WEST VIRGINIA CODE: §33-55-1

§33-55-1. Definitions.

For purposes of this article:

"Authorized representative" means:

(A) A person to whom a covered person has given express written consent to represent the covered person;

(B) A person authorized by law to provide substituted consent for a covered person; or

(C) The covered person’s treating health care professional, only when the covered person is unable to provide consent, or a family member of the covered person.

"Commissioner" means the Insurance Commissioner of this state.

"Covered benefit" or "benefit" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

"Covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan.

"Emergency medical condition" means a physical, mental, or behavioral health condition that manifests itself by acute symptoms of sufficient severity, including severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to reasonably expect, in the absence of immediate medical attention, to result in:

(A) Placing the individual’s physical, mental, or behavioral health, or, with respect to a pregnant woman, the woman’s or her fetus’s health in serious jeopardy;

(B) Serious impairment to a bodily function;

(C) Serious impairment of any bodily organ or part; or

(D) With respect to a pregnant woman who is having contractions:

(i) Inadequate time to affect a safe transfer to another hospital before delivery; or

(ii) When transfer to another hospital may pose a threat to the health or safety of the woman or fetus.

"Emergency services" means, with respect to an emergency condition:

(A) A medical or mental health screening examination that is within the capability of the

emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and

(B) Any further medical or mental health examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient.

"Essential community provider" or "ECP" means a provider that:

(A) Serves predominantly low-income, medically underserved individuals, including a health care provider defined in Section 340B(a)(4) of the Public Health Service Act (PHSA); or

(B) Is described in Section 1927(c)(1)(D)(i)(IV) of the Social Security Act, as set forth by Section 221 of Pub.L.111-8.

"Facility" means an institution providing health care services or a health care setting, including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, urgent care centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic health settings.

"Health benefit plan" means a policy, contract, certificate, or agreement entered into, offered, or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

"Health care professional" means a physician or other health care practitioner licensed, accredited, or certified to perform specified (physical, mental, or behavioral) health care services consistent with their scope of practice under state law.

"Health care provider" or "provider" means a health care professional, a pharmacy, or a facility.

"Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a physical, mental, or behavioral health condition, illness, injury, or disease, including mental health and substance use disorders.

"Health carrier" or "carrier" means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an insurer issuing an accident and sickness insurance policy pursuant to §33-15-1 *et seq*. of this code, an insurer issuing an accident and sickness group policy pursuant to §33-16-1 *et seq*. of this code, a hospital medical and dental corporation licensed pursuant to §33-24-1 *et seq*. of this code, a health care corporation licensed pursuant to §33-25-1 *et seq*. of this code, or a health maintenance organization licensed pursuant to §33-25A-1 *et seq*. of this code. For purposes of this article, the term "health carrier" or "carrier" does not include insurers or managed care organizations with

respect to their Medicaid or Children's Health Insurance Program (CHIP) plans or contracts which are reviewed and approved by the Bureau for Medical Services.

"Intermediary" means a person authorized to negotiate and execute provider contracts with health carriers on behalf of health care providers or on behalf of a network.

"Limited scope dental plan" means a plan that provides coverage, substantially all of which is for treatment of the mouth, including any organ or structure within the mouth, which is provided under a separate policy, certificate, or contract of insurance or is otherwise not an integral part of a group benefit plan.

"Limited scope vision plan" means a plan that provides coverage, substantially all of which is for treatment of the eye, that is provided under a separate policy, certificate, or contract of insurance or is otherwise not an integral part of a group benefit plan.

"Network" means the group or groups of participating providers providing services under a network plan.

"Network plan" means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with, or employed by the health carrier.

"Participating provider" means a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health carrier.

"Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

"Primary care" means health care services for a range of common physical, mental, or behavioral health conditions provided by a physician or nonphysician primary care professional.

"Primary care professional" means a participating health care professional designated by the health carrier to supervise, coordinate, or provide initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

"Specialist" means a physician or non-physician health care professional who:

(A) Focuses on a specific area of physical, mental, or behavioral health or a group of patients; and

(B) Has successfully completed required training and is recognized by the state in which he

or she practices to provide specialty care.

"Specialist" includes a subspecialist who has additional training and recognition above and beyond his or her specialty training.

"Specialty care" means advanced medically necessary care and treatment of specific physical, mental, or behavioral health conditions, or those health conditions which may manifest in particular ages or subpopulations, that are provided by a specialist, preferably in coordination with a primary care professional or other health care professional.

"Telemedicine" or "Telehealth" means health care services provided through telecommunications technology by a health care professional who is at a location other than where the covered person is located.

"Tiered network" means a network that identifies and groups some or all types of providers and facilities into specific groups to which different provider reimbursement, covered person cost-sharing, or provider access requirements, or any combination thereof, apply for the same services.

"To stabilize" means with respect to an emergency medical condition to provide such medical treatment of the condition as may be necessary to assure, within a reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual to or from a facility, or, with respect to an emergency birth with no complications resulting in a continued emergency to deliver the child and the placenta.

"Transfer" means the movement, including the discharge, of an individual outside a hospital’s facilities at the direction of any person employed by, or affiliated or associated, directly or indirectly, with the hospital, but does not include the movement of an individual who:

(A) Has been declared dead; or

(B) Leaves the facility without the permission of any such person.