

**State of Rhode Island and Providence Plantations
DEPARTMENT OF BUSINESS REGULATION**

Division of Insurance

**1511 Pontiac Avenue, Bldg. 69-2
Cranston, Rhode Island 02920**

Public Notice of Proposed Rule-Making

Pursuant to the provisions of R.I. Gen. Laws § 27-20.6-6 and in accordance with the Administrative Procedures Act Chapter 42-35 of the General Laws, the Department of Business Regulation hereby gives notice of its intent to amend Insurance Regulation 48 – Coordination of Benefits.

The purpose of this amendment is to bring the regulation into conformance with the most recent National Association of Insurance Commissioners model act.

The proposed amended regulation and concise summary of non-technical amendments are available for public inspection at www.dbr.ri.gov, in person at Department of Business Regulation, 1511 Pontiac Avenue, Cranston, Rhode Island 02920, or by email elizabeth.dwyer@dbr.ri.gov or by calling Elizabeth Kelleher Dwyer at (401) 462 9520.

In the development of the proposed amendment consideration was given to: (1) alternative approaches; (2) overlap or duplication with other statutory and regulatory provisions; and (3) significant economic impact on small business. No alternative approach, duplication, or overlap was identified based upon available information.

All interested parties are invited to submit written or oral comments concerning the proposed regulations by April 14, 2014 to Elizabeth Kelleher Dwyer, Department of Business Regulation, 1151 Pontiac Avenue, Cranston, Rhode Island 02920, elizabeth.dwyer@dbr.ri.gov. A public hearing to consider the proposed amendment shall be held on April 14, 2014 at 10:00 a.m. at 1511 Pontiac Avenue, Cranston, Rhode Island 02920 at which time and place all persons interested therein will be heard.

All are welcome at the Rhode Island Department of Business Regulation ("DBR"). If any reasonable accommodation is needed to ensure equal access, service or participation, please contact DBR at 401-462-9551, RI Relay at 7-1-1, or email directorofficeinquiry@dbr.ri.gov at least three (3) business days prior to the hearing.

Paul McGreevy
Director, Department of Business Regulation

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1511 Pontiac Avenue, Bldg. 69-2
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Concise Summary of Proposed Non-technical Amendments
to
Insurance Regulation Number 48 - Coordination of Benefits

In accordance with the Administrative Procedures Act, Section 42-35-3(a)(1) of the General Laws of Rhode Island, following is a concise summary of proposed non-technical amendments:

1. Section 1 removes a reference to the 1978 version of this regulation as that information is provided at the end of the regulation in the listing of amendments.
2. Section 2(a) conforms to the NAIC model act and clarifies the purpose of the regulation.
3. Section 2(b) provides that licensees may be required to use standard processes and forms. This is Rhode Island specific language designed to allow specific processes that will speed coordination of benefits (“COB”) and reduce administrative costs.
4. Section 3 amends the definitions of allowable expense, claim, coordination of benefits, hospital indemnity benefits, plan, primary plan and secondary plan and adds definitions of birthday, closed panel plan, COBRA, custodial parent and policyholder.
5. Section 4 regarding applicability and scope has been added.
6. Section 5 amends the model COB contract provisions to bring them into compliance with the NAIC model act.
7. Section 6 amends the rules for COB in accordance with the NAIC model.
8. Section 7 repeals the procedure to be followed by a secondary plan and replaces the language with the current NAIC model language.
9. Section 8 regarding notice to covered person was added in accordance with the current NAIC model.
10. Section 9 was amended to alter the provisions for plans claiming to be excess, to remove the provision on allowable expenses and to add a provision on payment in

the case of disagreements between plans all in accordance with the current NAIC model.

11. Section 12 was amended to provide clarification of the effective date in accordance with the current NAIC model.

State of Rhode Island and Providence Plantations
DEPARTMENT OF BUSINESS REGULATION
Division of Insurance

~~233 Richmond Street~~ 1511 Pontiac Avenue
~~Providence, RI 02903~~ Cranston, RI 02920

INSURANCE REGULATION 48

~~GROUP INSURANCE~~ COORDINATION OF BENEFITS

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Section 1 *Authority*

This regulation is adopted and promulgated by the Rhode Island Department of Business Regulation pursuant to R.I. Gen. Laws §§ 27-20.6-~~61 et seq.~~ ~~It replaces and repeals Part X of Regulation XXIII which took effect on October 9, 1978.~~

Section 2 *Purpose ~~and Applicability~~*

A. This regulation applies to all plans that are issued on or after the effective date of this regulation. The purpose of this Regulation is to:

~~A. Permit but not require, plans to include a coordination of benefits (COB) provision;~~

~~B.(1) Establish an a uniform order ~~in of~~ benefit determination under which plans pay their claims;~~

~~C. Provide the authority for the orderly transfer of information needed to pay claims promptly;~~

- ~~D.(2)~~ Reduce duplication of benefits by permitting a reduction of the benefits to be paid by a plans that, when the plan, pursuant to rules established by this Regulation, ~~does~~ not have to pay ~~its-their~~ benefits first; and
 - ~~E.~~ ~~Reduce claims payment delays; and~~
 - ~~F.~~ ~~Make all contracts that contain a COB provision consistent with this Regulation.~~
 - (3) Provide greater efficiency in the processing of claims when a person is covered under more than one plan.
- B. In order to accomplish the goals of this regulation the Department or the Office of Health Insurance Commissioner may require licensees to use a standardized process and form, including manual and electronic formats, to increase the accuracy of coverage information when multiple carriers are involved.

