

**WEST VIRGINIA
SECRETARY OF STATE
BETTY IRELAND
ADMINISTRATIVE LAW DIVISION**

Form #3

Do Not Mark In this Box

2008 AUG 29 PM 3: 38

OFFICE WEST VIRGINIA
SECRETARY OF STATE

**NOTICE OF AGENCY APPROVAL OF A PROPOSED RULE
AND
FILING WITH THE LEGISLATIVE RULE-MAKING REVIEW COMMITTEE**

AGENCY: Insurance Commissioner TITLE NUMBER: 114

CITE AUTHORITY W. Va. Code §§ 33-2-10, 33-25A-20, 33-16-3d, 33-25-6, and 33-25-11

AMENDMENT TO AN EXISTING RULE: YES NO

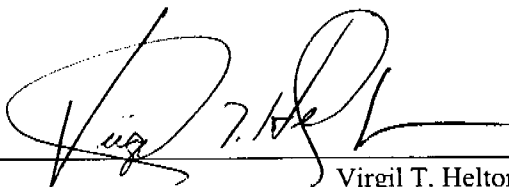
IF YES, SERIES NUMBER OF RULE BEING AMENDED: 28

TITLE OF RULE BEING AMENDED: Group Coordination of Health Benefits

IF NO, SERIES NUMBER OF RULE BEING PROPOSED: _____

TITLE OF RULE BEING PROPOSED: _____

THE ABOVE PROPOSED LEGISLATIVE RULE HAVING GONE TO A PUBLIC HEARING OR A PUBLIC COMMENT PERIOD IS HEREBY APPROVED BY THE PROMULGATING AGENCY FOR FILING WITH THE SECRETARY OF STATE AND THE LEGISLATIVE RULE MAKING REVIEW COMMITTEE FOR THEIR REVIEW.



Virgil T. Helton
Cabinet Secretary
West Virginia Department of Revenue

Offices of the Insurance Commissioner
Legislative Rule
Title 114, Series 28

COORDINATION OF HEALTH BENEFITS

TITLE 114, SERIES 28

BRIEF SUMMARY OF RULE

This rule, which is based on a model regulation adopted by the National Association of Insurance Commissioners, provides the process by which benefits are coordinated between and among various health insurance carriers when an insured is covered by more than one plan. The amendments take into account recent innovations such as health savings accounts and high deductible plans. A primary aim of the rule is to permit secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed an insured's total allowable expenses. The amendments also provide for coordination of benefits with respect to individual health plans; the current rule only applies to group plans.

QUESTIONNAIRE

(Please include a copy of this form with each filing of your rule: Notice of Public Hearing or Comment Period, Proposed Rule, and if needed, Emergency and Modified Rule.)

DATE: August 29, 2008

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

FROM: OFFICE OF THE INSURANCE COMMISSIONER
ATTN: Legal Division
1124 Smith Street
Post Office Box 50540
Charleston, West Virginia 25305-0540

LEGISLATIVE RULE TITLE: Coordination of Health Benefits, Title
114, Series 28

1. Authorizing statute(s) citation:

W. Va. Code §§ 33-2-10, 33-25A-20, 33-16-3d, 33-25-6, and
33-25-11

**2. a. Date filed in State Register with Notice of Hearing or
Public Comment Period:**

June 18, 2008 - Comment Period.

**b. What other notice, including advertising, did you give
of the hearing?**

N/A

**c. Date of Public Hearing(s) or Public Comment Period
ended:**

Comment period ended July 21, 2008.

**d. Attach list of persons who appeared at hearing, comments
received, amendments, reasons for amendments.**

Attached X No comments received

**e. Date you filed in State Register the agency approved
proposed Legislative Rule following public hearing:
(be exact)**

August 29, 2008 (following public comment period)

Insurance Commissioner
Title 114, Series 28

- f. Name, title, address and phone/fax/e-mail numbers of agency person(s) to receive all written correspondence regarding this rule: (Please type)

Timothy R. Murphy, Associate Counsel
West Virginia Insurance Commission
Legal Division
P.O. Box 50540
Charleston, WV 25305-0540
Phone: (304) 558-6279, Ext. 1210
Fax: (304) 558-1362
E-mail: timothy.murphy@wvinsurance.gov

- g. IF DIFFERENT FROM ITEM 'f', please give Name, title, address and phone number(s) of agency person(s) who wrote and/or has responsibility for the contents of this rule: (Please type)

Same.

