

STATE OF WEST VIRGINIA



OFFICES OF THE
INSURANCE COMMISSIONER

2100 WASHINGTON STREET, EAST
CHARLESTON, WEST VIRGINIA 25305
TELEPHONE (304) 348-3386

RICHARD G. SHAW
INSURANCE COMMISSIONER

JOHN D. ROCKEFELLER, IV
GOVERNOR

STATE REGISTER FILING

I, Richard G. Shaw, Commissioner,
Insurance, Department or Division,
hereby submit to record in
Department or Division

the State Register on 8 1/2 x 11" paper two (2) copies of

- (X) proposed rules and regulations concerning topics of material not covered by existing rules and regulations;
- () proposed rules and regulations superseding rules and regulations already on file;
- (X) notice of hearing;
- () findings and determinations;
- () rules and regulations; or
- (X) other - specify (Fiscal Note, Statement of Economic Impact, Cover Letter Explaining Filing)

This filing pertains to

Chapter 33
 Article 16
 Series XXI
 Section -
 Page No. -

FILED IN THE OFFICE OF
A. JAMES MANCHIN
SECRETARY OF STATE

THIS DATE 8/24/84
Administrative Law Division

- (X) proposed rules and regulations are required to go to Legislative Rule Making Committee;
- () proposed rules and regulations are excluded from Legislative Rule Making Committee;

August 24, 1984

Date Submitted

Signature of Person Authorizing
this Filing

STATE OF WEST VIRGINIA



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JOHN D. ROCKEFELLER, IV
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NOTICE OF PUBLIC HEARING BEFORE RICHARD G. SHAW
INSURANCE COMMISSIONER OF WEST VIRGINIA

August 22, 1984

IN THE MATTER OF:

Group Coordination of Benefits
Proposed Legislative Rule Series XXI
Administrative Hearing No. 84-21

FILED IN THE OFFICE OF
A. JAMES MANCHIN
SECRETARY OF STATE
THIS DATE 8/24/84
Administrative Law Division

TO: All Interested Persons

Please take notice that the Insurance Commissioner of the State of West Virginia will hold a public hearing on Wednesday, September 26, 1984, at 9:30 o'clock, a.m. in Room 522, Department of Motor Vehicles Building, 1800 Washington Street, East, Charleston, West Virginia. This public hearing has been scheduled, pursuant to the provisions of Chapter 29A, Article 3, Section 5 of the Code of West Virginia of 1931, as amended, to receive comment from any interested person in regard to proposed Legislative Rule of the Insurance Commissioner, Series XXI, concerning coordination of benefits among group health insurance policies

"We are an Equal Opportunity Employer"

The record of the hearing will be open for written comment from any interested person from the time of issuance of this Notice until the time of hearing. Such written comments should be submitted to the Honorable Richard G. Shaw, Insurance Commissioner of the State of West Virginia, 2100 Washington Street, East, Charleston, West Virginia 25305.



Richard G. Shaw
Insurance Commissioner of West Virginia



Cheryl E. Davis
Special Assistant Attorney General
Counsel for the Insurance Commissioner

STATE OF WEST VIRGINIA



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CHARLESTON, WEST VIRGINIA 25305
TELEPHONE (304) 348-3386

JOHN D. ROCKEFELLER, IV
GOVERNOR

RICHARD G. SHAW
INSURANCE COMMISSIONER

August 24, 1984

Honorable A. James Manchin
Secretary of State
State Capitol
Charleston, West Virginia 25305

Re: Proposed Legislative Rule of the
Insurance Commissioner, Series XXI,
Regulation Relating to the Use of
Coordination of Benefit Provisions in
Group Health Insurance Policies

Dear Secretary Manchin:

Pursuant to West Virginia Code § 29A-3-9, attached please find a proposed legislative rule (Series XXI) of the Insurance Commissioner relating to the use of coordination of benefit provisions in group health insurance policies. The objective of this rule is to establish uniform coordination of benefit provisions for group health insurance policies as well as guidelines for interpretation and enforcement of the policy provisions. Also attached is a fiscal note, statement of economic impact and a notice of hearing in regard to the proposed rule. Please file these documents in the State Register. This filing will constitute notice to all interested persons of the proposal by the Insurance Commissioner of this legislative rule.

