4685.0910 DEFINITIONS.

Subpart 1. **Scope.** The following words and terms, when used in parts 4685.0905 to 4685.0950, have the following meanings unless the context clearly indicates otherwise.

Subp. 2. **Allowable expense.**

A. "Allowable expense" means the necessary, reasonable, and customary item of expense for health care when the item of expense is covered at least in part under any of the plans involved, except where a statute requires a different definition.

B. Notwithstanding this definition, items of expense under coverages such as dental care, vision care, or prescription drug or hearing aid programs may be excluded from the definition of allowable expense. A plan that provides benefits only for such items of expense may limit its definition of allowable expenses to those items of expense.

C. When a plan provides benefits in the form of service, the reasonable cash value of each service is both an allowable expense and a benefit paid.

D. The difference between the cost of a private hospital room and the cost of a semiprivate hospital room is not an allowable expense under this definition unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice.

E. When coordination of benefits is restricted to specific coverage in a contract, for example, major medical or dental, the definition of allowable expense must include the corresponding expenses or services to which coordination of benefits applies.

F. When benefits are reduced under a primary plan because a covered person does not comply with the plan provisions, the amount of such reduction will not be considered an allowable expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

(1) Only benefit reductions based upon provisions similar in purpose to those described above and which are contained in the primary plan may be excluded from allowable expenses.

(2) This provision shall not be used by a secondary plan to refuse to pay benefits because a health maintenance organization enrollee has elected to have health care services provided by a nonhealth maintenance organization provider and the health maintenance organization, pursuant to its contract is not obligated to pay for providing those services.

Subp. 3. **Claim.** "Claim" means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of:

A. services, including supplies;

B. payment for all or a portion of the expenses incurred;

C. a combination of items A and B; or

D. an indemnification.

Subp. 4. **Claim determination period.**

A. "Claim determination period" means the period of time over which allowable expenses are compared with total benefits payable in the absence of coordination of benefits, to determine whether overinsurance exists and how much each plan will pay or provide. The claim determination period must not be less than 12 consecutive months.

B. The claim determination period is usually a calendar year, but a plan may use some other period of time that fits the coverage of the group contract. A person may be covered by a plan during a portion of a claim determination period if that person's coverage starts or ends during the claim determination period.

C. As each claim is submitted, each plan must determine its liability and pay or provide benefits based upon allowable expenses incurred to that point in the claim determination period. The determination may be adjusted as allowable expenses are incurred later in the same claim determination period.

Subp. 5. **Coordination of benefits.** "Coordination of benefits" means a provision establishing the order in which plans pay their claims.

Subp. 6. **Hospital indemnity benefits.** "Hospital indemnity benefits" are not related to expenses incurred. The term 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.

Subp. 7. **Plan.** "Plan" means a form of coverage with which coordination is allowed. The definition of plan in the group contract must state the types of coverage that will be considered in applying the coordination of benefits provision of that contract. The right to include a type of coverage is limited by the rest of this definition.

A. The definition shown in the Model Coordination of Benefits Provisions in part 4685.0950 is an example of what may be used. Any definition that satisfies this subpart may be used.

B. Instead of "plan," a group contract may use "program" or some other term.

C. Plan includes:

(1) Group insurance and group subscriber contracts.

(2) Uninsured arrangements of group or group-type coverage.

(3) Group or group-type coverage through health maintenance organizations and other prepayment, group practice, and individual practice plans.

(4) Group-type contracts. Group-type contracts are contracts that are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group. Group-type contracts may be included in the definition of plan, at the option of the insurer or the service provider and the contract client, whether or not uninsured arrangements or individual contract forms are used and regardless of how the group-type coverage is designated, for example, franchise or blanket. Individually underwritten and issued guaranteed renewable policies are not group-type even though 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.

(5) The amount by which group or group-type hospital indemnity benefits exceed $100 a day.

(6) The medical benefits coverage in group, group-type, and individual automobile no-fault and traditional automobile fault-type contracts.

(7) Medicare or other governmental benefits, except as provided in item D, subitem (7). That part of the definition of plan may be limited to the hospital, medical, and surgical benefits of the governmental program.

D. Plan does not include:

(1) individual or family insurance contracts;

(2) individual or family subscriber contracts;

(3) individual or family coverage through health maintenance organizations;

(4) individual or family coverage under other prepayment, group practice, and individual practice plans;

(5) group or group-type hospital indemnity benefits of $100 a day or less;

(6) school accident-type coverages that cover grammar, high school, and college students for accidents only, including athletic injuries, either on a 24-hour basis or on a to and from school basis; and

(7) a state plan under Medicaid, or a law or plan when, by law, its benefits are in excess of those of any private insurance plan or other nongovernmental plan.

Subp. 8. **Primary plan.** "Primary plan" means a plan that requires benefits for a person's health care coverage to be determined without taking into consideration the existence of any other plan. A plan is a primary plan if either of the following is true:

A. The plan either has no order of benefit determination rules or it has provisions that differ from those permitted by parts 4685.0905 to 4685.0950. There may be more than one primary plan.

B. All plans that cover the person use the order of benefit determination rules required by parts 4685.0905 to 4685.0950 and, under those rules, the plan determines its benefits first.

Subp. 9. **Secondary plan.** "Secondary plan" means a plan that is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules in parts 4685.0905 to 4685.0950 determine the order in which their benefits are determined in relation to each other. The benefits of each secondary plan may take into consideration the benefits of the primary plan or plans and the benefits of any other plan which under these rules has its benefits determined before those of that secondary plan.

Subp. 10. **This plan.** In a coordination of benefits provision, "this plan" refers to the part of the group contract providing the health care benefits to which the coordination of benefits provision applies and that may be reduced because of the benefits of other plans. Any other part of the group contract providing health care benefits is separate from this plan. A group contract may apply one coordination of benefits provision to certain of its benefits, such as dental benefits, coordinating only with like benefits, and may apply other separate coordination of benefits provisions to coordinate other benefits.

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