3. If the statute under which you promulgated the submitted rules requires certain findings and determinations to be made as a condition precedent to their promulgation:

N/A

- a. Give the date upon which you filed in the State Register a notice of the time and place of a hearing for the taking of evidence and a general description of the issues to be decided.

N/A

- b. Date of hearing or comment period:

N/A

- c. On what date did you file in the State Register the findings and determinations required together with the reasons therefor?

N/A

- d. Attach findings and determinations and reasons:

N/A

Insurance Commissioner
Title 114, Series 28

ATTACHEMENT TO QUESTION 2 (d):

One comment was received pertaining to this rule. Mountain State Blue Cross Blue Shield asserted that a provision in section 6 -- requiring added language to a member's Explanation of Benefits informing them post-payment to file all their claims with each plan if they are covered by more than one health plan -- would add "significant administrative expense involving system changes" and, inasmuch as the overwhelming majority of claims are submitted by providers and not the members, such a requirement would provide negligible value. MSBCBS suggests that the rule allow for alternative methods, with the approval of the Offices of the Insurance Commissioner, of communicating this message to their members, such as placing it in the member's benefit booklet and/or on Coordination of Benefits Questionnaires sent to members annually.

This section was added to comply with the changes adopted by the NAIC in 2005. Nevertheless, the Commissioner recognizes the potential for increased administrative costs and agrees that the intent of the rule could be achieved in alternative ways. Therefore, the Commissioner makes the following change to section 6, 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." Upon request of a plan, the Commissioner may approve an alternative method of communicating this notice to covered persons.



Mountain State Blue Cross Blue Shield

An Independent Licensee of the Blue Cross and Blue Shield Association

700 Market Square P.O. Box 1948 Parkersburg, West Virginia 26102

From the desk of

Chad B. McIntosh Corporate Counsel Mountain State Blue Cross Blue Shield 700 Market Street

Parkersburg, WV 26101

(304) 424-9875

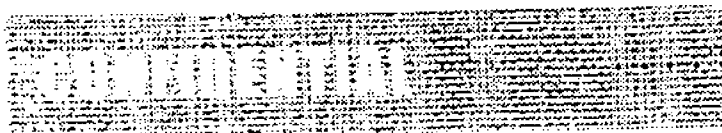
Fax: (304) 424-9875

TO: Timothy Murphy, Associate Counsel
FAX #: 304-558-1362
SUBJECT: Proposed Rule - Coordination of Health Benefits
DATE: July 18, 2008
PAGES: 2, INCLUDING THIS COVER SHEET.

The information contained in this facsimile message is ATTORNEY PRIVILEGED AND CONFIDENTIAL INFORMATION intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copy of this communication is strictly prohibited. If you have received this communication in error, please immediately notify us by telephone and return the original message to us at the address above via the U. S. postal service. Thank you.

COMMENTS:

Horizontal lines for handwritten comments.





700 Market Square
 P.O. Box 1948
 Parkersburg, West Virginia 26102

Local 304 / 424-7700
 Toll Free 800 / 344-5514

Writer's Direct Dial Number
 304-424-9858

July 18, 2008

Via Facsimile 304-558-1362

Timothy Murphy
 Associate Counsel
 West Virginia Insurance Commission
 PO Box 50540
 1124 Smith Street, Greenbrooke Building
 Charleston, WV 25305-0540

RE: Proposed Rule – Coordination of Health Benefits (Title 114, Series 28)

Dear Mr. Murphy:

The above referenced proposed regulation would result in significant increases in administrative expenses involving system changes. Specifically, the provision in section six requiring added language to a member's Explanation of Benefits informing them post-payment to file all their claims with each plan if they are covered by more than one health plan. The added language to a member's Explanation of Benefits would provide negligible value since the overwhelming majority of claims are submitted by providers and not the members.

Mountain State would like to suggest that the regulators allow for alternative methods, with the approval of the Insurance Commission, of communicating this message to our members, such as by placing it in the member's benefit booklet and/or on Coordination of Benefits Questionnaires sent to members annually.

Sincerely,

Chad McIntosh
 Director, Legal Services

Offices of the Insurance Commissioner
Legislative Rule
Title 114, Series 28

COORDINATION OF HEALTH BENEFITS

TITLE 114, SERIES 28

STATEMENT OF CIRCUMSTANCES

The rule, which is based on a National Association of Insurance Commissioners model, provides the process by which benefits are coordinated between and among various health insurance carriers when an insured is covered by more than one plan. The current version of this rule was promulgated in 1993. Since then, the NAIC has amended the model numerous times to take into account recent innovations such as health savings accounts and high deductible plans. The amendments also provide for coordination of benefits with respect to individual health plans; the current rule only applies to group plans.

