§ 1358.4. Definitions

The following definitions apply for the purposes of this article:

(a) "Applicant" means:

(1) An individual enrollee who seeks to contract for health coverage, in the case of an individual Medicare supplement contract.

(2) An enrollee who seeks to obtain health coverage through a group, in the case of a group Medicare supplement contract.

(b) "Bankruptcy" means that situation in which a Medicare Advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

(c) "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than 63 days.

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

(A) Any individual or group contract, policy, certificate, or program that is written or administered by a health care service plan, health insurer, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage.

(B) Part A or B of Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395c et seq.) (Medicare).

(C) Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) (Medicaid), other than coverage consisting solely of benefits under Section 1928 of that act.

(D) Chapter 55 of Title 10 of the United States Code (CHAMPUS).

(E) A medical care program of the Indian Health Service or of a tribal organization.

(F) A state health benefits risk pool.

(G) A health plan offered under Chapter 89 of Title 5 of the United States Code (Federal Employees Health Benefits Program).

(H) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(I) of the federal Public Health Service Act, as amended by Public Law 104-191, the federal Health Insurance Portability and Accountability Act of 1996.

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

(J) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care.

(K) Any other creditable coverage as defined by subsection (c) of Section 2701 of Title XXVII of the federal Public Health Service Act (42 U.S.C. Sec. 300gg(c)).

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

(A) Coverage for accident-only 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 onsite medical clinics.

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

(3) "Creditable coverage" shall not include the following benefits if they are provided under a separate policy, certificate, or contract or are otherwise not an integral part of the plan:

(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.

(C) Other similar, limited benefits as are specified in federal regulations.

(4) "Creditable coverage" shall not include the following benefits if offered as independent, noncoordinated benefits:

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

(B) Hospital indemnity or other fixed indemnity insurance.

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

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

(B) Coverage supplemental to the coverage provided under Chapter 55 of Title 10 of the United States Code.

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

(e) "Employee welfare benefit plan" means a plan, fund, or program of employee benefits as defined in Section 1002 of Title 29 of the United States Code (Employee Retirement Income Security Act).

(f) "Insolvency" means when an issuer, licensed to transact the business of a health care service plan in this state, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

(g) "Issuer" means a health care service plan delivering, or issuing for delivery, Medicare supplement contracts in this state, but does not include entities subject to Article 6 (commencing with Section 10192.1) of Chapter 1 of Part 2 of Division 2 of the Insurance Code.

(h) "Medicare" means the federal Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as amended.

(i) "Medicare Advantage Plan" means a plan of coverage for health benefits under Medicare Part C and includes:

(1) Coordinated care plans that provide health care services, including, but not limited to, health care service plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organizations plans.

(2) Medical savings account plans coupled with a contribution into a Medicare Advantage medical savings account.

(3) Medicare Advantage private fee-for-service plans.

(j) "Medicare supplement contract" means a group or individual plan contract of hospital and medical service associations or health care service plans, other than a contract issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Sec. 1395mm) or an issued contract under a demonstration project specified in Section 1395ss(g)(1) of Title 42 of the United States Code, that is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare. "Contract" means "Medicare supplement contract," unless the context requires otherwise. "Medicare supplement contract" does not include a Medicare Advantage plan established under Medicare Part C, an outpatient prescription drug plan established under Medicare Part D, or a health care prepayment plan that provides benefits pursuant to an agreement under subparagraph (A) of paragraph (1) of subsection (a) of Section 1833 of the federal Social Security Act.

(k) "1990 standardized Medicare supplement benefit plan," "1990 standardized benefit plan," or "1990 plan" means a group or individual Medicare supplement contract issued on or after July 21, 1992, and with an effective date prior to June 1, 2010, and includes Medicare supplement contracts renewed on or after that date that are not replaced by the issuer at the request of the enrollee or subscriber.

(*l*) "2010 standardized Medicare supplement benefit plan," "2010 standardized benefit plan," or "2010 plan" means a group or individual Medicare supplement contract issued with an effective date on or after June 1, 2010.

(m) "Secretary" means the Secretary of the United States Department of Health and Human Services.

HISTORY:

Added Stats 2000 ch 706 § 2 (SB 764). Amended Stats 2005 ch 206 § 1 (SB 375), effective January 1, 2006; Stats 2009 ch 10 § 1 (AB 1543), effective July 2, 2009; Stats 2010 ch 328 § 116 (SB 1330), effective January 1, 2011.