THE COORDINATION OF BENEFITS ACT (EXCERPT)
Act 64 of 1984

550.252 Definitions.

Sec. 2. (1) As used in this act:

(a) "Allowable expense" means a 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 individual. The amount of a reduction may be excluded from allowable expense if a covered person's benefits are reduced under a primary plan for either of the following reasons:

(*i*) Because the covered person does not comply with the plan provisions concerning second surgical opinions or precertification of admissions or services.

(*ii*) Because the covered person has a lower benefit because the covered person did not use a preferred provider.

(b) "Claim" means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of any of the following:

(*i*) Services including supplies.

(*ii*) Payment for all or a portion of the expenses incurred.

(*iii*) A combination of subparagraphs (*i*) and (*ii*).

(*iv*) An indemnification.

(c) "Closed panel plan" means a plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the insurer that issues the plan and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

(d) "Coordination of benefits" or "COB" means a provision that establishes an order in which insurers pay claims, and that permits benefits paid under secondary plans to be reduced so that the combined benefits paid under all plans do not exceed 100% of the total allowable expenses of the claims.

(e) "Custodial parent" means any of the following:

(*i*) The parent awarded custody of a child by a court order or judgment.

(*ii*) In the absence of a court order or judgment, the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

(f) "Dental care corporation" means a nonprofit dental care corporation incorporated under 1963 PA 125, MCL 550.351 to 550.373.

(g) "Group-type contract" means a contract that is not available to the general public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage. Group-type contract does not include an individually underwritten and issued guaranteed renewable policy even if the policy is purchased through payroll deduction at a premium savings to the insured, because the insured would have the right to maintain or renew the policy independently of continued employment with the employer.

(h) "Health maintenance organization" means that term as defined in section 3501 of the insurance code of 1956, 1956 PA 218, MCL 500.3501.

(i) "Insurer" means that term as defined in section 106 of the insurance code of 1956, 1956 PA 218, MCL 500.106.

(j) Subject to subsections (2) and (3), "plan" means a form of health care coverage with which coordination is allowed. Separate parts of a plan for members of a group that are provided through alternative contracts and that are intended to be part of a coordinated package of benefits are considered 1 plan and there is not COB among the separate parts of the plan. If benefits are coordinated under a plan, the contract must state the types of coverage that will be considered in applying the COB provision of the contract. Whether the contract uses the term "plan" or some other term such as "program", the contractual definition must not be broader than the definition of "plan" in this subdivision. Plan includes any of the following:

(*i*) Group and nongroup insurance contracts and subscriber contracts.

(*ii*) Uninsured arrangements of group or group-type coverage.

(*iii*) Group and nongroup coverage through closed panel plans.

(*iv*) Group-type contracts.

(*v*) The medical care components of long-term care contracts, including skilled nursing care.

(*vi*) Medicare or other governmental benefits, as permitted by law, except as provided in subsection (2)(g). Plan under this subdivision may be limited to the hospital, medical, and surgical benefits of the governmental program.

(*vii*) Group and nongroup insurance contracts and subscriber contracts that pay or reimburse for the cost of

dental care.

(*viii*) Group and nongroup dental insurance contracts and subscriber contracts issued by a dental care corporation.

(k) "Primary plan" means a plan under which benefits for an individual's health care coverage are determined without taking into consideration the existence of any other plan. A plan is a primary plan under either of the following circumstances:

(*i*) The plan either has no order of benefit determination rules or its rules differ from those authorized under this act.

(*ii*) All plans that cover the individual use the order of benefit determination rules required under this act and, under those rules, the benefits payable under the plan are determined to be payable first.

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

(2) For purposes of this act, plan does not include any of the following:

(a) Hospital indemnity coverage benefits or other fixed indemnity coverage.

(b) Accident-only coverage or disability income insurance.

(c) Specified disease or specified accident coverage.

(d) School-accident-type coverages that cover students for accidents only, including athletic injuries, either on a 24-hour basis or on a to-and-from-school basis.

(e) Benefits provided in long-term care insurance policies for nonmedical services, including 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.

(f) Medicare supplement plans.

(g) A state plan under Medicaid.

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

(3) For purposes of this act, plans are issued by any of the following:

(a) A health maintenance organization under which health services are provided, either directly or through contracts with affiliated providers, to individual or group enrollees.

(b) A dental care corporation under which dental benefits are provided to individual or group enrollees.

(c) An insurer that provides for hospital, medical, surgical, dental, or sick care benefits.

History: 1984, Act 64, Imd. Eff. Apr. 18, 1984;—Am. 2016, Act 275, Imd. Eff. July 1, 2016.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.