Respectfully,

A handwritten signature in black ink that reads "Richard G. Shaw".

Richard G. Shaw
Insurance Commissioner

RGS:amp

Enclosures

FILED IN THE OFFICE OF
A. JAMES MANCHIN
SECRETARY OF STATE
THIS DATE 8/24/84
Administrative Law Division

"We are an Equal Opportunity Employer"

STATEMENT OF ECONOMIC IMPACT OF PROPOSED RULES OR REGULATIONS

Agency Insurance Commissioner

Rule No. XXI Subject Coordination of Benefits

1. Explanation of Overall Economic Impact of Proposed Rule.

A. Economic Impact on State Government.

There should be no economic impact on State government

B. Economic Impact on Political Subdivisions; Specific Industries;
Specific groups of citizens.

The insurance industry should experience a cost saving due to a reduction in duplicative payments of health insurance claims.

C. Economic Impact on Citizens/Public at Large.

The cost saving to the insurance industry noted above should result in lower health insurance premiums for the general public.

Date August 24, 1984 Agency Insurance Commissioner

Signature of Agency Head

Richard P. O'Brien

Signature of Authorized Representative

Cheryl J. Davis

FILED IN THE OFFICE OF
A. JAMES MANCHIN
SECRETARY OF STATE
THIS DATE 8/24/84
Administrative Law Division

FISCAL NOTE FOR PROPOSED RULES

THIS DATE 8/24/84
Administrative Law Division

Rule No. XXI Subject Coordination of Benefits

Type of Rule: Legislative Interpretive Procedural

Agency Insurance Commissioner Address 2100 Washington Street, East
Charleston, West Virginia 25305

Authorized Representative Cheryl Davis Phone 348-3394

1. Effect of Proposed Rule	ANNUAL		FISCAL YEAR		
	Increase	Decrease	Current	Next	Thereafter
Estimated Total Cost	\$	\$	\$	\$	\$
Personal Services	-0-	-0-	-0-	-0-	-0-
Current Expense	-0-	-0-	-0-	-0-	-0-
Repairs and Alterations	-0-	-0-	-0-	-0-	-0-
Equipment	-0-	-0-	-0-	-0-	-0-
Others	-0-	-0-	-0-	-0-	-0-

2. Explanation of above estimates.
The proposed rule should have no Fiscal impact on the Insurance Department.

3. Date August 24, 1984 Agency Insurance Commissioner

Signature of Agency Head
Richard B. ...

Signature of Authorized Representative
Cheryl J. Davis

COORDINATION OF BENEFITS IN GROUP HEALTH INSURANCE

Chapter 33-16
Series XXI
1985

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WEST VIRGINIA LEGISLATIVE RULE
INSURANCE COMMISSIONER OF WEST VIRGINIA

Chapter 33-16
Series XXI
(1985)

FILED IN THE OFFICE OF
A. JAMES MANCHIN
SECRETARY OF STATE
THIS DATE 8/24/84
Administrative Law Division

Subject: Regulation Relating to the Use of Coordination of Benefit
Provisions in Group Health Insurance Policies

Section 1. General

1.01. Scope - The purpose of this Regulation is to adopt Model Group Coordination of Benefit provisions and uniform Guidelines for their interpretation and administration as promulgated by the National Association of Insurance Commissioners. This Regulation is intended to establish uniformity in the permissive use of overinsurance provisions to avoid claim delays and misunderstanding that otherwise result from the use of inconsistent or incompatible provisions among the several carriers.

This Regulation does not require the use of overinsurance provisions in group health insurance policies. If, however, such a policy or contract contains overinsurance provisions, such provisions must be consistent with the Model Group Coordination of Benefit Provisions and Guidelines herein established. To this end, overinsurance provisions, or provisions for the reduction of benefits otherwise payable because of other insurance by whatever name designated, other than the Model Coordination of Benefit Provisions herein contained may not be used, except that plans of coverage designed to be supplementary over the policyholder's underlying basic plan of coverage may provide that its coverage shall be excess to that specific policyholder's plan of basic coverage from whatever source provided.