Section 3 Definitions

The following words and terms, when used in this Regulation, shall have the following meanings unless the context clearly indicates otherwise:

A. Allowable Expense.

- (1) "Allowable Expense" means 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, except as set forth below or where a statute requires a different definition, means any health care expense, including coinsurance or co-payments and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering the person.
- (2) If a plan 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 in accordance with 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.
- (3) An expense or a portion of an expense that is not covered by any of the plans is not an allowable expense.
- (4) Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an

allowable expense.

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

- (a) If a person is confined in a private hospital room, the difference between the cost of a semi-private 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.
- (b) If a person is covered by two (2) 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 methodology, any amount charged by the provider in excess of the highest of the negotiated fees is not an allowable expense.
- (c) If a person is covered by two (2) 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) If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, that negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

(26) The definition of "allowable expense" may exclude certain types of ~~Notwithstanding the above definition, items of expense under coverages or benefits~~ such as dental care, vision care, prescription drug or hearing aids. ~~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 Expense to like items of expense 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 shall include similar expenses to which COB applies.

(37) When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered ~~as both~~ an ~~A~~allowable ~~E~~expense and a benefit paid.

~~(4) 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.~~

~~(5) When COB is restricted in its use to 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.~~

(8) The amount of the reduction may be excluded from allowable expense when a covered person's benefits are reduced under a primary plan:

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

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

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

BC. "Claim" means : a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of:

~~A request that benefits of a plan be provided or paid is a claim. 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.

~~C. Claim Determination Period.~~

~~This is the period of time, which must not be less than twelve (12) consecutive months, over which Allowable Expenses are compared with total benefits payable in the~~

~~absence of COB, to determine whether overinsurance exists and how much each plan will pay or provide.~~

~~(1) — The Claim Determination Period is usually 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 the 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. That determination is subject to adjustment as later Allowable Expenses are incurred in the same Claim Determination Period.~~

D. “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 plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

E. “Consolidated Omnibus Budget Reconciliation Act of 1985” or “COBRA” means coverage provided under a right of continuation pursuant to federal law.

DE. “Coordination of Benefits” or “COB” means: a provision establishing an order in which 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.

G. “Custodial parent” means:

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

(2) 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.

H. (1) “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.

(2) “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 since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.

This is a provision establishing an order in which plans pay their claims.

I. “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.

EJ. (1) “Hospital Indemnity Benefits” means These are benefits 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.~~

(2) “Hospital indemnity benefits” 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.

FK. (1) “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. 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 definition.

(2) If a plan coordinates benefits, its contract shall 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. The definition shown in the Model COB Provision, attached to this rule as in Appendix A, is an example of what may be used. Any definition that satisfies this subsection may be used.

(2) This subchapter uses the term “plan.” However, a group contract may, instead, use “program” or some other term.

(3) “Plan” may includes:

(a) Group insurance and 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 closed panel plans;

- (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 the 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"). Individually underwritten and issued guaranteed renewable policies would not be considered "group-type" even though purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.~~
 - (e) ~~The amount by which group or group-type hospital indemnity benefits exceed one hundred dollars (\$100) per day; The medical care components of long-term care contracts, such as skilled nursing care;~~
 - (f) ~~The medical benefits coverage in ~~group, group-type and individual~~ automobile "no fault" and traditional automobile "fault" type contracts; ~~and~~~~
 - (g) ~~Medicare or other governmental benefits, as permitted by law, except as provided in (4)(~~g~~) below. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program-; and~~
 - (h) Group and nongroup insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care.
- (4) "Plan" ~~shall~~ does not include:
- (a) Individual or family insurance contracts;
 - (b) Individual or family subscriber contracts;
 - (c) Individual or family coverage through ~~Health Maintenance Organizations (HMOs)~~ Closed Panel Plans;
 - (d) Individual or family coverage under other prepayment, group practice and individual practice plans;
 - (e) Group or group-type hospital indemnity benefits or other group or group-type fixed indemnity coverage of one hundred dollars (\$100) per

~~day or less;~~

(f) Accident only coverage;

(g) Specified disease or specified accident coverage;

(h) Limited benefit health coverage.

