WEST VIRGINIA CODE: §33-26A-5

§33-26A-5. Definitions.

As used in this article:

(1) “Account” means either of the two accounts created under §33-26A-6 of this code.

(2) “Association” means the West Virginia Life and Health Insurance Guaranty Association created under §33-26A-6 of this code.

(3) “Authorized assessment” or the term “authorized” when used in the context of assessments means 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.

(4) “Benefit plan” means a specific employee, union, or association of natural persons benefit plan.

(5) “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.

(6) “Commissioner” means the Insurance Commissioner of West Virginia.

(7) “Contractual obligation” means any obligation under a policy or contract or certificate under a group policy or contract, or portion thereof for which coverage is provided under §33-26A-3 of this code.

(8) “Covered contract” or “covered policy” means any policy or contract within the scope of this article under §33-26A-3 of this code.

(9) “Extra-contractual claims” shall include, for example, claims relating to bad faith in the payment of claims, punitive, or exemplary damages or attorneys’ fees and costs.

(10) “Health benefit plan” means any hospital or medical expense policy or certificate subject to §33-15-1 et seq. or §33-16-1 et seq. of this code and benefits provided subject to §33-24-1 et seq. or §33-25-1 et seq. of this code, or health maintenance organization subscriber contract or any other similar health contract subject to the provisions of §33-25A-1 et seq. of this code. “Health benefit plan” does not include:

(i) Accident only insurance;

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(ii) Credit insurance;

(iii) Dental only insurance;

(iv) Vision only insurance;

(v) Medicare Supplement insurance;

(vi) Benefits for long-term care, home health care, community-based care, or any combination thereof;

(vii) Disability income insurance;

(viii) Coverage for on-site medical clinics; or

(ix) 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.

(11) "Impaired insurer" means a member insurer which, after the effective date of this article, is not an insolvent insurer, and: (1) Is deemed by the commissioner to be potentially unable to fulfill its contractual obligations: or (2) is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(12) "Insolvent insurer" means a member insurer which, after the effective date of this article, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

(13) "Member insurer" means any insurer or health maintenance organization licensed or which holds a certificate of authority to transact in this state any kind of insurance or health maintenance organization business for which coverage is provided under §33-26A-3 of this code, and includes an insurer or health maintenance organization whose license or certificate of authority in this state may have been suspended, revoked, not renewed, or voluntarily withdrawn, and includes nonprofit service corporations as defined in §33-24-1 et seq. of this code and health care corporations as defined in §33-25-1 et seq. of this code, but does not include:

(A) A fraternal benefit society;

(B) A mandatory state pooling plan;

(C) A mutual assessment company or any entity that operates on an assessment basis;

(D) An insurance exchange;

(E) An organization which has a certificate or license limited to the issuance of charitable

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gift annuities under §33-13B-1 et seq. of this code; or

(F) Any entity similar to any of the above.

(14) "Moody's Corporate Bond Yield Average" means the Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto.

(15) "Owner" of a policy or contract and "policyholder", "policy owner", and "contract owner" mean 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.

(16) "Person" means any individual, corporation, limited liability company, partnership, association, or voluntary organization.

(17) "Plan sponsor" means:

(A) The employer in the case of a benefit plan established or maintained by a single employer;

(B) The employee organization in the case of a benefit plan established or maintained by an employee organization; or

(C) In a 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.

(18) "Premiums" means amounts or considerations (by whatever name called) received on covered policies or contracts less premiums, considerations, and deposits, and less dividends and experience credits thereon. "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 §33-26A-3(b) of this code, except that assessable premium shall not be reduced on account of §33-26A-3(b)(2)(C) of this code relating to interest limitations and §33-26A-3(c)(2) of this code relating to limitations with respect to any one individual, one participant, and one policy or contract owner. Premiums shall not include:

(A) Premiums in excess of $5 million on any unallocated annuity contract not issued under a government retirement plan or its trustee established under sections 401, 403(b), or 457 of the United States Internal Revenue Code; or

(B) 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

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whether the persons insured are officers, managers, employees, or other persons, premiums in excess of $5 million with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

(19) (A) "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 in which the executive or management committee of the board of directors (or similar governing person or persons) of the entity conducts the majority of its meetings; and

(v) The state from which the management of the overall operations of the entity is directed;

(vi) 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 the above factors; however

(vii) 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.

(B) The principal place of business of a plan sponsor of a benefit plan described in §33-26A-5(17)(C) of this code 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.

(20) "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.

(21) "Resident" means a person to whom a contractual obligation is owed and who resides in this state on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent

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insurer, whichever occurs first. 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 residents of foreign countries or residents of United States possessions, territories, or protectorates that do not have an association similar to the association created by this article, shall be deemed residents of the state of domicile of the member insurer that issued the policies or contracts.

(22) "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 suffered by the plaintiff or other claimant.

(23) "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health, or annuity policy or contract.

(24) "Unallocated annuity contract" means any annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under such contract or certificate.

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