Sec. 38a-554-2. Definitions

(A) "Plan" means any group policy issued by or reinsured through the Health Reinsurance Association or any subscriber contract issued by a residual market mechanism established by hospital and medical service corporations and providing comprehensive health care coverage as provided in Chapter 700c of the Connecticut General Statutes.

The term "Plan" shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

(B) "This Plan" means those portions of the policy which provide the benefits that are subject to this provision.

(C) "Allowable Expense" means any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the Plans covering the person for whom claim is made.

When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

(D) "Claim Determination Period" means a calendar year, or that portion of a calendar year during which the person for whom claim is made has been covered under this Plan.

(Effective September 25, 1992)