§ 7705. Definitions. As used in this article:

(a) "Account" means any of the two accounts created under section seven thousand seven hundred six of this article.

(b) "Contractual obligations" means any obligation under covered policies, but shall not include any obligation with respect to policyholder dividends unpaid or unapplied, retrospective rate credits or similar benefits or provisions.

(c) "Corporation" means The Life and Health Insurance Company Guaranty Corporation of New York created under section seven thousand seven hundred six of this article unless the context otherwise requires.

(d) "Covered policy" means any of the kinds of insurance specified in paragraph one, two or three of subsection (a) of section one thousand one hundred thirteen of this chapter, any supplemental contract, or any funding agreement referred to in section three thousand two hundred twenty-two of this chapter, or any portion or part thereof, within the scope of this article under section seven thousand seven hundred three of this article, except that any certificate issued to an individual under any group or blanket policy or contract shall be considered to be a separate covered policy for purposes of section seven thousand seven hundred eight of this article.

(e) "Health insurance" means the kinds of insurance specified under items (i) and (ii) of paragraph three and paragraph thirty-one of subsection (a) of section one thousand one hundred thirteen of this chapter, and section one thousand one hundred seventeen of this chapter; medical expense indemnity, dental expense indemnity, hospital service, or health service under article forty-three of this chapter; and comprehensive health services under article forty-four of the public health law. "Health insurance" shall not include hospital, medical, surgical, prescription drug, or other health care benefits pursuant to: (1) part C of title XVIII of the social security act (42 U.S.C. § 1395w-21 et seq.) or part D of title XVIII of the social security act (42 U.S.C. § 1395w-101 et seq.), commonly known as Medicare parts C and D, or any regulations promulgated thereunder; (2) titles XIX and XXI of the social security act (42 U.S.C. § 1396 et seq.), commonly known as the Medicaid and child health insurance programs, or any regulations promulgated thereunder; (3) the basic health program under section three hundred sixty-nine-gg of the social services law; (4) chapter 55 of part

II of subtitle A of title X (10 U.S.C §§ 1071-1110(b)), commonly known as TRICARE, or any regulations promulgated thereunder; or (5) subpart G of part III of title V (5 U.S.C. §§ 8101-9009), commonly known as the Federal Employees Program, or any regulations promulgated thereunder.

(f) "Impaired insurer" means a member insurer which after the effective date of this article is found to be impaired for the purposes of section one thousand three hundred ten or one thousand three hundred eleven of this chapter and is consequently placed under an order of liquidation, rehabilitation or conservation under article seventy-four of this chapter.

(g) "Insolvent insurer" means a member insurer which after the effective date of this article becomes insolvent for the purposes of section one thousand three hundred nine of this chapter and is placed under a final order of liquidation, rehabilitation or conservation by a court of competent jurisdiction.

(h) (1) "Member insurer" means:

(A) any life insurance company licensed to transact in this state any kind of insurance to which this article applies under section seven thousand seven hundred three of this article; provided, however, that the term "member insurer" also means any life insurance company formerly licensed to transact in this state any kind of insurance to which this article applies under section seven thousand seven hundred three of this article; and

(B) an insurer licensed or formerly licensed to write accident and health insurance or salary protection insurance in this state, corporation organized pursuant to article forty-three of this chapter, reciprocal insurer organized pursuant to article sixty-one of this chapter, cooperative property/casualty insurance company operating under or subject to article sixty-six of this chapter, nonprofit property/casualty insurance company organized pursuant to article sixty-seven of this chapter, and health maintenance organization certified pursuant to article forty-four of the public health law.

(2) "Member insurer" shall not include a municipal cooperative health benefit plan established pursuant to article forty-seven of this chapter, an employee welfare fund registered under article forty-four of this chapter, a fraternal benefit society organized under article forty-five of this chapter, an institution of higher education with a

certificate of authority under section one thousand one hundred twenty-four of this chapter, or a continuing care retirement community with a certificate of authority under article forty-six or forty-six-A of the public health law.

(i) "Premiums" means direct gross insurance premiums and annuity and funding agreement considerations received on covered policies, less return premiums and considerations thereon and dividends paid or credited to policyholders or contract holders on such direct business, subject to such modifications as the superintendent may establish by regulation or order as necessary to facilitate the equitable administration of this article. Premiums do not include premiums and considerations on contracts between insurers and reinsurers. For the purposes of determining the assessment for an insurer under this article, the term "premiums", with respect to a group annuity contract (or portion of any such contract) that does not guarantee annuity benefits to any specific individual identified in the contract and with respect to any funding agreement issued to fund benefits under any employee benefit plan, means the lesser of one million dollars or the premium attributable to that portion of such group contract that does not guarantee benefits to any specific individuals or such agreements that fund benefits under any employee benefit plan.

(j) "Person" means any individual or legal entity, including a corporation, partnership, association, limited liability company, trust, or voluntary organization.

(k) "Resident" means a person to whom a contractual obligation is owed and who either: (1) resides in this state on the date of entry of a court order of liquidation or rehabilitation with respect to a member insurer that is an impaired or insolvent insurer; or (2) resided in this state at the time a member insurer issued a covered policy to such person.

(l) "Supplemental contract" means an agreement or any other mechanism for the distribution of proceeds under a life insurance policy, health insurance policy, annuity contract, or funding agreement.

(m) "Long-term care insurance" means an insurance policy, rider, or certificate advertised, marketed, offered, or designed to provide coverage, subject to eligibility requirements, for not less than twenty-four consecutive months for each covered person on an expense

incurred, indemnity, prepaid or other basis and provides at least the benefits set forth in part fifty-two of title eleven of the official compilation of codes, rules and regulations of this state.