(i) School accident-type coverages. These contracts cover ~~grammar, high school and college~~ students for accidents only, including athletic injuries, either on a twenty four (24) hour basis or on a "to and from school" basis; and

(j) Benefits provided in long-term care insurance policies for non-medical 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;

(k) Medicare supplement policies;

~~(g)~~ A State plan under Medicaid, and shall not include a law plan (such as the Catastrophic Health Insurance Plan benefits provided pursuant to R.I. Gen. Laws §§ 42-62-5 through 42-62-8) ~~or plan~~ when, by law, its benefits are in excess of those of any private insurance plan or other non-governmental plan.

L. "Policyholder" means the primary insured named in a nongroup insurance policy.

GM. "Primary Plan" is 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 is a Primary Plan if either of the following conditions is true:

(1) The Plan either has no order of benefit determination rules, or it 's has rules ~~which~~ differ from those permitted by this subchapter regulation. ~~There may be more than one Primary Plan;~~ or

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

HN. "Secondary Plan" .A Secondary Plan is means a plan 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.~~

~~I. 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 because 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.~~

Section 4 *Applicability and Scope*

This regulation applies to all plans that are issued on or after the effective date of this regulation which is October 1, 1990.

Section 45 *Model COB Contract Provisions*

~~A. General. Appendix A contains a model COB provision for use in contracts. That use is subject to the provisions of subsections B, C and D below and to the provisions of Section 6 of this regulation. Appendix A contains a model COB provision for use in group contracts. That use is subject to the provisions of B and C below and to the provisions of Section 5.~~

~~B. Appendix B is a plain language description of the COB process that explains to the covered person how health plans will implement coordination of benefits. It is not intended to replace or change the provisions that are set forth in the contract. Its purpose is to explain the process by which the two (2) or more plans will pay for or provide benefits.~~

~~BC. Flexibility. A The group contract's COB provision provision contained in Appendix A and the plan language explanation in Appendix B do does not have to use the exact specific words and format shown in Appendix A. Changes may be made to fit the language and style of the rest of the group contract or to reflect the differences among plans whichthat provide services, whichthat pay benefits for expenses incurred, and whichthat indemnify. No other substantive changes are allowedpermitted.~~

~~CD. Prohibited Coordination and Benefit Design. A COB provision may not be used that permits a plan to reduce its benefits on the basis that:~~

~~(1) A group contract may not reduce benefits on the basis that:~~

- (a1) Another plan exists and the covered person did not enroll in that plan;
- (b2) A person is or could have been covered under another plan, except with respect to Part B of Medicare; or
- (c3) A person has elected an option under another plan providing a lower level of benefits than another option ~~which~~ that could have been elected.

(2E.) No ~~contract~~ plan may contain a provision that its benefits are "always -excess" or "always secondary" to any plan as defined in this Regulation, except in accordance with the rules permitted by this Regulation.

F. Under the terms of a closed panel plan, benefits are not payable if the covered person does not use the services of a closed panel provider. In most instances, COB does not occur if a covered person is enrolled in two (2) or more closed panel plans and obtains services from a provider in one of the closed panel plans because the other closed panel plan (the one whose providers were not used) has no liability. However, COB may occur during the plan year when the covered person receives emergency services that would have been covered by both plans. Then the secondary plan shall use the provision of Section 7 of this regulation to determine the amount it should pay for the benefit.

G. No plan may use a COB provision, or any other provision that allows it to reduce its benefits with respect to any other coverage its insured may have that does not meet the definition of plan under Section 3(K) of this regulation.

Section 56 Rules for Coordination of Benefits

When a person is covered by two (2) or more plans, the rules for determining the order of benefit payments are as follows:

A. (1) ~~General. The general order of benefits is as follows: The Primary Plan must shall pay or provide its benefits as if the Secondary Plan or Plans did not exist. A Plan that does not include a coordination of benefits provision may not take the benefits of another Plan as defined in Section 3 of this Regulation into account when it determines its benefits. There is one exception: a contract holder's coverage that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder.~~

(2) If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall pay or provide benefits as if it were the primary plan when a covered person uses a non-panel provider, except for emergency services or authorized referrals that are paid or

provided by the primary plan.

(3) When multiple contracts providing coordinated coverage are treated as a single plan under this regulation, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan shall be responsible for the plan's compliance with this regulation.

(4) 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 secondary plans benefits are determined in relation to each other. Each secondary plan shall 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.

B. (1) Except as provided in Paragraph (2), a plan that does not contain order of benefit determination provisions that are consistent with this regulation is always the primary plan unless the provisions of both plans, regardless of the provisions of this paragraph, state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

C. A plan may take into consideration the benefits paid or provided by another plan only when, under the rules of this regulation, it is secondary to that other plan.

