each Plan will pay or provide. However, it does include any part of a year before the date this COB provision or a similar provision takes effect.

(d) "Complying Plan" means a Plan with order of benefit determination rules which comply with this section.

(e) A "Coordination of benefits (COB) provision" means an insurance contract provision intended to avoid claims payment delays and duplication of benefits when a person is covered by 2 or more plans providing benefits or services for medical, dental or other care or treatment.

(f) "Group-type contracts" means contracts which are not available to the general public and may 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 issuing group-type plans 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 employe, subscriber or member to pay for the coverage is not sufficient, of itself, to make an individual contract part of a group-type plan. Group-type contracts do not include individually underwritten and issued, guaranteed renewable policies that may be purchased through payroll deduction at a premium savings to the insured.

(g) "Hospital indemnity benefits" means benefits for hospital confinement which are not related to expenses incurred but does not include plans that reimburse a person for actual hospital expenses incurred even if the plans are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

(h) "Noncomplying Plan" means a Plan that declares its benefits to be "excess" or "always secondary" or that uses order of benefit determination rules inconsistent with those contained in this section.

(i) "Plan" means a form of coverage providing benefits for medical or dental care, except as limited under sub. (6), with which coordination is allowed.

(j) "Primary Plan" means a health care plan, determined by the order of benefit determination rules, whose benefits shall be determined before those of the other Plan and without taking the existence of any other Plan into consideration.

(k) "Secondary Plan" means a plan which is not a Primary Plan according to the order of benefit determination rules and whose benefits are determined after those of another Plan and may be reduced because of the other plan's benefits.

(l) "This Plan" means the part of the group contract that provides the health care benefits to which the COB provision applies and which 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.

(4) ALLOWABLE EXPENSE USES AND LIMITATIONS. (a) Items of expense under 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 these items may limit its definition of allowable expense to these items of expense.

(b) When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be considered as both an allowable expense and a benefit paid.

(c) 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 in terms of generally accepted medical practice or as specifically defined in the Plan.

(d) 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 shall include the corresponding expenses or services to which COB applies.

(5) CLAIM DETERMINATION PERIOD USES AND LIMITATIONS. (a) A claim determination period may not be less than 12 months and 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.

(b) As each claim is submitted, each Plan shall determine its liability and pay or provide benefits based upon allowable expenses incurred to that point in the claim determination period. However, that determination is subject to adjustment as later allowable expenses are incurred in the same claim determination period.

(6) PLAN USES, LIMITATIONS AND VARIATIONS. (a) The definition of Plan in the group contract shall state the types of coverage which shall 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.

(b) The definition of Plan shown in the model COB provision in APPENDIX A is an example of what may be used. Any definition that satisfies sub. (3) (i) and this subsection may be used.

(c) Notwithstanding the fact that this section uses the term "Plan," a group contract may instead use "Program" or some other term.

(d) "Plan" shall not include individual or family insurance or subscriber contracts or individual or family coverage through health maintenance organizations (HMOs), limited service health organizations (LSHOs), or any other prepayment, group practice or individual practice plan except as provided in pars. (e) and (f).

(e) "Plan" may include: group insurance and group subscriber contracts; uninsured arrangements of group or group-type coverage; group or group-type coverage through HMOs, LSHOs and other prepayment, group practice and individual practice plans; and group-type contracts.

(f) "Plan" may include the medical benefits coverage in group, group-type, and individual automobile "no-fault" contracts; but, as to the traditional automobile "fault" contracts, only the medical benefits written on a group or group-type basis may be included.

Applicability. 1) Except as provided in 2), the treatment of s. Ins 3.40 (2), (12) and (13) by this October, 1991 rule revision first applies to a group contract providing health care benefits:

a) For group contracts that are issued or renewed on January 1, 1992, on the effective date of this rule.

b) For group contracts that are issued or renewed after January 1, 1992, on the date of issuance or the first anniversary or renewal date following the effective date of this rule.

2) If a group contract providing health care benefits is written pursuant to a collectively bargained agreement, the treatment of s. Ins 3.40 (2), (12) and (13) by this October, 1991 rule revision first applies on whichever of the following occurs later:

a) January 1, 1992.

b) The expiration date of the collectively bargained agreement pursuant to which the group contract was written if the agreement prohibits changes to the health care benefits prior to its expiration date.

History: Cr. Register, July, 1980, No. 295, eff. 9-1-80; am. (2), Register, Janaury, 1981, No. 301, eff. 2-1-81; r. and recr. (7) (d) and (e), r. (19) under s. 13.93 (2m) (b) 16, Stats., renum. (8) to (18) to be (9) to (19), am. (20), Register, July, 1985, No. 355, eff. 8-1-85; r. and recr. Register, December 1986, No. 372, eff. 1-1-87; am. (2), (6) (d) and (f), (18) (b) (intro.) and Appendix A, cr. (11) (b) 4. e., Register, August, 1989, No. 404, eff. 9-1-89; am. (2), (3) (b), (c) and (k), (6) (b) and (c), (7) (b), (11) (b) 2., (12) (a) and (b), (14) and Appendix A, r. (12) (b) (intro.), (c) and (d), (13) (b) to (f), (18) (a) and (20), cr. (11) (b) 5m., and (c), renum. (13) (a) and (18) (b) to be (12) (c) and (18) and am. (12) (c) and (18) (intro.), Register, October, 1991, No. 430, eff. 1-1-92; correction in (11) made under s. 13.93 (2m) (b) 1, Stats., Register, April, 1992, No. 436.

Ins 3.40 APPENDIX A

Model COB Provision

This appendix provides model COB provision language. The terms and conditions of all insurance contracts containing a COB provision must comply with Ins 3.40.

COORDINATION OF THE GROUP CONTRACT'S BENEFITS WITH OTHER BENEFITS

(I) APPLICABILITY.

(A) This Coordination of Benefits ("COB") provision applies to This Plan when an employee or the employee's covered dependent has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

(B) If this COB provision applies, the order of benefit determination rules shall be looked at first. The rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

(i) shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but

(ii) may be reduced when, under the order of benefit determination rules, another Plan determines its benefits first. This reduction is described in Section (IV) Effect on the Benefits of This Plan.

(II) DEFINITIONS.

(A) *"Allowable Expense"* means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made.

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 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.

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

(B) *"Claim Determination Period"* means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan or any part of a year before the date this COB provision or a similar provision takes effect.

(C) *"Plan"* means any of the following which provides benefits or services for, or because of, medical or dental care or treatment:

(i) Group insurance or group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.