This Regulation applies to group policies delivered or issued for delivery in this State pursuant to Chapter 33, Articles 16, 16A, 24 and 25A of the Code of West Virginia of 1931, as amended.

1.02. Authority - This legislative rule is issued under the authority of Chapter 33, Article 2, Section 10 of the Code of West Virginia, as amended.

1.03. Filing Date - This legislative rule was promulgated on the ____ day of _____, 1985, and was filed on the ____ day of _____, 1985, in the Office of the Secretary of State.

1.04. Effective Date - This legislative rule becomes effective on the ____ day of _____, 1985.

Section 2. Policy Provisions for Coordination of Benefits

2.01. Required Provisions - The following constitutes the policy provisions, with explanatory Notes and Guidelines, which must be utilized by insurers which elect inclusion of overinsurance provisions in group health insurance policies.

A. Benefits Subject To This Provision

All of the benefits provided under this policy are subject to this provision.

(Note: When the policy or service contract provides both integrated Major Medical Expense Benefits and the Basic Benefits, but the Coordination of Benefit provision applies to the Major Medical Expense Benefits

only, use the following alternate wording: Only the Major Medical Expense Benefits provided under this policy are subject to this provision.)

B. Definitions

(Note: Include here the definition of a Plan; that is, the benefits, including those provided by this policy, that are to be coordinated. The following definition is illustrative only.)

1. "Plan" means any plan providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided by (i) group, blanket or franchise insurance coverage, (ii) service plan contracts, group practice, individual practice and other prepayment coverage, (iii) any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans, and (iv) any coverage under governmental programs, and any coverage required or provided by any statute.

The term "Plan" shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other Plans into consider-

ation in determining its benefits and that portion which does not.

GUIDELINE ONE: Definition Of A "Plan": Individual And Group Contracts: The definition of a "Plan" within the COB provision of group contracts enumerates the types of coverage which the insurer may consider in determining whether overinsurance exists with respect to a specific claim. Such definition:

1. May not include individual or family policies, or individual or family subscriber contracts, except as provided in the next succeeding paragraph and in Guideline Two.
2. May include all group policies or group subscriber contracts as well as such group-type contracts as are not available to the general public and can be obtained and maintained only because of the covered person's membership in or connection with a particular organization or group. Group-type contracts answering this description may be included in the definition, at the option of the insurer and its policy-client, whether or not individual policy forms are utilized and whether the group-type coverage is designated as "franchise" or "blanket" or in some other fashion.

GUIDELINE TWO: Definition Of A "Plan": "No-Fault"

Automobile Insurance: The definition of "Plan" may include both group and individual automobile "no-fault" contracts but, as to the traditional automobile "fault" contracts, only the medical benefits written on a group-type basis may be included.

GUIDELINE THREE: Definition of a "Plan": Hospital

Indemnity Type Coverages: Interpretation of the definition of a "Plan" may not include group or group-type hospital indemnity benefits (written on a non-expense incurred basis) of \$30 per day or less unless they are characterized as reimbursement type benefits but are designed or administered so as to give the insured the right to elect indemnity type benefits, in lieu of such reimbursement type benefits, at the time of claim. In any event, the amount of group and group-type hospital indemnity benefits which exceeds \$30 per day may be construed as being included under the definition of a "Plan."

GUIDELINE FOUR: Definition of a "Plan": Student

Accident Coverages: School accident type coverages, written on either an individual, group, blanket, or franchise basis should not be taken into consideration in coordination of benefits. In this context, school

accident type coverages are defined to mean coverage covering grammar school and high school students for accidents only, including athletic injuries, either on a 24 hour basis or "to and from school." for which the parent pays the entire premium.

GUIDELINE FIVE: Definition of a "Plan": Medicare or Similar Governmental Benefits: If "Medicare" or similar governmental benefits are included in the definition of a "Plan," such benefits may be taken into consideration without expanding any of the definitions of this provision beyond the hospital, medical, and surgical benefits as may be provided by the governmental program.