D. Order of Benefit Determination

Each Plan determines its order of benefits using the first of the following rules that applies:

(1) Non-Dependent or Dependent

(a) Subject to Subparagraph (b) of this paragraph, the plan that covers the person other than as a dependent, for example as an employee, member, subscriber, policyholder or retiree, is the primary plan and the plan that covers the person as a

dependent is the secondary plan.

(b) (i) If the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:

(I) Secondary to the plan covering the person as a dependent; and

(II) Primary to the plan covering the person as other than a dependent (e.g. a retired employee),

(ii) Then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.

~~(2) A Secondary Plan may take the benefits of another plan into account only when, under these rules, it is Secondary to that other plan.~~

~~(3) The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent.~~

~~B.(2) Dependent Child/Parents Not Separated or Divorced. Covered Under More Than One Plan~~

Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

~~(a) The Rules for the order of benefits fFor a dependent child when the parents are not separated or divorced are as followswhose parents are married or are living together, whether or not they have ever been married-:~~

~~(1)(i) The benefits of the plan of the parent whose birthday falls earlier in a the calendar year are determined before those of the plan of the parent whose birthday falls later in that year;is the primary plan; or~~

~~(i)(2)~~ If both parents have the same birthday, ~~the benefits of the plan which that has~~ covered the parent longest ~~are determined before those of the plan which covered the other parent for a shorter period of time;~~ is the primary plan.

~~(3)~~ ~~The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born;~~

~~(4)~~ ~~If the other plan does not have the rule described in B(1), (2) and (3) above, but instead has a rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the rule based upon the gender of the parent will determine the order of benefits.~~

~~(b)C.~~ ~~For a dependent child whose parents are separated or divorced or are not living together, whether or not they have ever been married:~~ Parents:

~~(i)~~ ~~If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of two (2) or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are as follows:~~ determined in this order:

~~(1)~~ ~~First, the plan of the parent with covering the custody of the child;~~ custodial parent;

~~(2)~~ ~~Then, the plan covering the custodial parent's spouse;~~ of the spouse of the parent with the custody of the child, and

~~(3)~~ ~~Finally, the plan of the covering the non-custodial parent; and then not having custody of the child.~~

~~(IV)~~ ~~The plan covering the non-custodial parent's spouse.~~

~~(4ii)~~ If ~~the specific terms of~~ a court decree states that one of the parents is responsible for the health care expenses or health care coverage of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, ~~the benefits of that plan are determined first~~ is

primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any ~~Claim Determination Period or Period~~ or plan year during which ~~any~~ benefits are ~~actually~~ paid or provided before the entity has ~~that actual~~ knowledge of the court decree provision;

(iii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) of this paragraph shall determine the order of benefits;

~~(5iv)~~—If the specific terms of a court decree states that the parents shall share have joint custody, without stating that one of the parents is responsible for the health care expenses or health care coverage of the dependent child, the plans covering the child shall follow the order of benefit determination rules outlined in Section 5(B) of this Regulation, Dependent Child/Parents Not Separated or Divorced. provisions of Subparagraph (a) of this paragraph shall determine the order of benefits.

(c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under Subparagraph (a) or (b) of this paragraph as if those individuals were parents of the child.

(d) (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.

(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

(3)D. Active/~~Inactive~~ Employee or Retired or Laid-Off Employee:

- (a) The ~~benefits of a plan which that~~ covers a person as an active employee who is, neither laid off nor retired (or as that employee's dependent) ~~are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent) is the primary plan~~. If the other plan does not have this rule; and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.
- (b) If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.
- (c) This rule does not apply if the rule in Paragraph (1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage

- (a) If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.
- (b) If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- (c) This rule does not apply if the rule in Paragraph (1) can determine the order of benefits.

(5)E. Longer/or Shorter Length of Coverage.

- (a) If ~~none of the above~~the preceding rules do not determines the order of benefits, the ~~benefits of the plan which that~~ covered an employee, member or subscriberthe person longer ~~are determined before those of the plan which~~

covered that person for the shorter term is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.

(1b) To determine the length of time a person has been covered under a plan, two successive plans shall be treated as one if the claimant-covered person was eligible under the second plan within twenty four (24) hours after coverage from -the first plan ended.

(2c) The start of a new plan does not include:

(ai) A change in the amount of r scope of a plan's benefits;

(bii) A change in the entity which pays, provides or administers the plan's benefits; or

(eiii) A change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).

(3d) The claimant's-person's length of time covered under a plan is measured from the claimant's-person's first date of coverage under that plan. If that date is not readily available, the date the claimant-person first became a member of the group shall be used as the date from which to determine the length of time the claimant's-person's coverage under the present plan has been in force.

(6) If none of the preceding rules determines the order of benefits, the allowable expenses shall be shared equally between the plans.

Section 67 *Procedure to be followed by Secondary Plan to Calculate Benefits and Pay a Claim*

Total Allowable Expenses.