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Coordination of Health Benefits (Title 114, Series 28)

Type of Rule: Legislative Interpretive Procedural

Agency: Insurance Commission

Address: Post Office Box 50540
1124 Smith Street, Greenbrooke Building
Charleston, West Virginia 25305-0540

Phone Number: (304) 558-0401 Email: Timothy.Murphy@wvinsurance.gov

Fiscal Note Summary

Summarize in a clear and concise manner what impact this measure will have on costs and revenues of state government.

The rule will have no additional fiscal impact upon state government.

Fiscal Note Detail

Show over-all effect in Item 1 and 2 and, in Item 3, give an explanation of Breakdown by fiscal year, including long-range effect.

FISCAL YEAR			
Effect of Proposal	Current Increase/Decrease (use "-")	Next Increase/Decrease (use "-")	Fiscal Year (Upon Full Implementation)
1. Estimated Total Cost	N/A	N/A	N/A
Personal Services	N/A	N/A	N/A
Current Expenses	N/A	N/A	N/A
Repairs & Alterations	N/A	N/A	N/A
Assets	N/A	N/A	N/A
Equipment	N/A	N/A	N/A
Other	N/A	N/A	N/A
2. Estimated Total Revenues	N/A	N/A	N/A

Rule Title: Coordination of Health Benefits (Title 114, Series 28)

3. **Explanation of above estimates (including long-range effect):**
Please include any increase or decrease in fees in your estimated total revenues.

N/A

MEMORANDUM

Please identify any areas of vagueness, technical defects, reasons the proposed rule **would not** have a fiscal impact, and/or any special issues **not** captured elsewhere on this form.

Date: _____

Signature of Agency Head or Authorized Representative

Timothy Murphy, Associate Counsel

**TITLE 114
LEGISLATIVE RULE
INSURANCE COMMISSIONER**

**SERIES 28
GROUP COORDINATION OF HEALTH BENEFITS**

Section

- 114-28-1. General.
- 114-28-2. Definitions.
- 114-28-3. Model COB Contract Provision.
- 114-28-4. Rules for Coordination of Benefits.
- 114-28-5. Procedure to be Followed by Secondary Plan to Calculate Benefits and Pay a Claim.
- 114-28-6. ~~Miscellaneous Provisions~~ Notice to Covered Person.
- 114-28-7. ~~Model Coordination of Benefits Provision~~ Miscellaneous Provisions.
- ~~114-28-8.~~ Severability.

APPENDIX A MODEL COB PROVISIONS

APPENDIX B CONSUMER EXPLANATORY BOOKLET

TITLE 114
LEGISLATIVE RULE
INSURANCE COMMISSIONER

SERIES 28
~~GROUP~~ COORDINATION OF HEALTH BENEFITS

FILED
2008 AUG 29 PM 3: 39

OFFICE WEST VIRGINIA
SECRETARY OF STATE

§114-28-1. General.

~~1.1. Scope. --~~

~~1.1.1. This regulation is applicable to every group insurance contract which provides health care benefits and which is issued on or after the effective date of this regulation.~~

~~1.1.2. Group insurance contracts which provide health care benefits and which were issued before the effective date of this regulation shall be brought into compliance by the later of:~~

~~a. The next anniversary date or renewal date of the group contract; or~~

~~b. The expiration of any applicable collectively bargained contract pursuant to which it was written.~~

1.1. Scope. -- This rule is applicable to every insurance contract which provides health care benefits and which is issued on or after the effective date of this rule. Insurance contracts which provide health care benefits and which were issued before the effective date of this rule shall be brought into compliance by the later of the next anniversary date or renewal date of the contract or the expiration of any applicable collectively bargained contract pursuant to which it was written. This rule is based on the "Coordination of Benefits Model Regulation (Model 120)" adopted by the National Association of Insurance Commissioners, as amended in 2005.

