 the drug, device, procedure, or other therapy that is the subject of the final denial of a claim. The independent
73 review organization shall not be a subsidiary of, nor owned or controlled by, a health plan, a trade association
74 of health plans, or a professional association of health care providers. There shall be no liability on the part of
75 and no cause of action shall arise against any officer or employee of an independent review organization for
76 any actions taken or not taken or statements made by such officer or employee in good faith in the
77 performance of his powers and duties.

78 4. Include coverage for early intervention services. For purposes of this section, "early intervention
79 services" means medically necessary speech and language therapy, occupational therapy, physical therapy
80 and assistive technology services and devices for dependents from birth to age three who are certified by the
81 Department of Behavioral Health and Developmental Services as eligible for services under Part H of the
82 Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.). Medically necessary early intervention
83 services for the population certified by the Department of Behavioral Health and Developmental Services
84 shall mean those services designed to help an individual attain or retain the capability to function age-
85 appropriately within his environment, and shall include services that enhance functional ability without
86 effecting a cure.

87 For persons previously covered under the plan, there shall be no denial of coverage due to the existence of
88 a preexisting condition. The cost of early intervention services shall not be applied to any contractual
89 provision limiting the total amount of coverage paid by the insurer to or on behalf of the insured during the
90 insured's lifetime.

91 5. Include coverage for prescription drugs and devices approved by the United States Food and Drug
92 Administration for use as contraceptives.

93 6. Not deny coverage for any drug approved by the United States Food and Drug Administration for use
94 in the treatment of cancer on the basis that the drug has not been approved by the United States Food and
95 Drug Administration for the treatment of the specific type of cancer for which the drug has been prescribed, if
96 the drug has been recognized as safe and effective for treatment of that specific type of cancer in one of the
97 standard reference compendia.

98 7. Not deny coverage for any drug prescribed to treat a covered indication so long as the drug has been
99 approved by the United States Food and Drug Administration for at least one indication and the drug is
100 recognized for treatment of the covered indication in one of the standard reference compendia or in
101 substantially accepted peer-reviewed medical literature.

102 8. Include coverage for equipment, supplies, and outpatient self-management training and education,
103 including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes,
104 gestational diabetes, and noninsulin-using diabetes if prescribed by a health care professional legally
105 authorized to prescribe such items under law. To qualify for coverage under this subdivision, diabetes
106 outpatient self-management training and education shall be provided by a certified, registered, or licensed
107 health care professional.

108 9. Include coverage for reconstructive breast surgery. For purposes of this section, "reconstructive breast
109 surgery" means surgery performed on and after July 1, 1998, (i) coincident with a mastectomy performed for
110 breast cancer or (ii) following a mastectomy performed for breast cancer to reestablish symmetry between the
111 two breasts. For persons previously covered under the plan, there shall be no denial of coverage due to
112 preexisting conditions.

113 10. Include coverage for annual pap smears, including coverage, on and after July 1, 1999, for annual
114 testing performed by any FDA-approved gynecologic cytology screening technologies.

115 11. Include coverage providing a minimum stay in the hospital of not less than 48 hours for a patient
116 following a radical or modified radical mastectomy and 24 hours of inpatient care following a total
117 mastectomy or a partial mastectomy with lymph node dissection for treatment of breast cancer. Nothing in
118 this subdivision shall be construed as requiring the provision of inpatient coverage where the attending
119 physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

120 12. Include coverage (i) to persons age 50 and over and (ii) to persons age 40 and over who are at high

121 risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society,
122 for one prostate-specific antigen test in a 12-month period and digital rectal examinations.

