WEST VIRGINIA CODE: §33-48-1

§33-48-1. Definitions.

For purposes of this article:

(a) "Board" means the board of directors of the plan.

(b) "Church plan" has the meaning given such term under Section 3(33) of the federal Employee Retirement Income Security Act of 1974.

(c) "Commissioner" means the Insurance Commissioner of this state.

(d)(1) "Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

(A) A group health plan;

(B) Health insurance coverage;

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

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

(E) Chapter 55 of Title 10, U.S.C.;

(F) A medical care program of the federal Indian health service or of a tribal organization;

(G) A state health benefits risk pool;

(H) A health plan offered under Chapter 89 of Title 5, U.S.C.;

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

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

(2) A period of creditable coverage shall not be counted, with respect to the enrollment of an individual who seeks coverage under this article, if, after such period and before the enrollment date, the individual experiences a significant break in coverage.

(e) "Department" means the Insurance Commissioner of West Virginia.

(f) "Dependent" means a resident spouse or resident unmarried child under the age of nineteen years, a child who is a student under the age of twenty-three years and who is

financially dependent upon the parent or a child of any age who is disabled and dependent upon the parent.

(g) "Federally defined eligible individual" means an individual:

(1) For whom, as of the date on which the individual seeks coverage under this article, the aggregate of the periods of creditable coverage as defined in subsection (d) of this section is eighteen or more months;

(2) Whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan or health insurance coverage offered in connection with such a plan;

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

(4) With respect to whom the most recent coverage within the period of aggregate creditable coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;

(5) Who, if offered the option of continuation coverage under a COBRA continuation provision or under a similar state program, elected this coverage; and

(6) Who has exhausted the continuation coverage under this provision or program, if the individual elected the continuation coverage described in subdivision (5) of this subsection.

(h) "Governmental plan" has the meaning given such term under Section 3(32) of the federal Employee Retirement Income Security Act of 1974 and any federal government plan.

(i) "Group health plan" means an employee welfare benefit plan as defined in Section 3(1) of the federal Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care as defined in subsection (m) of this section 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.

(j)(1) "Health insurance coverage" means any hospital and medical expense incurred policy, nonprofit health care service plan contract, health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes medical or healthcare services whether by insurance or otherwise.

(2) "Health insurance coverage" shall not include one or more, or any combination of, the following:

(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) Automobile medical payment insurance;

(F) Credit-only insurance;

(G) Coverage for on-site medical clinics; and

(H) Other similar insurance coverage, specified in federal regulations issued pursuant to PL 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.

(3) "Health insurance coverage" shall 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 coverage:

(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; or

(C) Other similar, limited benefits specified in federal regulations issued pursuant to PL 104-191.

(4) "Health insurance coverage" shall 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:

(A) Coverage only for a specified disease or illness; or

(B) Hospital indemnity or other fixed indemnity insurance.

(5) "Health insurance coverage" shall not include the following if offered as a separate policy, certificate or contract of insurance:

(A) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;

(B) Coverage supplemental to the coverage provided under Chapter 55 of Title 10, U.S.C.

(Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or

(C) Similar supplemental coverage provided to coverage under a group health plan.

(k) "Health maintenance organization" means an organization licensed in this state pursuant to the provisions of article twenty-five-a of this chapter.

(l) "Insurer" means any entity that provides health insurance coverage in this state. For the purposes of this article, insurer includes an insurance company, a prepaid limited health service organization as operating under a certificate of authority pursuant to article twenty-five-d of this chapter, a fraternal benefit society, a health maintenance organization and any other entity providing a plan of health insurance coverage or health benefits subject to state insurance regulation.

(m) "Medical care" means amounts paid for:

(1) The diagnosis, care, 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) of this subsection; and

(3) Insurance covering medical referred to in subdivisions (1) and (2) of this subsection.

(n) "Medicare" means coverage under both Parts A and B of Title XVIII of the Social Security Act, 42 U.S.C. 1395, et seq., as amended.

(o) "Participating insurer" means any insurer providing health insurance coverage to residents of this state.

(p) "Plan" means the West Virginia health insurance plan as created in section two of this article.

(q) "Plan of operation" means the articles, bylaws and operating rules and procedures adopted by the board pursuant to section two of this article.

(r) "Resident" means an individual who has been legally domiciled in this state for a period of at least thirty days, except that for a federally defined eligible individual, there shall not be a thirty-day requirement. "Resident" also means an individual who is legally domiciled in this state on the date of application to the plan and is eligible for the credit for health insurance costs under Section 35 of the Internal Revenue Code of 1986.

(s) "Significant break in coverage" means a period of sixty-three consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.

Terms within this article with meaning ascribed by federal law shall have the meaning as in effect in federal law December 31, 2003.