1.2. Authority. -- W. Va. Code §§33-2-10, 33-25A-20, 33-16-3d, 33-25-6, and 33-25-11.

1.3. Filing Date. -- ~~June 18, 1993~~

1.4. Effective Date. -- ~~June 18, 1993~~

1.5. Purpose. -- The purpose of this regulation rule is to:

~~1.5.1. Permit, but not require, plans to include a coordination of benefits (COB) provision;~~

~~1.5.2. a. Establish an a uniform order in of benefit determination under which plans pay their claims;~~

**Insurance Commissioner
Title 114, Series 28
Legislative Rule**

~~1.5.3. Provide the authority for the orderly transfer of information needed to pay claims promptly;~~

~~1.5.4. b. Reduce duplication of benefits by permitting a reduction of the benefits paid by a plan when the plan that, pursuant to rules established by regulation this rule, does not have to pay its benefits first; and~~

~~1.5.5. Reduce claims payment delays; and~~

~~1.5.6. Make all contracts that contain a COB provision consistent with this regulation.~~

c. Provide greater efficiency in the processing of claims when a person is covered under more than one plan.

§114-28-2. Definitions.

~~2.1.~~ The following words and terms, when used in this regulation rule shall have the following meanings unless the context clearly indicates otherwise:

~~2.1.1~~ 2.1. Allowable Expenses.

a. "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, including coinsurance or copayments and without reduction for any applicable deductible.

~~b. Notwithstanding the above definition, items of expense under coverages such as dental care, vision care, prescription drug or hearing aid programs may be excluded from the definition of "Allowable Expense". A plan which provides benefits only for any such items of expense may limit its definition of Allowable Expenses to like items of expense.~~

~~c. When a plan provides benefits in the form of service, the reasonable cash value of each service will be considered as both an Allowable Expense and a benefit paid.~~

~~d. 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~~

~~e. 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~~

**Insurance Commissioner
Title 114, Series 28
Legislative Rule**

corresponding expenses or services to which COB applies:

~~f. When benefits are reduced under a Primary Plan because a covered person does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements:~~

~~A. Only benefit reductions based upon provisions similar in purpose to those described above and which are contained in the Primary Plan may be excluded from Allowable Expenses:~~

~~B. This provision shall not be used by a Secondary Plan to refuse to pay benefits because an HMO member has elected to have health care services provided by a non-HMO provider and the HMO, pursuant to its contract, is not obligated to pay for providing those services:~~

b. 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.

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

d. 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.

e. The following are examples of expenses that are not allowable expenses:

1. 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;

2. 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 reimbursement amount for a specified benefit is not an allowable expense;

Insurance Commissioner
Title 114, Series 28
Legislative Rule

3. 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;

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 or other similar reimbursement methodology and another plan that provides it 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.

f. The definition of "allowable expense" may exclude certain types of coverage or benefits such as dental care, vision care, prescription drug or hearing aids. A plan that limits the application of Coordination of Benefits (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.

g. 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.

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

1. Because the covered person does not comply with the plan provisions concerning second surgical opinions or precertification of admissions or services; or

2. Because the covered person has a lower benefit because the covered person did not use a preferred provider.

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

~~2.1.2~~ 2.3. "Claim" means a request that benefits of a plan be provided or paid. is a claim The benefits claimed may be in the form of:

- a. Services (including supplies);
- b. Payment for all or a portion of the expenses incurred;

**Insurance Commissioner
Title 114, Series 28
Legislative Rule**

- c. A combination of ~~(1) and (2) above~~ subdivision a and b of this subsection; or
- d. An indemnification.

~~2.1.3. Claim Determination Period - This is the period of time, which must not be less than twelve 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.~~

~~a. 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.~~

~~b. 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.~~

2.4. "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.

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

~~2.1.4~~ 2.6. "Coordination of Benefits" - This is or "COB" means a provision establishing an order in which plans pay their claims, permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

2.7. "Custodial parent" means:

- a. The parent awarded custody of a child by a court decree; or
- b. In the absence of a court decree, the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

2.8. a. "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.

**Insurance Commissioner
Title 114, Series 28
Legislative Rule**

b. "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.

2.9. "High-deductible health plan" has the meaning given to 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.

~~2.1.5~~ 2.10. "Hospital Indemnity Benefits" ~~These are~~ means 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.

~~2.1.6~~ 2.11. a. "Plan" means a form of coverage with which coordination is allowed. ~~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. Separate parts of a plan for members of a group that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one plan and there is no COB among the separate parts of the plan.~~

a b. 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 subdivision. The definition of "Plan" 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.

b. ~~This regulation uses the term "Plan". However, a group contract may, instead, use "program" or some other term.~~

c. "Plan" may include includes:

~~A~~ 1. Group insurance and group and nongroup insurance contracts and subscriber contracts;

~~B~~ 2. Uninsured arrangements of group or group-type coverage;

~~C~~ 3. Group or group-type and nongroup coverage through HMOs and other prepayment, group practice and individual practice plans closed panel plans;

