# WEST VIRGINIA CODE: §33-15-2a

**§33-15-2a. Definitions.**

For purposes of this section and sections two-b, two-c, two-d, two-e, two-f, two-g and four-e:

(a) "Accident and sickness 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 of certificate, hospital or medical service plan contract, or health maintenance organization contract offered by an insurer, but does not include short-term limited duration insurance.

(b) "Bona fide association" means an association which has been actively in existence for at least five years; has been formed and maintained in good faith for purposes other than obtaining insurance; does not condition membership in the association on any health status-related factor relating to an individual; makes accident and sickness insurance coverage offered through the association available to all members regardless of any health status-related factor relating to the members or individuals eligible for coverage through a member; does not make accident and sickness insurance coverage offered through the association available other than in connection with a member of the association; and meets any additional requirements as may be set forth in this chapter or by rule.

(c) "COBRA continuation provision" means any of the following:

(1) Section 4980B of the Internal Revenue Code of 1986, 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, other than Section 609 of such act; or

(3) Title XXII of the Public Health Service Act.

(d) "Creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:

(1) A group health plan;

(2) Accident and sickness insurance coverage;

(3) Part A or Part B of Title XVIII of the Social Security Act;

(4) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;

(5) Chapter 55 of Title 10 of the United States Code;

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(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 of the United States Code;

(9) A public health plan (as defined in federal regulations); or

(10) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

The term "creditable coverage" does not include those benefits set forth in section two-g of this article.

(e) "Eligible individual" means an individual:

(1) For whom, as of the date on which the individual seeks coverage, the aggregate period of creditable coverage is eighteen months or more and whose most recent prior creditable coverage was under a group health plan, governmental plan (as defined in section 3(32) of the Employee Retirement Income Security Act of 1974), church plan (as defined in section 3(33) of the Employee Retirement Income Security Act of 1974), or accident and sickness insurance coverage offered in connection with any such plan;

(2) Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act, or state plan under Title XIX of such act (or any successor program), and does not have other accident and sickness insurance coverage;

(3) With respect to whom the most recent prior creditable coverage was not terminated as a result of fraud, intentional misrepresentation of material fact under the terms of the coverage, or nonpayment of premium;

(4) Who did not turn down an offer of continuation of coverage under a COBRA continuation provision or under a similar state program if it was offered; and

(5) Who, if the individual elected such continuation coverage, has exhausted that coverage under the COBRA continuation provision or similar state program.

(f) "Group health plan" means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974) to the extent that the plan provides medical care to employees and their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement or otherwise.

(g) "Health status-related factor" means an individual's health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, and evidence of insurability (including conditions arising out of acts of domestic violence) or disability.

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(h) "Higher-level coverage" means a policy form for which the actuarial value of the benefits under the coverage is at least fifteen percent greater than the actuarial value of lower-level coverage offered by the insurer in this state, and the actuarial value of the benefits under the coverage is at least one hundred percent but not greater than one hundred twenty percent of a weighted average.

(i) "Individual market" means the market for accident and sickness insurance coverage offered to individuals other than in connection with a group health plan.

(j) "Insurer" means an entity licensed by the commissioner to transact accident and sickness insurance in this state and subject to this chapter, but does not include a group health plan or short term limited duration insurance.

(k) "Lower-level coverage" means a policy form for which the actuarial value of the benefits under the coverage is at least eighty-five percent but not greater than one hundred percent of a weighted average.

(l) "Medical care" means amounts paid for, or paid for insurance covering, the diagnosis, cure, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body, including the amounts paid for transportation primarily for and essential to such care.

(m) "Network plan" means accident and sickness insurance coverage of an insurer 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 definite set of providers under contract with the insurer.

(n) "Preexisting condition exclusion" means 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 coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before such date.

(o) "Weighted average" means the average actuarial value of the benefits provided by all the accident and sickness insurance coverage issued (as elected by the insurer) either by that insurer or by all insurers in this state in the individual accident and sickness market during the previous year (not including coverage issued under this section), weighted by enrollment for the different coverage.

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