191—38.13 (509,514) Definitions. As used in this division, these terms have the following meanings, unless the context clearly indicates otherwise:

"Allowable expense," except as set forth below or where a statute requires a different definition, means any health care expense, including coinsurance or copayments and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering the person.

1. If a plan is advised by a covered person that all plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan's deductible is not an allowable expense, except for any health care expense incurred that may not be subject to the deductible as described in Section 223(c)(2)(C) of the Internal Revenue Code of 1986.

2. An expense or a portion of an expense that is not covered by any of the plans is not an allowable expense.

3. Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

4. The following are examples of expenses that are not allowable expenses:

a. If a person is confined in a private hospital room, the difference between the cost of a semiprivate room in the hospital and the private room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

b. If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged by the provider in excess of the highest reimbursement amount for a specified benefit is not an allowable expense.

c. If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.

d. If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and by another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different from the primary plan's payment arrangement and if the provider's contract permits, that negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

5. The definition of "allowable expense" may exclude certain types of coverage or benefits such as dental care, vision care, prescription drugs or hearing aids. A plan that limits the application of COB to certain coverages or benefits may limit the definition of "allowable expense" in its contract to expenses that are similar to the expenses that it provides. When COB is restricted to specific coverages or benefits in a contract, the definition of "allowable expense" shall include similar expenses to which COB applies.

6. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.

7. The amount of the reduction may be excluded from allowable expense when a covered person's benefits are reduced under a primary plan:

a. Because the covered person does not comply with the plan provisions concerning second surgical opinions or precertification of admissions or services; or

b. Because the covered person has a lower benefit because the covered person did not use a preferred provider.

"Birthday" refers only to month and day in a calendar year and does not include the year in which the individual is born.

"Claim" means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of services (including supplies); payment for all or a portion of the expenses incurred; a combination of services or expenses incurred; or an indemnification.

"Closed panel plan" means a plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

"Consolidated Omnibus Budget Reconciliation Act of 1985" or *"COBRA"* means coverage provided under a right of continuation pursuant to federal law.

"Coordination of benefits" or *"COB"* means a provision establishing an order in which plans pay their claims and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

"Custodial parent" means the parent awarded custody of a child by a court decree or, in the absence of a court decree, the parent with whom the child resides more than one-half of the calendar year without regard to any temporary visitation.

"Group-type contract" means a contract that is not available to the general public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage. "Group-type contract" does not include an individually underwritten and issued guaranteed renewable policy even if the policy is purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.

"High-deductible health plan" has the meaning given the term under Section 223 of the Internal Revenue Code of 1986, as amended by the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

"Hospital indemnity benefits" means benefits not related to expenses incurred. "Hospital indemnity benefits" does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

"Plan" means a form of coverage with which coordination is allowed. Separate parts of a plan for members of a group that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one plan and there is no COB among the separate parts of the plan.

If a plan coordinates benefits, its contract shall state the types of coverage that will be considered in applying the COB provision of that contract. Whether the contract uses the term "plan" or some other term such as "program," the contractual definition may be no broader than the definition of "plan" in paragraph 1 below. A model COB provision is contained in Appendix A of this division.

1. "Plan" includes:

a. Group and nongroup insurance contracts and subscriber contracts;

b. Uninsured arrangements of group or group-type coverage;

c. Group and nongroup coverage through closed panel plans;

d. Group-type contracts;

e. The medical care components of long-term care contracts, such as skilled nursing care;

f. The medical benefits coverage in automobile "no fault" and traditional automobile "fault" contracts; and

g. Medicare or other governmental benefits, as permitted by law, except as provided in paragraph 2*"h"* below. This part of a plan may be limited to the hospital, medical and surgical benefits of the governmental program.

2. "Plan" does not include:

a. Hospital indemnity coverage benefits or other fixed indemnity coverage;

b. Accident-only coverage;

c. Specified disease or specified accident coverage;

d. Limited benefit health insurance coverage, as defined in 191—subrule 36.6(10);

e. School accident-type coverages that cover students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis;

f. Benefits provided in long-term care insurance policies for nonmedical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care, or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;

g. Medicare supplement policies;

h. A state plan under Medicaid; or

i. A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.

"Policyholder" means the primary insured named in a nongroup insurance policy.

"Primary plan" means a plan whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration. A plan is a "primary plan" if:

1. The plan either has no order of benefit determination rules, or its rules differ from those permitted by this division; or

2. All plans that cover the person use the order of benefit determination rules required by this division, and under those rules the plan determines its benefits first.

"Secondary plan" means a plan that is not a primary plan.