**Insurance Commissioner
Title 114, Series 28
Legislative Rule**

~~Ð 4. 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 5. The amount by which group or group-type hospital indemnity benefits exceed \$100 per day medical care components of long-term care contracts, such as skilled nursing care;~~

~~F 6. The medical benefits coverage in group, group-type and individual automobile "no fault" and traditional automobile "fault" type contracts; and~~

~~G 7. Medicare or other governmental benefits, except as provided in 2.1.7.d.G below paragraph 8, subdivision d of this subsection. That part of the definition of "Plan" may be limited to the hospital, medical and surgical benefits of the governmental program.~~

d. "Plan" shall not include:

~~A 1. Individual or family insurance contracts Hospital indemnity coverage benefits or other fixed indemnity coverage;~~

~~B 2. Individual or family subscriber contracts Accident only coverage;~~

~~C 3. Individual or family coverage through Health Maintenance Organizations (HMOs) Specified disease or specified accident coverage;~~

~~Ð 4. Individual or family coverage under other prepayment, group practice and individual practice plans Limited benefit health coverage;~~

~~E 5. Group or group-type hospital indemnity benefits of \$100 per day or less 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 for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;~~

**Insurance Commissioner
Title 114, Series 28
Legislative Rule**

~~F 6. School accident-type coverages—These contracts that 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~~

7. Medicare supplement policies;

~~6 8. A State plan under Medicaid; and shall not include a law or plan when, by law, its benefits are in excess of those of any private insurance plan or other non-governmental plan.~~

9. A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

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

~~2.1.7~~ 2.13. "Primary Plan" —A 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 primary plan if either of the following conditions is true:

a. The plan either has no order of benefit determination rules, or it has rules which differ from those permitted by this regulation rule; ~~There may be more than one Primary Plan; or~~

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

~~2.1.8~~ 2.14. "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. Any employer group minimum benefits plan issued in accordance with West Virginia Code Chapter 33, Article 16C is a Secondary Plan if other applicable health insurance coverage exists. If a person is covered by more than one employer group minimum benefits plan, the order of benefits determination rules of this regulation decide the order in which their benefits are determined in relation to each other. Provided, That under the provisions of W. Va. Code §5-16-12(a), *~~§5-16-13(a)~~ (This is an incorrect statutory citation. The correct statutory reference is shown above in brackets.) coverage issued pursuant to the Public Employees Insurance Act is secondary to an employer group minimum benefits plan and any other applicable health insurance coverage. 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

**Insurance Commissioner
Title 114, Series 28
Legislative Rule**

~~this regulation, has its benefits determined before those of that Secondary Plan.~~

~~2.1.9. 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.~~

§114-28-3. Model COB Contract Provision.

3.1. ~~General:~~ Appendix A contains a model COB provision for use in group contracts. That use is subject to the provisions of subsections 3.2, and 3.3 and 3.4 below of this section and to the provisions of Section 5 of this rule.

3.2. 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.

~~3.2~~ 3.3. Flexibility. A group contract's The COB provision does contained in Appendix A and the plain language explanation in Appendix B do not have to use the specific words and format shown at in Appendix A or Appendix B. Changes may be made to fit the language and style of the rest of the group contract or to reflect the difference among plans which provide services, which pay benefits for expenses incurred, and which indemnify. No other substantive changes are allowed.

~~3.3. Prohibited Coordination and Benefit Design:~~

~~3.3.1. A group contract may not reduce benefits on the basis that:~~

3.4. A COB provision may not be used that permits a plan to reduce its benefits on the basis that:

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

Insurance Commissioner
Title 114, Series 28
Legislative Rule

~~3.3.2~~ 3.5. 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 accord accordance with the rules permitted by this regulation this rule.

~~3.3.3~~ 3.6. 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 provisions of section 7 of this rule to determine the amount it should pay for the benefit.

~~3.3.4~~ 3.7. 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 subdivision c, subsection 2.11 of this rule.

§114-28-4. Rules for Coordination of Benefits.

~~4.1. The following rules shall apply when determining the order of benefits:~~

~~4.1.1. General. The general~~ When a person is covered by two (2) or more plans, the rules for determining the order of benefits is benefit payments are as follows:

~~4.1. a. The Primary Plan must 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 2 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.~~

b. 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.

c. When multiple contracts providing coordinated coverage are treated as a single plan under this rule, 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 rule.

**Insurance Commissioner
Title 114, Series 28
Legislative Rule**

d. If a person is covered by more than one secondary plan, the order of benefit determination rules of this rule 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 rule, has its benefits determined before those of that secondary plan.

