Sec. 38a-480-3. Definitions

(a) **Plan**.

(1) A "Plan" is a form of coverage with which coordination is allowed. The definition of Plan in the group contract must state the types of coverage which will be considered in applying the COB provision of that contract. The right to include a type of coverage is limited by the rest of this subsection 38a-480-3 (a).

(2) The definition shown in the COB Provision in Section 38a-480-4 is an example of what may be used. Any definition that satisfies this subsection 38a-480-3 (a) may be used.

(3) This regulation uses the term "Plan." However, a group contract may, instead, use "Program" or some other term.

(4) "Plan" shall not include individual or family:

(A) insurance contracts;

(B) subscriber contracts;

(C) coverage through Health Maintenance Organizations (HMOs); or

(D) coverage under other prepayment, group practice and individual practice plan; except as provided in (5) and (6) below.

(5) "Plan" may include:

(A) group insurance and group subscriber contracts;

(B) uninsured arrangements of group or group-type coverage;

(C) group or group-type coverage through HMOs and other prepayment, group practice and individual practice plans; and

(D) group-type contracts.

Group type contracts are contracts which 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 answering this description may be included in the definition of Plan, at the option of the insurer or the service provider and its 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"). The use of payroll deductions by the employee, subscriber or member to pay for the coverage is not sufficient, of itself, to make an individual contract part of a group-type plan.

(6) "Plan" may include the medical benefits coverage in group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts.

(7) "Plan" may include Medicare or other governmental benefits. That part of the definition of "Plan" may be limited to the hospital, medical and surgical benefits of the governmental program. However, "Plan" shall not include a state plan under Medicaid, and shall not include a law or plan when, by law, its benefits are excess to those of any private insurance plan or other non-governmental plan.

(8) "Plan":

(A) shall not be construed to include group or group-type hospital indemnity benefits of $30 per day or less; but

(B) may be construed to include the amount by which group or group-type hospital indemnity benefits exceed $30 per day.

"Hospital indemnity benefits" are those 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.

(9) "Plan" shall not include student accident or student accident and health coverages for which the student or parent pays the entire premium.

(10) "Plan" shall not include:

(A) group contracts issued by or reinsured through the Health Reinsurance Association; or

(B) subscriber contracts issued by a residual market mechanism established by hospital and medical service corporations and providing comprehensive health care coverage as provided in Chapter 700a of Connecticut General Statutes.

(b) **This Plan.** In a COB provision, this term refers to the part of the group contract providing the health care benefits to which the COB provision applies and which may be reduced on account 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 COB provision to certain of its benefits (such as dental benefits), coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.

(c) **Primary Plan.** A Primary Plan is one 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 either (1) or (2) below is true:

(1) The Plan either has no order of benefit determination rules, or it has rules which differ from those permitted by this regulation.

(2) All plans which cover the person use the order of benefit determination rules required by this regulation and under those rules the Plan determines its benefits first. There may be more than one Primary Plan (for example, two Plans which have no order of benefit determination rules).

(d) **Secondary Plan.** A Secondary Plan is one which is not a Primary Plan. If a person is covered by more than one Secondary Plan, the order of benefit determination rules of this regulation decide 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 the rules of this regulation, has its benefits determined before those of that Secondary Plan.

(e) **Allowable Expense**.

(1) "Allowable Expense" is 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. However, items of expense under coverages such as dental care, vision care, prescription drug or hearing aid programs may be excluded from the definition of Allowable Expense. A plan which provides benefits only for any such items of expense may limit its definition of Allowable Expenses to like items of expense.

(2) When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an Allowable Expense and a benefit paid.

(3) The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of

generally accepted medical practice, or as specifically defined in the Plan.

(4) When COB is restricted in its use to a 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 COB applies.

(f) **Claim.** A request that benefits of a Plan be provided or paid. The benefits claimed may be in the form of:

(1) services (including supplies);

(2) payment for all or a portion of the expenses incurred;

(3) a combination of (1) and (2) above; or

(4) an indemnification.

(g) **Claim Determination Period**.

(1) This is the period of time, which must be not less than twelve consecutive months, over which Allowable Expenses are compared with total benefits payable in the absence of COB, to determine:

(A) whether overinsurance exists; and

(B) how much each Plan will pay or provide.

It usually is 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 that Claim Determination Period.

(2) As each claim is submitted, each Plan is to determine its liability and pay or provide benefits based upon Allowable Expenses incurred to that point in the Claim Determination Period; but that determination is subject to adjustment as later Allowable Expenses are incurred in the same Claim Determination Period.

(Effective September 25, 1992)