123 13. Permit any individual covered under the plan direct access to the health care services of a participating
124 specialist (i) authorized to provide services under the plan and (ii) selected by the covered individual. The
125 plan shall have a procedure by which an individual who has an ongoing special condition may, after
126 consultation with the primary care physician, receive a referral to a specialist for such condition who shall be
127 responsible for and capable of providing and coordinating the individual's primary and specialty care related
128 to the initial specialty care referral. If such an individual's care would most appropriately be coordinated by
129 such a specialist, the plan shall refer the individual to a specialist. For the purposes of this subdivision,
130 "special condition" means a condition or disease that is (i) life-threatening, degenerative, or disabling and (ii)
131 requires specialized medical care over a prolonged period of time. Within the treatment period authorized by
132 the referral, such specialist shall be permitted to treat the individual without a further referral from the
133 individual's primary care provider and may authorize such referrals, procedures, tests, and other medical
134 services related to the initial referral as the individual's primary care provider would otherwise be permitted
135 to provide or authorize. The plan shall have a procedure by which an individual who has an ongoing special
136 condition that requires ongoing care from a specialist may receive a standing referral to such specialist for the
137 treatment of the special condition. If the primary care provider, in consultation with the plan and the
138 specialist, if any, determines that such a standing referral is appropriate, the plan or issuer shall make such a
139 referral to a specialist. Nothing contained herein shall prohibit the plan from requiring a participating
140 specialist to provide written notification to the covered individual's primary care physician of any visit to
141 such specialist. Such notification may include a description of the health care services rendered at the time of
142 the visit.

143 14. Include provisions allowing employees to continue receiving health care services for a period of up to
144 90 days from the date of the primary care physician's notice of termination from any of the plan's provider
145 panels. The plan shall notify any provider at least 90 days prior to the date of termination of the provider,
146 except when the provider is terminated for cause.

147 For a period of at least 90 days from the date of the notice of a provider's termination from any of the
148 plan's provider panels, except when a provider is terminated for cause, a provider shall be permitted by the
149 plan to render health care services to any of the covered employees who (i) were in an active course of
150 treatment from the provider prior to the notice of termination and (ii) request to continue receiving health care
151 services from the provider.

152 Notwithstanding the provisions of this subdivision, any provider shall be permitted by the plan to continue
153 rendering health services to any covered employee who has entered the second trimester of pregnancy at the
154 time of the provider's termination of participation, except when a provider is terminated for cause. Such
155 treatment shall, at the covered employee's option, continue through the provision of postpartum care directly
156 related to the delivery.

157 Notwithstanding the provisions of this subdivision, any provider shall be permitted to continue rendering
158 health services to any covered employee who is determined to be terminally ill (as defined under §
159 1861(dd)(3)(A) of the Social Security Act) at the time of a provider's termination of participation, except
160 when a provider is terminated for cause. Such treatment shall, at the covered employee's option, continue for
161 the remainder of the employee's life for care directly related to the treatment of the terminal illness.

162 A provider who continues to render health care services pursuant to this subdivision shall be reimbursed
163 in accordance with the carrier's agreement with such provider existing immediately before the provider's
164 termination of participation.

165 15. Include coverage for patient costs incurred during participation in clinical trials for treatment studies
166 on cancer, including ovarian cancer trials.

167 The reimbursement for patient costs incurred during participation in clinical trials for treatment studies on
168 cancer shall be determined in the same manner as reimbursement is determined for other medical and surgical
169 procedures. Such coverage shall have durational limits, dollar limits, deductibles, copayments, and
170 coinsurance factors that are no less favorable than for physical illness generally.

171 For purposes of this subdivision:

172 "Cooperative group" means a formal network of facilities that collaborate on research projects and have
173 an established NIH-approved peer review program operating within the group. "Cooperative group" includes
174 (i) the National Cancer Institute Clinical Cooperative Group and (ii) the National Cancer Institute
175 Community Clinical Oncology Program.

176 "FDA" means the Federal Food and Drug Administration.

177 "Multiple project assurance contract" means a contract between an institution and the federal Department
178 of Health and Human Services that defines the relationship of the institution to the federal Department of
179 Health and Human Services and sets out the responsibilities of the institution and the procedures that will be
180 used by the institution to protect human subjects.

181 "NCI" means the National Cancer Institute.

182 "NIH" means the National Institutes of Health.

183 "Patient" means a person covered under the plan established pursuant to this section.