4.2. a. Except as provided in subdivision b of this subsection, a plan that does not contain an order of benefit determination provisions that are consistent with this rule 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.

b. 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.

b 4.3. A Secondary Plan plan may take into consideration the benefits of paid or provided by another plan into account only when, under these rules, it is secondary to that other plan.

4.4. Order of Benefit Determination. Each plan determines its order of benefits using the first of the following rules that applies:

a. Non-Dependent or Dependent

c 1. ~~The benefits of~~ Subject to paragraph 2 of this subdivision, the plan ~~which that~~ covers the person other than as a dependent, for example as an employee, member or subscriber, (that is, other than as a dependent) are determined before those of policyholder or retiree, is the primary plan and the plan which that covers the person as a dependent is the secondary plan.

2. A. If the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing rules, Medicare is:

1. Secondary to the plan covering the person as a dependent; and

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

**Insurance Commissioner
Title 114, Series 28
Legislative Rule**

B. 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.

b. Dependent Child 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:

~~4.1.2. Dependent Child/Parents Not Separated or Divorced. The rules for the order of benefits for a dependent child when the parents are not separated or divorced are as follows:~~

1. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

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

~~b B. If both parents have the same birthday, the benefits of the plan which that has covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time longest is the primary plan.~~

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

~~d. A group contract which includes COB and which is issued or renewed, or which has an anniversary date on or after sixty days after the effective date of this regulation shall include the substance of the provisions in 4.1.2.a, b, and c above. Until those provisions become effective, the group contract may instead contain wording such as:~~

~~"Except as stated in C below, the benefits of a plan which covers a person as a dependent of a male are determined before those of a plan which covers the person as a dependent of a female."~~

~~e. If the other plan does not have the rule described in 4.1.2.a, b, and c 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.~~

~~4.1.3. Dependent Child/Separated or Divorced Parents. If two or more plans cover a~~

**Insurance Commissioner
Title 114, Series 28
Legislative Rule**

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

2. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

A. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan 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. This item shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of this court decree provision;

B. 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;

C. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent, the provisions of subparagraph A of this paragraph shall determine the order of benefits; or

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

a 1. First, the ~~The plan of covering~~ the parent with custody of the child;

b 2. ~~Then, the ~~The plan of covering~~ the spouse of the parent with the custody of the child; and~~

c 3. Finally, the ~~The plan of covering~~ the parent not having custody of the child; and

4. The plan covering the spouse of the parent not having custody of the child.

~~d. 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~~

**Insurance Commissioner
Title 114, Series 28
Legislative Rule**

~~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.~~

~~e. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in Section 4.1.2, Dependent Child/Parents Not Separated or Divorced.~~

~~4.1.4 c. Active/Inactive Employee or Retired or Laid-Off Employee. 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. 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. 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. This rule does not apply if the rule in subdivision a of this subsection can determine the order of benefits.~~

~~4.1.5 d. COBRA or State Continuation Coverage~~

~~1. 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.~~

~~2. 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.~~

~~3. This rule does not apply if the rule in paragraph 1 can determine the order of benefits.~~

~~4.1.6 e. Longer/Shorter Longer or Shorter Length of Coverage.~~

~~1. If none of the above the preceding rules determines do not determine the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the person for the longer period of time is the primary plan and the plan which covered that the person for the shorter term period of time is the secondary plan.~~

**Insurance Commissioner
Title 114, Series 28
Legislative Rule**

a 2. 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 within twenty-four (24) hours after coverage under the first plan ended.

b 3. The start of a new plan does not include:

- A. A change in the amount or scope of a plan's benefits;
- B. A change in the entity which that pays, provides or administers the plan's benefits; or
- C. A change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).

c 4. 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 for a group plan, 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.

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

§114-28-5. Procedure to be Followed by Secondary Plan to Calculate Benefits and Pay a Claim.

~~5.1. Total Allowable Expenses shall be as follows:~~

~~5.1.1. When it is determined, pursuant to Section 4, 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 one hundred percent (100%) of the total amount actually charged by provider. 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.~~

~~5.1.2. 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~~

**Insurance Commissioner
Title 114, Series 28
Legislative Rule**

~~other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds the actual charges incurred 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 one hundred percent (100%) of total charges to the insured:~~

~~a. 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.~~

~~b. Paragraph 5.1.2.a. above may be omitted if the plan provides only one benefit, or may be altered to suit the coverage provided.~~

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 one-hundred percent (100%) 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.