GUIDELINE SIX: Definition of a "Plan": Design of Benefits: A Plan may not coordinate or design benefits so that the benefits payable are altered solely on the basis that:

- (1) another Plan exists; or
- (2) except with respect to Part B of Medicare, that the claimant is or could have been covered under another Plan; or

- (3) the claimant has elected an option under another Plan providing a lower level of benefits than another option for which the claimant was eligible.
2. "This Plan" means that portion of this policy which provides the benefits that are subject to this provision.

(Note: Any benefits provided under this policy that are not subject to this provision constitute another Plan.)

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

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

GUIDELINE SEVEN: "Definition of Allowable Expenses":

The difference between the cost of a private hospital room and the cost of a semi-private hospital room shall not be deemed to be an "Allowable Expense," except for the period of time during which the patient's confinement to a private hospital room is deemed medically necessary in terms of generally accepted medical practice.

4. "Claim Determination Period" means _____.

(Note: Insert here an appropriate period of time such as, "calendar year" or "Benefit Period as defined elsewhere in this policy.")

C. Effect On Benefits

1. This provision shall apply in determining the benefits as to a person covered under this Plan for any Claim Determination Period if, for the Allowable Expenses incurred as to such person during such period, the sum of:
 - (a) the benefits that would be payable under this Plan in the absence of this provision, and
 - (b) the benefits that would be payable under all other Plans in the absence therein of provisions of similar purpose to this provisionwould exceed such Allowable Expenses.

2. As to any Claim Determination Period with respect to which this provision is applicable, the benefits that would be payable under this Plan in the absence of this provision for the Allowable Expenses incurred as to such person during such Claim Determination Period shall be reduced to the extent necessary so that the sum of such reduced benefits and

all the benefits payable for such Allowable Expenses under all other Plans, except as provided in paragraph C3 below, shall not exceed the total of such Allowable Expenses. Benefits payable under another Plan include the benefits that would have been payable had claim been duly made therefor.

(Note: A Plan may select one of the following two alternatives for paragraphs C1 and C2, or a version thereof which is more favorable to a covered person to determine the amount payable by the Plan when it is secondary, that is, when it pays benefits after another Plan.)

Alternative 1:

1. This provision shall apply in determining the benefits as to a person covered under this Plan for any Claim Determination Period if, for the Allowable Expenses incurred as to such person during such period, the sum of:
 - (a) the benefits that would be payable under this Plan in the absence of this provision, and
 - (b) the benefits that would be payable under all other Plans in the absence therein of provisions of similar purpose to this provision

would exceed the greater of (i) 80% of such Allowable Expenses, or (ii) the amount of benefits that would be payable under this Plan in the absence of this provision.

2. As to any Claim Determination Period with respect to which this provision is applicable, the benefits that would be payable under this Plan in the absence of this provision for the Allowable Expenses incurred as to such person during such Claim Determination Period shall be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such Allowable Expenses under all other Plans, except as provided in paragraph C3 below, shall not exceed the greater of (a) 80% of such Allowable Expenses, or (b) the amount of benefits that would be payable under this Plan in the absence of this provision. Benefits payable under another Plan include the benefits that would have been payable had claim been duly made therefore.

Alternative 2:

(Note: A Plan may use the provisions of Alternative 2 only if it provides benefits after any applicable deductible of not less than 75% of the expenses covered by the Plan, or not less than 50% of expenses covered by the Plan for treatment of mental or nervous disorders or alcoholism or drug abuse or for alternative benefits under a provision relating to cost containment, such as

second surgical opinions, precertification of hospital stay, etc. This restriction shall not apply to a Plan's benefits for dental care, vision care, prescription drugs, or hearing aids.)

1. Except as provided in paragraph C3, the benefits that would be payable under This Plan in the absence of this provision shall be reduced by the benefits payable under all other Plans for the expenses covered in whole or in part under This Plan.
2. Benefits payable under another Plan include the benefits that would have been payable had claim been duly made therefor. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be a benefit payable.