184 "Patient cost" means the cost of a medically necessary health care service that is incurred as a result of the
185 treatment being provided to a patient for purposes of a clinical trial. "Patient cost" does not include (i) the
186 cost of nonhealth care services that a patient may be required to receive as a result of the treatment being
187 provided for purposes of a clinical trial, (ii) costs associated with managing the research associated with the
188 clinical trial, or (iii) the cost of the investigational drug or device.

189 Coverage for patient costs incurred during clinical trials for treatment studies on cancer shall be provided
190 if the treatment is being conducted in a Phase II, Phase III, or Phase IV clinical trial. Such treatment may,
191 however, be provided on a case-by-case basis if the treatment is being provided in a Phase I clinical trial.

192 The treatment described in the previous paragraph shall be provided by a clinical trial approved by:

193 a. The National Cancer Institute;

194 b. An NCI cooperative group or an NCI center;

195 c. The FDA in the form of an investigational new drug application;

196 d. The federal Department of Veterans Affairs; or

197 e. An institutional review board of an institution in the Commonwealth that has a multiple project
198 assurance contract approved by the Office of Protection from Research Risks of the NCI.

199 The facility and personnel providing the treatment shall be capable of doing so by virtue of their
200 experience, training, and expertise.

201 Coverage under this subdivision shall apply only if:

202 (1) There is no clearly superior, noninvestigational treatment alternative;

203 (2) The available clinical or preclinical data provide a reasonable expectation that the treatment will be at
204 least as effective as the noninvestigational alternative; and

205 (3) The patient and the physician or health care provider who provides services to the patient under the
206 plan conclude that the patient's participation in the clinical trial would be appropriate, pursuant to procedures
207 established by the plan.

208 16. Include coverage providing a minimum stay in the hospital of not less than 23 hours for a covered
209 employee following a laparoscopy-assisted vaginal hysterectomy and 48 hours for a covered employee
210 following a vaginal hysterectomy, as outlined in Milliman & Robertson's nationally recognized guidelines.
211 Nothing in this subdivision shall be construed as requiring the provision of the total hours referenced when
212 the attending physician, in consultation with the covered employee, determines that a shorter hospital stay is
213 appropriate.

214 17. Include coverage for biologically based mental illness.

215 For purposes of this subdivision, a "biologically based mental illness" is any mental or nervous condition
216 caused by a biological disorder of the brain that results in a clinically significant syndrome that substantially
217 limits the person's functioning; specifically, the following diagnoses are defined as biologically based mental
218 illness as they apply to adults and children: schizophrenia, schizoaffective disorder, bipolar disorder, major
219 depressive disorder, panic disorder, obsessive-compulsive disorder, attention deficit hyperactivity disorder,
220 autism, and drug and alcoholism addiction.

221 Coverage for biologically based mental illnesses shall neither be different nor separate from coverage for
222 any other illness, condition, or disorder for purposes of determining deductibles, benefit year or lifetime
223 durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits, copayment and
224 coinsurance factors, and benefit year maximum for deductibles and copayment and coinsurance factors.

225 Nothing shall preclude the undertaking of usual and customary procedures to determine the
226 appropriateness of, and medical necessity for, treatment of biologically based mental illnesses under this
227 option, provided that all such appropriateness and medical necessity determinations are made in the same
228 manner as those determinations made for the treatment of any other illness, condition, or disorder covered by
229 such policy or contract.

230 18. Offer and make available coverage for the treatment of morbid obesity through gastric bypass surgery
231 or such other methods as may be recognized by the National Institutes of Health as effective for the long-term
232 reversal of morbid obesity. Such coverage shall have durational limits, dollar limits, deductibles, copayments,
233 and coinsurance factors that are no less favorable than for physical illness generally. Access to surgery for
234 morbid obesity shall not be restricted based upon dietary or any other criteria not approved by the National
235 Institutes of Health. For purposes of this subdivision, "morbid obesity" means (i) a weight that is at least 100
236 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan
237 Life Insurance tables, (ii) a body mass index (BMI) equal to or greater than 35 kilograms per meter squared
238 with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep
239 apnea, or diabetes, or (iii) a BMI of 40 kilograms per meter squared without such comorbidity. As used
240 herein, "BMI" equals weight in kilograms divided by height in meters squared.