§114-28-6. 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." Upon request of a plan, the Commissioner may approve an alternative method of communicating this notice to covered persons.

§114-28-6 7. Miscellaneous Provisions.

~~6 7.1. Reasonable Cash Values of Services:~~ A Secondary Plan which that 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.

~~6.2. Excess and Other Nonconforming Provisions shall be determined as follows:~~

~~6.2.1. Some plans have order of benefit determination rules not consistent with this~~

**Insurance Commissioner
Title 114, Series 28
Legislative Rule**

regulation which declare that 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 brought into conformity:

6.2.2: 7.2. a. A plan with order of benefit determination rules which that comply with this regulation rule (Complying Plan) may coordinate its benefits with a plan which that is "excess" or "always secondary" or which that uses order of benefit determination rules which that are inconsistent with those contained in this regulation rule (Noncomplying Plan) on the following basis:

a 1. If the Complying Plan is the Primary Plan, it shall pay or provide its benefits ~~on a primary basis first~~ first;

b 2. 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 3. 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. ~~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. 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.~~

6.2.3 b. If the Noncomplying Plan reduces its benefits so that the ~~employee, subscriber, or member covered person~~ receives less in benefits than ~~he or she~~ the covered person 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 the covered person or on behalf of the ~~employee, subscriber or member covered person~~ an amount equal to such the difference.

c. ~~However, in~~ In no event shall the Complying Plan advance more than the Complying Plan would have paid had it been the Primary Plan less any amount it previously paid for the same expense or service. In consideration of ~~such the~~ advance, the Complying Plan shall be subrogated to all rights of the ~~employee, subscriber or member covered person~~ against the Noncomplying Plan. ~~Such The~~ advance by the Complying Plan shall also be without prejudice to any claim it may have against the Noncomplying Plan in the absence of such subrogation.

**Insurance Commissioner
Title 114, Series 28
Legislative Rule**

~~6.3. 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.~~

~~6.4 7.3. 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.~~

~~6.5 7.4. 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.~~

~~§114-28-7. Model Coordination of Benefits Provisions:~~

~~The attached Appendix A is offered as a model which demonstrates acceptable provisions which can be adopted in a plan. This is a model only. Actual plan provisions may differ to suit particularized needs so long as they otherwise meet the requirements of these regulations:~~

~~§114-28-8. Severability:~~

~~If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances shall not be affected thereby.~~

APPENDIX A
MODEL COB PROVISIONS

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

I. APPLICABILITY

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

~~B. 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 benefit determination rules, another plan determines its benefits first. The above reduction is described in Section IV, "Effect on the Benefits of This Plan."~~

B. 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 one-hundred percent (100%) of the total allowable expense.

II. DEFINITIONS

A. "Plan" is any of these which 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) 1. Group insurance or group-type "Plan" includes group and nongroup insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage, whether insured or uninsured. This includes~~

**Insurance Commissioner
Title 114, Series 28
Legislative Rule**

~~prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage. "Plan" also includes 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.~~

~~(2) Coverage under a governmental plan, or coverage required or 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).~~

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, school accident type coverage, benefits for non-medical components of long-term care policies, Medicare supplement policies, Medicaid policies, or coverage under other federal governmental plans, unless permitted by law.

B. "This Plan" is means, in a COB provision, the part of the group contract that provides benefits for health care expenses: 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 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 whether This Plan this plan is a Primary Plan primary plan or Secondary Plan as to another plan covering the person a secondary plan when the person has health care coverage under more than one plan.

1. When This Plan this plan is a Primary Plan primary plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

2. When This Plan this plan is a Secondary Plan secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits and may reduce the benefits it pays so that all plan benefits do not exceed one-hundred percent (100%) of the total allowable expense.

~~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 a necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made is a health care expense, including deductibles,~~

**Insurance Commissioner
Title 114, Series 28
Legislative Rule**

coinsurance and copayments, that is covered at least in part by a plan covering the person. 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.

1. The following are examples of expenses that are not allowable expenses:

(a) 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 allowable expense unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the plan 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 methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

(c) If a person is covered by two (2) or more plans that provide benefit payment on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees 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:

(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 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.

(e) When benefits are reduced under a Primary Plan The amount of any benefit reduction by the primary plan because a covered person does not has failed to comply with the plan provisions, the amount of such reduction will not be considered is not an Allowable-Expense allowable expense. Examples of such these types of plan provisions are

**Insurance Commissioner
Title 114, Series 28
Legislative Rule**

those related to include second surgical opinions, precertification of admissions ~~or services~~, and preferred provider arrangements.