GUIDELINE EIGHT: Benefits Payable by each Plan:

(1) The primary Plan, which is the Plan which pays benefits first, pays the benefits that would be payable under its terms in the absence of this provision.

(2) Under Section C, paragraphs 1 and 2 of Alternative 1, the secondary Plan, which is the Plan which pays benefits after the primary Plan, may limit the benefits it

pays so that the sum of its benefit and all other benefits payable by the Primary Plan will not exceed the greater of:

(a) a specified percentage of total Allowable Expenses (which may not be less than 80% nor more than 100%; or

(b) the amount of benefits it would have paid had it been the primary Plan.

(3) Under Section C, paragraphs 1 and 2 of Alternative 2, the secondary Plan may limit the benefits it pays to:

(a) the amount of benefits it would have paid had it been the primary Plan; less

(b) all other benefits payable for the same expenses by the primary Plan.

Plans using the provisions of paragraphs 1 and 2 of Alternative 2 may exclude reference to Allowable Expenses, Claim Determination Period, or both.

A Plan may use the provisions of Alternative 2 only if it provides benefits after any applicable deductible of not less than 75% of the expenses covered by the Plan, or not less than 50% of expenses covered by the Plan for treatment of mental or nervous disorders or alcoholism or drug abuse or for alternative benefits under a provision relating to cost containment, such as second surgical opinions precertification of hospital stay, etc. This restriction shall not apply to a Plan's benefits for dental care, vision care, prescription drugs, or hearing aids.

(4) If a Plan uses either the provisions of Section C, paragraphs 1 and 2 of Alternative 1, as described in Guideline (8)(2) with a percentage less than 100%, or the provisions of Section C, paragraphs 1 and 2 of Alternative 2, as described in Guideline (8)(3), that Plan (hereafter called "The Plan") must also comply with the following requirements:

(a) The Plan must provide prior notice to employees or members that, when it is secondary, its benefits, plus those of primary plan, will not reimburse 100% of Allowable Expenses unless the primary plan by itself reimburses at 100% of Allowable Expenses.

(b) The Plan must permit a person to be enrolled for its health care coverage when that person's health care coverage under another Plan terminates for any reason, other than termination while that person remains eligible for coverage under that other Plan or a Plan which replaces it without interruption of that person's coverage, provided:

(i) such person is eligible under The Plan; and

(ii) such enrollment is made before the end of the 31-day period immediately following either that termination or the end of any continuation period elected by or for that person.

If such person is enrolled before the end of the period, there shall be no interruption of coverage. In addition, the requirements concerning active work or confinement of dependents on the effective date of coverage shall not be applied. However, coverage for the person under The Plan shall be subject to the same requirements, including underwriting

requirements, and restrictions, including pre-existing condition limitations, that would have applied had the person been enrolled under The Plan on the later either of the date the person was first eligible for coverage thereunder, or the date the employee or member became covered under The Plan. Credit shall be given under any pre-existing condition limitation from the date such person was initially eligible for coverage under The Plan.

3. If:

- (a) another Plan which is involved in paragraph C2 above and which contains a provision coordinating its benefits with those of this Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined, and
- (b) the rules set forth in paragraph C4 below would require this Plan to determine its benefits before such other Plan

then the benefits of such other Plan will be ignored for the purposes of determining the benefits under this Plan.

4. For the purpose of paragraph C3 above, the rules establishing the order of benefit determination are:
 - (a) The benefits of a Plan which covers the person on whose expenses claim is based other than as a dependent shall be determined before the benefits of a Plan which covers such person as a dependent;
 - (b) The benefits of a Plan which covers the person on whose expense claim is based as a dependent, shall be determined as follows:
 - (i) Except for cases of a person for whom claim is made as a dependent child whose parents are separated or divorced, the benefits of a plan which covers the person on whose expenses claim is based as a dependent of a person whose date of birth, excluding year of birth, occurs earlier in a calendar year, shall be determined before the benefits of a Plan which covers such person as a dependent of a person whose date of birth, excluding year of birth, occurs later in a calendar year. If either Plan does not have the provisions of this paragraph (b) (i) regarding dependents, which results either in each Plan determining its benefits before the other or in each Plan determining its benefits after the other, the provisions of this paragraph (b) (i) shall not apply, and the rule set forth in the Plan which does not have the provisions of this paragraph (b) (i) shall determine the order of benefits.