241 19. Include coverage for colorectal cancer screening, specifically screening with an annual fecal occult
242 blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in
243 accordance with the most recently published recommendations established by the American College of

244 Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and
 245 frequencies referenced in such recommendations. The coverage for colorectal cancer screening shall not be
 246 more restrictive than or separate from coverage provided for any other illness, condition, or disorder for
 247 purposes of determining deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar
 248 limits, lifetime episodes or treatment limits, copayment and coinsurance factors, and benefit year maximum
 249 for deductibles and copayments and coinsurance factors.

250 20. On and after July 1, 2002, require that a prescription benefit card, health insurance benefit card, or
 251 other technology that complies with the requirements set forth in § 38.2-3407.4:2 be issued to each employee
 252 provided coverage pursuant to this section, and shall upon any changes in the required data elements set forth
 253 in subsection A of § 38.2-3407.4:2, either reissue the card or provide employees covered under the plan such
 254 corrective information as may be required to electronically process a prescription claim.

255 21. Include coverage for infant hearing screenings and all necessary audiological examinations provided
 256 pursuant to § 32.1-64.1 using any technology approved by the United States Food and Drug Administration,
 257 and as recommended by the national Joint Committee on Infant Hearing in its most current position statement
 258 addressing early hearing detection and intervention programs. Such coverage shall include follow-up
 259 audiological examinations as recommended by a physician, a physician assistant, an advanced practice
 260 registered nurse, or an audiologist and performed by a licensed audiologist to confirm the existence or
 261 absence of hearing loss.

262 22. *Include coverage for medically necessary prosthetic devices and their repair, fitting, replacement, and*
 263 *components. Such coverage shall be consistent with the terms and conditions provided in § 38.2-3408.15:1.*

264 23. Notwithstanding any provision of this section to the contrary, every plan established in accordance
 265 with this section shall comply with the provisions of § 2.2-2818.2.

266 C. Claims incurred during a fiscal year but not reported during that fiscal year shall be paid from such
 267 funds as shall be appropriated by law. Appropriations, premiums, and other payments shall be deposited in
 268 the employee health insurance fund, from which payments for claims, premiums, cost containment programs,
 269 and administrative expenses shall be withdrawn from time to time. The funds of the health insurance fund
 270 shall be deemed separate and independent trust funds, shall be segregated from all other funds of the
 271 Commonwealth, and shall be invested and administered solely in the interests of the employees and their
 272 beneficiaries. Neither the General Assembly nor any public officer, employee, or agency shall use or
 273 authorize the use of such trust funds for any purpose other than as provided in law for benefits, refunds, and
 274 administrative expenses, including but not limited to legislative oversight of the health insurance fund.

275 D. For the purposes of this section:

276 "Peer-reviewed medical literature" means a scientific study published only after having been critically
 277 reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in a journal that has
 278 been determined by the International Committee of Medical Journal Editors to have met the Uniform
 279 Requirements for Manuscripts submitted to biomedical journals. "Peer-reviewed medical literature" does not
 280 include publications or supplements to publications that are sponsored to a significant extent by a
 281 pharmaceutical manufacturing company or health carrier.

282 "Standard reference compendia" means:

- 283 1. American Hospital Formulary Service Drug Information;
- 284 2. National Comprehensive Cancer Network's Drugs & Biologics Compendium; or
- 285 3. Elsevier Gold Standard's Clinical Pharmacology.

286 "State employee" means state employee as defined in § 51.1-124.3; employee as defined in § 51.1-201;
 287 the Governor, Lieutenant Governor and Attorney General; judge as defined in § 51.1-301 and judges, clerks,
 288 and deputy clerks of regional juvenile and domestic relations, county juvenile and domestic relations, and
 289 district courts of the Commonwealth; interns and residents employed by the School of Medicine and Hospital
 290 of the University of Virginia, and interns, residents, and employees of the Virginia Commonwealth
 291 University Health System Authority as provided in § 23.1-2415; and employees of the Virginia Alcoholic
 292 Beverage Control Authority as provided in § 4.1-101.05.