In determining the amount to be paid by the secondary plan on a claim, should the plan wish to coordinate benefits, the secondary plan shall calculate the benefits it would have paid on the claim in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

~~A. —When it is determined, pursuant to Section 5 of this Regulation, that this Plan is a Secondary Plan, it may reduce its benefits so that the total benefits paid or provided by all plans during a Claim Determination Period are not more than total Allowable Expenses. The amount by which the Secondary Plan's benefits have been reduced shall be used by the Secondary Plan to pay Allowable Expenses, not otherwise paid, which were incurred during the Claim Determination Period by the person for whom the claim is made. As each claim is submitted, the Secondary Plan determines its obligation to pay for Allowable Expenses based on all claims which were submitted up to that point in time during the Claim Determination Period.~~

~~B. —The benefits of the Secondary Plan will be reduced when the sum of the benefits that would be payable for the Allowable Expenses under the Secondary Plan in the absence of this COB provision and the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of the Secondary Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.~~

~~(1) —When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.~~

~~(2) —Paragraph B(1) above may be omitted if the plan provides only one benefit or may be altered to suit the coverage provided.~~

Section 8 ***Notice to Covered Persons***

A plan shall, in its explanation of benefits provided to covered persons, include the following language: “If you are covered by more than one health benefit plan, you should file all your claims with each plan.”

Section 97 ***Miscellaneous Provisions***

A. ~~Reasonable Cash Values of Services.~~ A Secondary Plan which provides benefits in the form of services may recover the reasonable cash value of ~~providing~~ the services from the Primary Plan, to the extent that benefits for the services are covered by the Primary Plan and have not already been paid or provided by the Primary Plan. Nothing in this provision shall be interpreted to require a plan to reimburse a covered person in cash for the value of services provided by a plan which provides benefits in the form of services.

B. ~~Excess and Other Nonconforming Provisions.~~

~~(1) — Some plans have order of benefit determination rules not consistent with this Regulation which declare the plan's coverage is "excess" to all others, or "always secondary." This occurs because certain plans may not be subject to insurance Regulation, or because some group contracts have not yet been conformed with this Regulation pursuant to Section 2.~~

(21) A plan with order of benefit determination rules ~~which that~~ comply with this regulation (Complying Plan) may coordinate its benefits with a plan which is "excess" or "always secondary" or ~~which that~~ uses order of benefit determination rules ~~which that~~ are inconsistent with those contained in this regulation (Noncomplying Plan) on the following basis:

- (a) If the Complying Plan is the Primary Plan, it shall pay or provide its benefits ~~on a primary basis first~~;
- (b) If the Complying Plan is the Secondary Plan, it shall, ~~nevertheless,~~ pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the Complying Plan were the Secondary Plan. In such a situation, ~~such the~~ payment shall be the limit of the Complying Plan's liability; and
- (c) If the Noncomplying Plan does not provide the information needed by the Complying Plan to determine its benefits within a reasonable time after it is requested to do so, the Complying Plan shall assume that the benefits of the Noncomplying Plan are identical to its own, and shall pay its benefits accordingly. ~~If, within two (2) years of payment, the complying plan receives information as to the actual benefits of the non-complying plan, it shall adjust payments accordingly. However, the Complying Plan must adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the Noncomplying Plan.~~

(32) If the Noncomplying Plan reduces its benefits so that the ~~employee, subscriber or member~~ covered person receives less in benefits than he or she would have received had the Complying Plan paid or provided its benefits as the Secondary Plan and the Noncomplying Plan paid or provided its benefits as the Primary Plan, and governing State law allows the right of subrogation set forth below, then the Complying Plan shall advance to or on behalf of the ~~employee, subscriber or member~~ covered person an amount equal to ~~such the~~ difference.

(3) ~~However, i~~n no event shall the Complying Plan advance more than the Complying Plan would have paid had it been the Primary Plan less any

amount ~~is~~ previously paid for the same expense or service. In consideration of such advance, the Complying Plan shall be subrogated to all rights of ~~the employee, subscriber or member~~ covered person against the Noncomplying Plan. Such advance by the Complying Plan shall also be without prejudice to any claim it may have against the Noncomplying Plan in the absence of subrogation.

~~C. Allowable Expense.~~

~~A term such as "usual and customary," "usual and prevailing," or "reasonable and customary," may be substituted for the term "necessary, reasonable and customary." Terms such as "medical care" or "dental care" may be substituted for "health care" to describe the coverages to which the COB provisions apply.~~

~~CD. Subrogation.~~

~~The COB concept clearly~~ differs from ~~that of~~ subrogation. Provisions for one may be included in health care benefits contracts without compelling the inclusion or exclusion of the other.

