WEST VIRGINIA CODE: §33-16-1A

§33-16-1a. Definitions.

As used in this article:

(a) "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 offered through the association available to all members regardless of any health status-related factor relating to 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.

(b) "Commissioner" means the commissioner of insurance.

(c) "Creditable coverage" means, with respect to an individual, coverage of the individual after June 30, 1996, under any of the following, other than coverage consisting solely of excepted benefits:

(1) A group health plan;

(2) A health benefit plan;

(3) Medicare Part A or Part B, 42 U. S. C. §1395 et seq.; Medicaid, 42 U. S. C. §1396a et seq. (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act); Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), 10 U. S. C., Chapter 55; and a medical care program of the Indian Health Service or of a tribal organization;

(4) A health benefits risk pool sponsored by any state of the United States or by the District of Columbia; a health plan offered under 5 U. S. C., chapter 89; a public health plan as defined in regulations promulgated by the federal secretary of health and human services; or a health benefit plan as defined in the Peace Corps Act, 22 U. S. C. §2504(e).

(d) "Dependent" means an eligible employee's spouse or any unmarried child or stepchild under the age of twenty-five if that child or stepchild meets the definition of a "qualifying child" or a "qualifying relative" in section 152 of the Internal Revenue Code.

(e) "Eligible employee" means an employee, including an individual who either works or resides in this state, who meets all requirements for enrollment in a health benefit plan.

(f) "Excepted benefits" means:

(1) Any policy of liability insurance or contract supplemental thereto; coverage only for accident or disability income insurance or any combination thereof; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; workers' compensation insurance; or other similar insurance under which benefits for medical care are secondary or incidental to other insurance benefits; or

(2) If offered separately, a policy providing benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof, dental or vision benefits or other similar, limited benefits; or

(3) If offered as independent, noncoordinated benefits under separate policies or certificates, specified disease or illness coverage, hospital indemnity or other fixed indemnity insurance, or coverage, such as Medicare supplement insurance, supplemental to a group health plan; or

(4) A policy of accident and sickness insurance covering a period of less than one year.

(g) "Group health plan" means an employee welfare benefit plan, including a church plan or a governmental plan, all as defined in section three of the Employee Retirement Income Security Act of 1974, 29 U. S. C. §1003, to the extent that the plan provides medical care.

(h) "Health benefit plan" means benefits consisting of medical care provided directly, through insurance or reimbursement, or indirectly, including items and services paid for as medical care, under any hospital or medical expense incurred policy or certificate; hospital, medical or health service corporation contract; health maintenance organization contract; or plan provided by a multiple-employer trust or a multiple-employer welfare arrangement. "Health benefit plan" does not include excepted benefits.

(i) "Health insurer" means an entity licensed by the commissioner to transact accident and sickness in this state and subject to this chapter. "Health insurer" does not include a group health plan.

(j) "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, evidence of insurability (including conditions arising out of acts of domestic violence) or disability.

(k) "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 amounts paid for transportation primarily for and essential to such care.

(l) "Mental health benefits" means benefits with respect to mental health services, as defined under the terms of a group health plan or a health benefit plan offered in connection with the group health plan.

(m) "Network plan" means a health benefit plan under which the financing and delivery of medical care are provided, in whole or in part, through a defined set of providers under contract with the health insurer.

(n) "Preexisting condition exclusion" means, with respect to a health benefit plan, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the enrollment date for such coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before the enrollment date.