293 E. Provisions shall be made for retired employees to obtain coverage under the above plan, including, as
 294 an option, coverage for vision and dental care. The Commonwealth may, but shall not be obligated to, pay all
 295 or any portion of the cost thereof.

296 F. Any self-insured group health insurance plan established by the Department of Human Resource
 297 Management that utilizes a network of preferred providers shall not exclude any physician solely on the basis
 298 of a reprimand or censure from the Board of Medicine, so long as the physician otherwise meets the plan
 299 criteria established by the Department.

300 G. The plan shall include, in each planning district, at least two health coverage options, each sponsored
 301 by unrelated entities. No later than July 1, 2006, one of the health coverage options to be available in each
 302 planning district shall be a high deductible health plan that would qualify for a health savings account
 303 pursuant to § 223 of the Internal Revenue Code of 1986, as amended.

304 In each planning district that does not have an available health coverage alternative, the Department shall
 305 voluntarily enter into negotiations at any time with any health coverage provider who seeks to provide

306 coverage under the plan.

307 This subsection shall not apply to any state agency authorized by the Department to establish and
308 administer its own health insurance coverage plan separate from the plan established by the Department.

309 H. Any self-insured group health insurance plan established by the Department of Human Resource
310 Management that includes coverage for prescription drugs on an outpatient basis may apply a formulary to
311 the prescription drug benefits provided by the plan if the formulary is developed, reviewed at least annually,
312 and updated as necessary in consultation with and with the approval of a pharmacy and therapeutics
313 committee, a majority of whose members are actively practicing licensed (i) pharmacists, (ii) physicians, and
314 (iii) other health care providers.

315 If the plan maintains one or more drug formularies, the plan shall establish a process to allow a person to
316 obtain, without additional cost-sharing beyond that provided for formulary prescription drugs in the plan, a
317 specific, medically necessary nonformulary prescription drug if, after reasonable investigation and
318 consultation with the prescriber, the formulary drug is determined to be an inappropriate therapy for the
319 medical condition of the person. The plan shall act on such requests within one business day of receipt of the
320 request.

321 Any plan established in accordance with this section shall be authorized to provide for the selection of a
322 single mail order pharmacy provider as the exclusive provider of pharmacy services that are delivered to the
323 covered person's address by mail, common carrier, or delivery service. As used in this subsection, "mail order
324 pharmacy provider" means a pharmacy permitted to conduct business in the Commonwealth whose primary
325 business is to dispense a prescription drug or device under a prescriptive drug order and to deliver the drug or
326 device to a patient primarily by mail, common carrier, or delivery service.

327 I. Any plan established in accordance with this section requiring preauthorization prior to rendering
328 medical treatment shall have personnel available to provide authorization at all times when such
329 preauthorization is required.

330 J. Any plan established in accordance with this section shall provide to all covered employees written
331 notice of any benefit reductions during the contract period at least 30 days before such reductions become
332 effective.

333 K. No contract between a provider and any plan established in accordance with this section shall include
334 provisions that require a health care provider or health care provider group to deny covered services that such
335 provider or group knows to be medically necessary and appropriate that are provided with respect to a
336 covered employee with similar medical conditions.

337 L. The Department of Human Resource Management shall appoint an Ombudsman to promote and protect
338 the interests of covered employees under any state employee's health plan.

339 The Ombudsman shall:

340 1. Assist covered employees in understanding their rights and the processes available to them according to
341 their state health plan.

342 2. Answer inquiries from covered employees by telephone and electronic mail.

343 3. Provide to covered employees information concerning the state health plans.

344 4. Develop information on the types of health plans available, including benefits and complaint
345 procedures and appeals.