~~D. If the plans cannot agree on the order of benefits within thirty (30) calendar days after the plans have received all of the information needed to pay the claim, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan shall be required to pay more than it would have paid had it been the primary plan.~~

Section 810 Effective Date: for Existing Contracts

~~A. This subchapter is applicable to every group contract which provides health care benefits and which is issued on or after the effective date of this regulation, which is October 1, 1990.~~

~~BA.~~ A ~~group~~ contract ~~which that~~ provides health care benefits and ~~that~~ was issued before the effective date of this regulation shall be brought into compliance with this regulation by

~~(1) ~~the~~~~ The later of:

~~(1a)~~ The next anniversary date or renewal date of the ~~group~~ contract; or

~~(b) Twelve months (12) following June 1, 2014.~~

(2) The expiration of any applicable collectively bargained contract pursuant to which it was written.

B. For the transition period between the adoption of this regulation and the timeframe for which plans are to be in compliance pursuant to Subsection A, a plan that is subject to the prior COB requirements shall not be considered a non-complying plan by a plan subject to the new COB requirements and if there is a conflict between the prior COB requirements under the prior regulation and the new COB requirements under the amended regulation, the prior COB requirements shall apply.

FORMER REGULATION; Part X of Regulation XXIII effective October 9, 1978

EFFECTIVE DATE: October 1, 1990

AMENDED: None

REFILED: December 19, 2001

AMENDED: May , 2014

APPENDIX A

MODEL COB CONTRACT PROVISIONS

COORDINATION OF ~~THE GROUP~~THIS CONTRACT'S BENEFITS -WITH OTHER BENEFITS

~~I.~~ APPLICABILITY

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

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense. If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of "This Plan" are determined before or after those of another plan. The benefits of "This Plan":

- ~~(1) — Shall not be reduced when, under the order of benefit determination rules, "This Plan" determines its benefits before another plan; but~~
- ~~(2) — May be reduced when, under the order of benefits determination rules, another plan determines its benefits first. The above reduction is described in Section IV "Effect on the Benefits of "This Plan"."~~

~~H.~~ DEFINITIONS

~~A.~~ A. **"Plan"** is any of the following ~~which that~~ provides benefits or services for, ~~or because of~~, medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

- ~~(1)~~ **Plan includes:** Group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured) ; medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident type coverage.

- (2) Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under a other federal governmental plans, unless permitted by law, or coverage required to be provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

Each contract ~~or other arrangement~~ for coverage under (1) or (2) is a separate ~~plan~~. ~~Also, if~~ Plan. ~~If an arrangement a~~ “Plan” has two parts and COB rules apply only to one of the two, each of the parts is a separate ~~plan~~ Plan.

- B. “This Plan” means, in a COB provision, is the part of the group contract that provides benefits for the health care expenses benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

- C. “Primary Plan/Secondary Plan:” The order of benefit determination rules state determine whether “This Plan” is a Primary Plan or Secondary Plan as to another plan covering the person when the person has health care coverage under more than one Plan.

When “This Plan” is a Primary Plan, its benefits are determined payment for its benefits first before those of ~~the any~~ other ~~plan~~ “Plan” and without considering the ~~any~~ other ~~p~~ Plan's benefits. When “This Plan” is a Secondary Plan, its benefits are determined its benefits after those of ~~the other another~~ ~~p~~ Plan and may be reduced ~~the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.~~ because of the other plan's benefits. When there are more than two plans covering the person, “This Plan” may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

- D. “Allowable Expense” means is a necessary, reasonable and customary item of expense for health care expense; when the item of expense that is covered at least in part by one or more any pPlans covering the person, for whom the claim is made. 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. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a provider by law or in

accordance with a contractual agreement is prohibited from charging a covered person is not an **Allowable expense**.

The following are examples of expenses that are not **Allowable expenses**:

- (1) The difference between the cost of a **semi-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 unless one of the **Plans** provides coverage for private hospital room expenses.~~
- (2) If a person is covered by 2 or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**. ~~When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.~~
- (3) If a person is covered by 2 or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.
- (4) If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.
- (5) The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. **Closed panel plan** is a **Plan** that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the **Plan**, and that excludes coverage for services

provided by other providers, except in the cases of emergency or referral by a panel member.

~~"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.~~

F. **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

~~III.~~ **ORDER OF BENEFIT DETERMINATION RULES**

When a person is covered by two or more "Plans," the rules for determining the order of benefit payments are as follows:

A. ~~The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other **Plan**. General. When there is a basis for a claim under "This Plan" and another plan, "This Plan" is a **Secondary Plan** which has its benefits determined after those of the other plan, unless:~~

B. (1) Except as provided in Paragraph (2), a **Plan** that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both **Plans** state that the complying plan is primary. The other plan has rules coordinating its benefits with those of "This Plan"; and

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits. Both those rules and "This Plan"'s rules, in Subsection B below, require that "This Plan"'s benefits be determined before those of the other plan.