~~E. "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.~~

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 cases of emergency or referral by a panel member.

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. 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:~~

~~(1) The other plan has rules coordinating its benefits with those of This Plan, and~~

~~(2) 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.~~

A. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.

B. 1. Except as provided in paragraph (2) below, a plan that does not contain a coordination of benefits that is consistent with this rule is always primary unless the provisions of both plans state that the complying plan is primary.

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 coverage that are written in

**Insurance Commissioner
Title 114, Series 28
Legislative Rule**

connection with a closed panel plan to provide out-of-network benefits.

C. A plan may consider the benefits paid or provided by another plan in calculation payment of its benefits only with it is secondary to that other plan.

~~B: D. Rules. This Plan~~ Each plan determines its order of benefits using the first of the following rules ~~which applies that apply:~~

~~(1) 1. Non-Dependent/Dependent. The benefits of the plan which covers the person other than as a dependent, for example as an employee, member, or policyholder, subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent or retiree 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) 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 persons, 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:~~

~~(a) (1) The benefits of the plan of the parent whose birthday falls earlier in a 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~~

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

~~However, if the other plan does not have the rule described in (a) immediately 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 in the other plan will determine the order of benefits.~~

~~(b) For a dependent child whose parents are divorced or separated or not~~

**Insurance Commissioner
Title 114, Series 28
Legislative Rule**

living together, whether or not they have ever been married:

~~(3) Dependent Child/Separated or Divorced Parents. 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:~~

(1) 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:

child; (a) (i) First, the The plan of the parent with custody of the

the (b) (ii) Then, the The plan of the spouse of the parent with custody of the child; and

custody of the child; and (c) (iii) Finally, the The plan of the parent not having

custody of the child; (iv) The plan of the spouse of the parent not having

~~(2) However, if If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the dependent 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 that plan is primary. 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. This rule applies to plan years commencing after the plan is given notice of the court decree;~~

(3) 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 (a) above shall determine the order of benefits.

(4) Joint Custody. If the specific terms of a court decree state states that the parents shall share have joint custody, without stating that one of the parents is responsible for the health care expenses of the dependent child, the plans covering the child shall follow the order of benefit determination rules outlined in Paragraph III B(2) provisions of (a) above shall determine the order of benefits.

**Insurance Commissioner
Title 114, Series 28
Legislative Rule**

(c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

~~(5) 3. Active/Inactive Employee Employees or Retired or Laid-Off Employee.~~ The benefits of a 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 plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this Rule (5) this rule is ignored. This rule does not apply if the rule labeled D(1) of this section 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 plans do 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) of this section can determine the order of benefits.

~~(6) 5. Longer/Shorter Longer or Shorter Length of Coverage. If none of the above rules determines the order of the benefits, the benefits of the~~ The plan which that covered a person as an employee, member, or subscriber or retiree longer are determined before those of is the primary plan and the Plan plan which covered that person for the shorter term 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 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.~~

**Insurance Commissioner
Title 114, Series 28
Legislative Rule**

~~B. 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 Expense 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, exceed one hundred percent (100%) of the actual charges by providers to the insured 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 actual charges.~~

~~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.~~

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 another 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 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.

V. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage are needed to apply these COB rules and to determine benefits payable under this plan and other plans. [insurer] has the right to decide which facts it needs. [Organization responsible for COB administration] It may get needed facts from or give them to any other organization or person to the extent reasonably necessary to apply these rules and to determine benefits payable under this plan and other plans covering the person claiming benefits. [Organization responsible for COB administration] To the extent permissible under existing law and to the extent reasonably required [insurer] need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan this plan must give [insurer Organization responsible for COB administration] any facts it reasonably needs to pay the claim to apply those rules and determine benefits payable.

VI. FACILITY OF PAYMENT

**Insurance Commissioner
Title 114, Series 28
Legislative Rule**

A payment made under another plan may include an amount ~~which that~~ should have been paid under ~~This Plan this plan~~. If it does, [~~insurer~~ Organization responsible for COB administration] 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 this plan~~. [~~insurer~~ Organization responsible for COB administration] will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

VII. RIGHT OF RECOVERY

If the amount of the payments made by [~~insurer~~ Organization responsible for COB administration] 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.

~~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 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 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:

**Insurance Commissioner
Title 114, Series 28
Legislative Rule**

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,

**Insurance Commissioner
Title 114, Series 28
Legislative Rule**

coinsurance and deductibles.

- If there is a difference between the amount 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**