- (ii) In the case of a person for whom claim is made as a dependent child whose parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a Plan which covers the child as a dependent of the parent without custody;
- (iii) In the case of a person for whom claim is made as a dependent child whose parents are divorced and the parent with custody of the child has remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a Plan which covers that child as a dependent of the stepparent, and the benefits of a Plan which covers that child as a dependent of the stepparent will be determined before the benefits of a Plan which covers that child as a dependent of the parent without custody.
- (iv) In the case of a person for whom claim is made as a dependent child whose parents are separated or divorced, where there is a court decree which would otherwise

establish financial responsibility for the medical, dental or other health care expenses with respect to the child, then, notwithstanding paragraphs (ii) and (iii) above, the benefits of a Plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan which covers the child as a dependent child.

- (c) When rules (a) and (b) do not establish an order of benefit determination, the benefits of a Plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a Plan which has covered such person the shorter period of time, provided that:
- (i) the benefits of a plan covering the person on whose expenses claim is based as a laid-off or retired employee, or dependent of such person, shall be determined after the benefits of any other Plan covering such person as an employee, other than a laid-off or retired employee, or dependent of such person; and
 - (ii) if either Plan does not have a provision regarding laid-off or retired employees, which results in each Plan determining its benefits after the other, then the provisions of (i) above shall not apply.

GUIDELINE NINE: Order Of Benefit Determination: When a claim under a Plan with a COB provision involves another Plan which also has a COB provision, the carriers involved should use the above rules to decide the order in which the benefits payable under the respective plans will be determined.

- (1) In determining the length of time an individual has been covered under a given Plan, two successive Plans of a given group shall be deemed to be one continuous Plan so long as the claimant concerned was eligible for coverage within 24 hours after the prior Plan terminated. Thus, neither a change in the amount or scope of benefits provided by a Plan, a change in the carrier insuring the Plan, nor a change from one type of Plan to another, (e.g., single employer to multiple employer Plan, or vice versa, or single employer to a Taft-Hartley Welfare Plan) would constitute the start of a new Plan for purposes of this guideline.

- (2) If a claimant's effective date of coverage under a given Plan is subsequent to the date the carrier first contracted to provide the Plan for the group concerned (employer, union, association, etc.), then, in the absence of specific information to the contrary, the carrier shall assume, for purposes of this guideline, that the claimant's length of time covered under that Plan shall be measured from claimant's effective date of coverage. If a claimant's effective date of coverage under a given Plan is the same as the date the carrier first contracted to provide the Plan for the group concerned, then the carrier shall request the group concerned to furnish the date the claimant first became covered under the earliest of any prior Plans the group may have had. If such date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time his coverage under that Plan has been in force.

GUIDELINE TEN: Excess And Other Nonconforming Provisions: It is recognized that there may be existing group plans containing provisions under which the coverage is declared to be "excess" to all other coverages, or other overinsurance provisions not consistent with the provisions of this Regulation. Such plans may have been written by certain self-insured or nonregulated entities not presently subject to insurance regulation, or by insurers or service organizations under policies or contracts issued prior to the effective date of this Regulation but which have not yet been brought into conformance with this Regulation pursuant to Guideline 15 and Section 4. Carriers are urged to use the following claims administration procedures when one such plan is "excess" to all other coverages and their policy or contract contains the COB provisions. A group COB plan should pay first if it would be primary under the COB order of benefit determination provision. In those cases where a group COB plan would normally be considered secondary, the carrier should make every effort to coordinate in a secondary position with benefits available through any such "excess" plan. The carrier should try to secure the necessary

information from the "excess" plan. But if such excess plan is unwilling to provide the carrier with the necessary information, the carrier should assume the primary position in order to avoid undue claim delays and hardships to the insured.

5. When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during any Claim Determination Period, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of this Plan.