C. A **Plan** may consider the benefits paid or provided by another **Plan** in calculating payment of its benefits only when it is secondary to that other **Plan**.

~~E.~~

D. Each **Plan** determines its order of benefits using the first of the following rules which that applies:

(1) ~~Non-Dependent/ or Dependent. The benefits of the p~~**Plan** ~~which that~~ covers the person other than as a dependent, for example as an employee, member, policyholder, or subscriber or retiree (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent. ~~is the~~ **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

(2) ~~Dependent Child/Parents Not Separated or Divorced Covered Under More Than One Plan. Except as stated in Paragraph B(3) below, when “This Plan” and another plan cover the same child as a dependent of different person, called “parents:” Unless there is a court decree stating otherwise, when a dependent child is covered by more than one “Plan” the order of benefits is determined as follows:~~

(a) For a dependent child whose parents are married or are living together whether or not they have ever been married:

(ai) ~~The benefits of the p~~**Plan** of the parent whose birthday falls earlier in at the calendar year are determined before those of the plan of the parent whose birthday falls later in that year; but is the Primary plan; or

(bii) ~~If both parents have the same birthday, the benefits of the plan birthday the Plan which that has covered the parents longer st are determined before those of the plan which covered the other parent for a shorter period of time: is the Primary plan.~~

~~However, if the other plan does not have the rule described in (a) immediately above, but instead has the rule based upon the gender of the patient, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.~~

(3b) For a Ddependent Cchild/ whose parents are divorced or Sseparated or Divorced or not living together, whether or not they have ever been married:-

(i) If a court decree states that one of the parents is responsible for the health care expenses or health care coverage of the dependent child, and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

~~If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:~~

~~(a) — First, the plan of the parent with custody of the child;~~

~~(b) — Then, the plan of the spouse of the parent with the custody of the child; and~~

~~(c) — Finally, the plan of the parent not having custody of the child.~~

~~However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.~~

(iii)(4) Joint Custody. If the specific terms of a court decree states that the parents ~~shall share~~ have joint custody, without ~~stating~~ specifying that one of the parents is ~~has~~ responsibility for the health care expenses ~~or health care coverage~~ of the ~~dependent~~ child, the ~~plans covering the child shall follow the order of benefit determination rules outlined in Paragraph HIB(2).~~ the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The **Plan** covering the **Custodial Parent**;
- The **Plan** covering the spouse of the **Custodial Parent**;
- The **Plan** covering the **non-custodial parent**; and then
- The **Plan** covering the spouse of the **non-custodial parent**.

(c) For a dependent child covered under more than one **Plan** of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(35) Active/~~Inactive~~ Employee or Retired or Laid-off Employee. The ~~benefits of a p~~**Plan** ~~which that~~ covers a person as an active employee, that is, an employee who is neither laid off nor retired, ~~(or as that employee's dependent) are determined before those of a plan which covers that person as a laid-off or retired employee (or as that employee's dependent)~~ is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of -an active employee and that same person is a dependent of a retired or laid-off employee. If the other ~~p~~**Plan** does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this Rule ~~(5)~~ is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on

the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(56) Longer/ or Shorter Length of Coverage. ~~If none of the above rules determines the order of benefits, the benefits of the~~ **The Pplan** ~~which that~~ covered the person as an employee, member, policyholder, or subscriber or retiree longer ~~are determined before those of the Plan which covered that person for the shorter term is~~ **the Primary plan** and the **Plan** that covered the person the shorter period of time is **the Secondary plan.**

(6) If the preceding rules do not determine the order of benefits, the **Allowable expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This plan** will not pay more than it would have paid had it been the **Primary plan.**

IV. — EFFECT ON THE BENEFITS OF “THIS PLAN”

A. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the **Secondary plan** will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **allowable expense** under its **Plan** that is unpaid by the **Primary plan**. **The Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **primary plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable expense** for the claim. In addition, **the Secondary plan** shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.~~When This Section Applies. This Section IV applies when, in accordance with Section III "Order of Benefit Determination Rules," "This Plan" is a Secondary Plan as to one or more other plans. In that event the benefits of "This Plan" may be reduced under this section. Such other plan or plans are referred to as "the other plans" in B immediately below.~~

B. If a covered person is enrolled in two or more **Closed panel plans** and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one **Closed panel plan**, COB shall not apply between the **Plan** and other **Closed panel plans**. Reduction in “This Plan”'s Benefits. The benefits of “This Plan” will be reduced when the sum of:

- (1) — The benefits that would be payable for the Allowable Expenses under “This Plan” in the absence of this COB provision; and
- (2) — The benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable

~~Expenses in a Claim Determination Period. In that case, the benefits of “This Plan” will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.~~

~~When the benefits of “This Plan” are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of “This Plan”.~~

