**WAC 284-51-195 Definitions.** As used in this chapter, these words and terms have the following meanings, unless the context clearly indicates otherwise:

(1) "Allowable expense," except as outlined below 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. When coordinating benefits, any secondary plans must pay an amount which, together with the payment made by the primary plan, cannot be less than the same allowable expense as the secondary plan would have paid if it was the primary plan. In no event will a secondary plan be required to pay an amount in excess of its maximum benefit plus accrued savings. When medicare, Part A, Part B, Part C, or Part D is primary, medicare's allowable amount is the allowable expense.

(a) If an issuer 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 according to 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.

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

(c) The following are examples of expenses that are not allowable expenses:

(i) 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.

(ii) 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 method, any amount charged by the provider in excess of the highest reimbursement amount for a specified benefit is not an allowable expense.

(iii) 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) 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 must include similar expenses to which COB applies.

(e) 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.

(f) If a secondary plan has been informed of the payment made by the primary plan but has not been informed of the amount of the primary plan's allowable expense within the period set forth in WAC 284-51-215 (2)(c), the secondary plan may use its allowable expense as the highest allowable expense.

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

(3) "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 (a) and (b) of this subsection; or

(d) An indemnification.

(4) "Claim determination period" means calendar year.

(5) "Closed panel plan" means a plan that provides health benefits to covered persons in the form of services primarily through a panel of providers that 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.

(6) "Consolidated Omnibus Budget Reconciliation Act of 1985" or "COBRA" means coverage provided under a right of continuation according to federal law.

(7) "Coordination of benefits" or "COB" means a provision establishing the order that 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.

(8) "Custodial parent" means:

(a) The parent awarded custody of a child by a court decree; or

(b) 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; or

(c) In cases where a court decree awards more than half of the calendar year's residential time to one parent without the use of "custodial" terminology, the parent to whom the greater residential time is awarded.

(9) "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.

(10)(a) "Hospital indemnity benefits" or "hospital fixed payment plan" means benefits not related to expenses incurred.

(b) "Hospital indemnity benefits" or "hospital fixed payment plan" 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.

(11) "Issuer" means a disability carrier, health care service contractor, health maintenance organization, and any other entity issuing a plan as defined in this chapter.

(12) "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.

(a) If a plan coordinates benefits, its contract must 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 this subsection.

(b) "Plan" includes:

(i) Group, individual or blanket disability insurance contracts, and group or individual contracts marketed by issuers as defined in this chapter;

(ii) Closed panel plans or other forms of group or individual coverage;

(iii) The medical care components of long-term care contracts, such as skilled nursing care; and

(iv) Medicare or other governmental benefits, as permitted by law, except as provided in (c)(vii) of this subsection. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program.

(c) "Plan" does not include:

(i) Hospital indemnity or fixed payment coverage benefits or other fixed indemnity or payment coverage;

(ii) Accident only coverage;

(iii) Specified disease or specified accident coverage;

(iv) Limited benefit health coverage, as defined in WAC 284-50-370;

(v) School accident and similar coverages that cover students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a "to and from school" basis;

(vi) 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;

(vii) Medicare supplement policies;

(viii) A state plan under medicaid;

(ix) A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan;

(x) Automobile insurance policies required by statute to provide medical benefits;

(xi) Benefits provided as part of a direct agreement with a direct patient-provider primary care practice as defined at section 3, chapter 267, Laws of 2007.

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

(14) "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 subject to this chapter is a primary plan if:

(a) The plan either has no order of benefit determination rules, or its rules differ from those permitted by this chapter; or

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

(15) "Secondary plan" means a plan that is not a primary plan.

[Statutory Authority: RCW 48.02.060, 48.21.200, 48.44.050, and 48.46.200. WSR 11-19-064 (Matter No. R 2011-06), § 284-51-195, filed 9/15/11, effective 10/16/11; WSR 09-16-073 (Matter No. R 2008-20), § 284-51-195, filed 7/30/09, effective 9/1/09; WSR 07-13-008 (Matter No. R 2005-07), § 284-51-195, filed 6/8/07, effective 7/9/07.]