346 5. Make available, either separately or through an existing Internet web site utilized by the Department of
347 Human Resource Management, information as set forth in subdivision 4 and such additional information as
348 he deems appropriate.

349 6. Maintain data on inquiries received, the types of assistance requested, any actions taken and the
350 disposition of each such matter.

351 7. Upon request, assist covered employees in using the procedures and processes available to them from
352 their health plan, including all appeal procedures. Such assistance may require the review of health care
353 records of a covered employee, which shall be done only in accordance with the federal Health Insurance
354 Portability and Accountability Act privacy rules. The confidentiality of any such medical records shall be
355 maintained in accordance with the confidentiality and disclosure laws of the Commonwealth.

356 8. Ensure that covered employees have access to the services provided by the Ombudsman and that the
357 covered employees receive timely responses from the Ombudsman or his representatives to the inquiries.

358 9. Report annually on his activities to the standing committees of the General Assembly having
359 jurisdiction over insurance and over health and the Joint Commission on Health Care by December 1 of each
360 year.

361 M. The plan established in accordance with this section shall not refuse to accept or make reimbursement
362 pursuant to an assignment of benefits made to a dentist or oral surgeon by a covered employee.

363 For purposes of this subsection, "assignment of benefits" means the transfer of dental care coverage
364 reimbursement benefits or other rights under the plan. The assignment of benefits shall not be effective until
365 the covered employee notifies the plan in writing of the assignment.

366 N. Beginning July 1, 2006, any plan established pursuant to this section shall provide for an identification

367 number, which shall be assigned to the covered employee and shall not be the same as the employee's social
368 security number.

369 O. Any group health insurance plan established by the Department of Human Resource Management that
370 contains a coordination of benefits provision shall provide written notification to any eligible employee as a
371 prominent part of its enrollment materials that if such eligible employee is covered under another group
372 accident and sickness insurance policy, group accident and sickness subscription contract, or group health
373 care plan for health care services, that insurance policy, subscription contract, or health care plan may have
374 primary responsibility for the covered expenses of other family members enrolled with the eligible employee.
375 Such written notification shall describe generally the conditions upon which the other coverage would be
376 primary for dependent children enrolled under the eligible employee's coverage and the method by which the
377 eligible enrollee may verify from the plan that coverage would have primary responsibility for the covered
378 expenses of each family member.

379 P. Any plan established by the Department of Human Resource Management pursuant to this section shall
380 provide that coverage under such plan for family members enrolled under a participating state employee's
381 coverage shall continue for a period of at least 30 days following the death of such state employee.

382 Q. The plan established in accordance with this section that follows a policy of sending its payment to the
383 covered employee or covered family member for a claim for services received from a nonparticipating
384 physician or osteopath shall (i) include language in the member handbook that notifies the covered employee
385 of the responsibility to apply the plan payment to the claim from such nonparticipating provider, (ii) include
386 this language with any such payment sent to the covered employee or covered family member, and (iii)
387 include the name and any last known address of the nonparticipating provider on the explanation of benefits
388 statement.

389 R. The plan established by the Department of Human Resource Management pursuant to this section shall
390 provide that coverage under such plan for an incapacitated child enrolled under a participating state
391 employee's coverage shall be valid without regard to whether such child lives with the covered employee as a
392 member of the employee's household so long as the child is dependent upon the employee for more than half
393 of the child's financial support and the child is receiving residential support services.

394 For purposes of this subsection, "incapacitated child" means an adult child who is incapacitated due to a
395 physical or mental health condition that existed prior to the termination of coverage due to such child
396 attaining the limiting age under the plan for eligible children dependents.

397 S. The Department of Human Resource Management shall report annually, by November 30 of each year,
398 on cost and utilization information for each of the mandated benefits set forth in subsection B, including any
399 mandated benefit made applicable, pursuant to subdivision B 22, to any plan established pursuant to this
400 section. The report shall be in the same detail and form as required of reports submitted pursuant to
401 § 38.2-3419.1, with such additional information as is required to determine the financial impact, including the
402 costs and benefits, of the particular mandated benefit.