~~V. — RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION~~

~~Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans.~~

~~[Insurer/Organization responsible for COB administration] has the right to decide which facts it needs. It may get needed facts from or give them to any other organizations or persons for the purpose of applying these rules and determining benefits payable under “This plan” and other “Plans” covering the person claiming benefits.~~

~~[Insurer/Organization responsible for COB administration] need not tell, or get the consent of, any person to do this. Each person claiming benefits under “This Pplan” must give [Organization responsible for COB administration insurer] any facts it needs to apply those rules and determine benefits payable. pay the claim.~~

~~VI. — FACILITY OF PAYMENT~~

~~A payment made under another pPlan may include an amount ~~which that~~ should have been paid under “This Plan”. If it does, [Organization responsible for COB administration Insurer] may pay that amount to the organization ~~which that~~ made that payment. That amount will then be treated as though it were a benefit paid under “This Plan”. [Organization responsible for COB administration Insurer] will not have to pay that amount again. The term "payment made" ~~means includes providing reasonable cash value of the~~ benefits ~~provided~~ in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.~~

~~VII. — RIGHT OF RECOVERY~~

~~If the amount of the payments made by [Organization responsible for COB administration Insurer] is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.~~

~~A. — The persons it has paid or for whom it has paid;~~

~~B. — Insurance companies; or~~

~~C.—Other organizations.~~

~~The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.~~

APPENDIX B. CONSUMER EXPLANATORY BOOKLET

COORDINATION OF BENEFITS

IMPORTANT NOTICE

This is a summary of only a few of the provisions of your health plan to help you understand coordination of benefits, which can be very complicated. This is not a complete description of all of the coordination rules and procedures, and does not change or replace the language contained in your insurance contract, which determines your benefits.

Double Coverage

It is common for family members to be covered by more than one group health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.

When you are covered by more than one group health plan, state law permits your insurers to follow a procedure called “coordination of benefits” to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

Coordination of benefits (COB) is complicated, and covers a wide variety of circumstances. This is only an outline of some of the most common ones. If your situation is not described, read your evidence of coverage or contact your state insurance department.

Primary or Secondary?

You will be asked to identify all the plans that cover members of your family. We need this information to determine whether we are the “primary” or “secondary” benefit payer. The primary plan always pays first when you have a claim.

Any plan that does not contain your state’s COB rules will always be primary.

When This Plan is Primary

If you or a family member are covered under another plan in addition to this one, we will be primary when:

Your Own Expenses

- The claim is for your own health care expenses, unless you are covered by Medicare and both you and your spouse are retired.

Your Spouse’s Expenses

- The claim is for your spouse, who is covered by Medicare, and you are not both retired.

Your Child’s Expenses

- The claim is for the health care expenses of your child who is covered by this plan and
 - You are married and your birthday is earlier in the year than your spouse's or you are living with another individual, regardless of whether or not you have ever been married to that individual, and your birthday is earlier than that other individual's birthday. This is known as the "birthday rule";

or
 - You are separated or divorced and you have informed us of a court decree that makes you responsible for the child's health care expenses;

or
 - There is no court decree, but you have custody of the child.

Other Situations

We will be primary when any other provisions of state or federal law require us to be.

How We Pay Claims When We Are Primary

When we are the primary plan, we will pay the benefits in accordance with the terms of your contract, just as if you had no other health care coverage under any other plan.

How We Pay Claims When We Are Secondary

We will be secondary whenever the rules do not require us to be primary.

How We Pay Claims When We Are Secondary

When we are the secondary plan, we do not pay until after the primary plan has paid its benefits. We will then pay part or all of the allowable expenses left unpaid, as explained below. An "allowable expense" is a health care expense covered by one of the plans, including copayments, coinsurance and deductibles.

- If there is a difference between the amounts the plans allow, we will base our payment on the higher amount. However, if the primary plan has a contract with the provider, our combined payments will not be more than the amount called for in our contract or the amount called for in the contract of the primary plan, whichever is higher. Health maintenance organizations (HMOs) and preferred provider organizations (PPOs) usually have contracts with their providers.
- We will determine our payment by subtracting the amount the primary plan paid from the amount we would have paid if we had been primary. We may reduce our payment by any amount so that, when combined with the amount paid by the primary plan, the total benefits paid do not exceed the total allowable expense for your claim. We will credit any amount we would have paid in the absence of your other health care coverage toward our own plan deductible.
- If the primary plan covers similar kinds of health care expenses, but allows expenses that we do not cover, we may pay for those expenses.
- We will not pay an amount the primary plan did not cover because you did not follow its rules and procedures. For example, if your plan has reduced its benefit because you did not obtain pre-certification, as required by that plan, we will not pay the amount of the reduction, because it is not an allowable expense.

Questions About Coordination of Benefits?
Contact Your State Insurance Department

EFFECTIVE DATE: ~~October 1, 1990~~

AMENDED: ~~None~~

REFILED: ~~December 19, 2001~~