(Note: This Item 5 may be omitted if the Plan provides only one benefit. The wording shown is illustrative.)

D. Right To Receive And Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provision of similar purpose of any other Plan, the insurer or service plan may, without the consent of or notice to any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which the insurer or service plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the insurer or service plan such information as may be necessary to implement this provision.

GUIDELINE ELEVEN: Coordinating Benefit Payments:

Carriers are urged to use the following claims administration procedures to expedite claim payments where COB is involved:

- (1) Improving Exchange Of Benefit Information.
 - (a) There should be continued and improved education of claim personnel, stressing accurate and prompt completion of the HIC Duplicate Coverage Inquiry (DUP-1) Form by the inquiring carrier and the responding carrier. This education effort should also be encouraged through local claim associations.
 - (b) Claim personnel should be encouraged to make every effort, including use of the telephone, to speed up exchange of COB information.
 - (c) Carriers should encourage building a local data file of other group plans in the area, with at least basic information on group health plans for major employers.
- (2) Each carrier should establish a time limit after which full or partial payment should be made.
When payment of a claim is necessarily delayed for

reasons other than the application of a COB provision, investigation of other valid coverage should be conducted concurrently so as to create no further delay in the ultimate payment of benefits. Occasionally this will necessitate a carrier making payment as the primary carrier with a right of recovery in the event that subsequent investigation proves that payment as a secondary carrier should have been made.

GUIDELINE TWELVE: Small Claim Waivers: Carriers are urged to waive the investigation of possible other coverage for COB purposes on claims less than \$50, but if additional liability is incurred to raise the small claim above \$50, the entire liability may be included in the COB computation.

E. Facility Of Payment

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other Plans, the insurer or service plan shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, the insurer or service plan shall be fully discharged from liability under this Plan.

F. Right Of Recovery

Whenever payments has been made by the insurer with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the insurer or service plan shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the insurer or service plan shall determine: any persons to or for or with respect to whom such payments were made, any other insurers, service plans or any other organizations.

Section 3. Additional Guidelines

3.01 Additional Guidelines - The following constitute additional guidelines for the interpretation and administration of this Rule:

GUIDELINE THIRTEEN: Subrogation: The concept of coordination of benefits is clearly distinguishable from that of subrogation. Provisions for either may be included in a group health insurance policy without compelling the inclusion or exclusion of the other.

GUIDELINE FOURTEEN: Public Education: Each carrier has an affirmative obligation to urge its respective group clients to take reasonable steps to assure that

those insured by the group policy or subscriber contract have been exposed to reasonably concise explanations, with as little technical terminology as is commensurate with accuracy, as to the purpose and operation of COB. Such educational effort may take the form of articles in the company magazines or newspapers, speeches before the appropriate labor organization in the case of a unionized company, brochures added to pay envelopes, notices on the company bulletin board, materials used by personnel department in counseling employees, and the like. To facilitate compliance with this Guideline, there are attached several illustrations of such materials prepared by various carriers and easily adaptable to the special circumstances and convenience of the various insurer-employer relationships.

GUIDELINE FIFTEEN: Retroactivity: Group policies or contracts which are in force at the time of the effective date of this Regulation which contain an "excess" clause, "anti-duplication" provision, or any other provision by whatever name designated under which benefits would be reduced because of other existing coverages, other than the COB provisions established herein, shall be brought into compliance with the requirements of this Regulation

by the later of the next anniversary or renewal date of the group policy or contract, or the expiration of the applicable collectively bargained contract pursuant to which they are written, if any.

Section 4. Applicability

4.01. Applicability - The provisions of this Regulation shall apply to all policy and contract forms subject to this Regulation that are issued on or after this effective date, and all policy and contract forms subject to this Regulation that were issued prior to said effective date shall be brought into compliance with the requirements of this Regulation by the later of the next anniversary date or renewal date of the group policy or contract, or the expiration of any applicable collectively bargained contract pursuant to which they are written.

Section 5. Separability

5.01. Partial Invalidity - If any provision of this Regulation is held invalid, the remainder of this Regulation shall not be affected thereby.