

**WEST VIRGINIA  
SECRETARY OF STATE  
NATALIE E. TENNANT  
ADMINISTRATIVE LAW DIVISION**

Form #4

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OFFICE WEST VIRGINIA  
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**NOTICE OF RULE MODIFICATION OF A PROPOSED RULE**

AGENCY: Insurance Commission TITLE NUMBER: 114

CITE AUTHORITY W.Va. Code §33-2-10

AMENDMENT TO AN EXISTING RULE: YES  NO

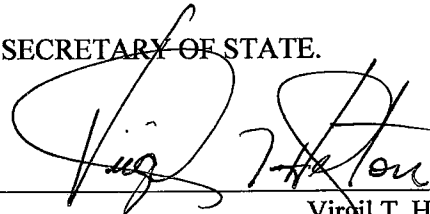
IF YES, SERIES NUMBER OF RULE BEING AMENDED: 28

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, FOLLOWING REVIEW BY THE LEGISLATIVE  
RULE MAKING REVIEW COMMITTEE IS HEREBY MODIFIED AS A RESULT OF REVIEW AND  
COMMENT BY THE LEGISLATIVE RULE-MAKING REVIEW COMMITTEE. THE ATTACHED  
MODIFICATIONS ARE FILED WITH THE SECRETARY OF STATE.



Virgil T. Helton  
Cabinet Secretary  
West Virginia Department of Revenue

**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

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LEGISLATIVE RULE  
INSURANCE COMMISSIONER

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SERIES 28  
GROUP COORDINATION OF HEALTH BENEFITS

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

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;~~

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~~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~~

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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, as amended, 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, as amended.

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;

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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 its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, that negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

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;

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- 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.

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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;

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~~D 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;~~

~~D 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;~~

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~~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;

~~G 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

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~~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.

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~~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.

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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 this rule, 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).

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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~~

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~~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~~

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~~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.~~

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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~~

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~~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~~

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~~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;

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.

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~~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

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~~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,~~

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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

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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

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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

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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  
custody of the child; and

(b) ~~(ii) Then, the~~ The plan of the spouse of the parent with

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.

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(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.~~

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~~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**

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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:

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**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.

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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**

## 26 USCS § 223

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\*\*\* CURRENT THROUGH PL 111-2, APPROVED 1/29/2009 \*\*\*

TITLE 26. INTERNAL REVENUE CODE  
 SUBTITLE A. INCOME TAXES  
 CHAPTER 1. NORMAL TAXES AND SURTAXES  
 SUBCHAPTER B. COMPUTATION OF TAXABLE INCOME  
 PART VII. ADDITIONAL ITEMIZED DEDUCTIONS FOR INDIVIDUALS

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## 26 USCS § 223

## § 223. Health savings accounts.

(a) Deduction allowed. In the case of an individual who is an eligible individual for any month during the taxable year, there shall be allowed as a deduction for the taxable year an amount equal to the aggregate amount paid in cash during such taxable year by or on behalf of such individual to a health savings account of such individual.

## (b) Limitations.

(1) In general. The amount allowable as a deduction under subsection (a) to an individual for the taxable year shall not exceed the sum of the monthly limitations for months during such taxable year that the individual is an eligible individual.

(2) Monthly limitation [Caution: For calendar year 2008, see § 4 of *Rev. Proc. 2007-36* (note to this section) for inflation adjustments to monthly limitations on deductions under this paragraph.]. The monthly limitation for any month is 1/12 of--

(A) in the case of an eligible individual who has self-only coverage under a high deductible health plan as of the first day of such month, \$ 2,250.

(B) in the case of an eligible individual who has family coverage under a high deductible health plan as of the first day of such month, \$ 4,500.

## (3) Additional contributions for individuals 55 or older.

(A) In general. In the case of an individual who has attained age 55 before the close of the taxable year, the applicable limitation under subparagraphs (A) and (B) of paragraph (2) shall be increased by the additional contribution amount.

(B) Additional contribution amount. For purposes of this section, the additional contribution amount is the amount determined in accordance with the following table:

For taxable years beginning in: The  
 additional  
 contribution  
 amount is:

2004 .....	\$ 500
2005 .....	\$ 600
2006 .....	\$ 700
2007 .....	\$ 800
2008 .....	\$ 900
2009 and thereafter .....	\$ 1,000.

(4) Coordination with other contributions. The limitation which would (but for this paragraph) apply under this subsection to an individual for any taxable year shall be reduced (but not below zero) by the sum of--

(A) the aggregate amount paid for such taxable year to Archer MSAs of such individual,

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(B) the aggregate amount contributed to health savings accounts of such individual which is excludable from the taxpayer's gross income for such taxable year under section 106(d) [26 USCS § 106(d)] (and such amount shall not be allowed as a deduction under subsection (a)), and

(C) the aggregate amount contributed to health savings accounts of such individual for such taxable year under section 408(d)(9) [26 USCS § 408(d)(9)] (and such amount shall not be allowed as a deduction under subsection (a)).

Subparagraph (A) shall not apply with respect to any individual to whom paragraph (5) applies.

(5) Special rule for married individuals. In the case of individuals who are married to each other, if either spouse has family coverage--

(A) both spouses shall be treated as having only such family coverage (and if such spouses each have family coverage under different plans, as having the family coverage with the lowest annual deductible), and

(B) the limitation under paragraph (1) (after the application of subparagraph (A) and without regard to any additional contribution amount under paragraph (3))--

(i) shall be reduced by the aggregate amount paid to Archer MSAs of such spouses for the taxable year, and

(ii) after such reduction, shall be divided equally between them unless they agree on a different division.

(6) Denial of deduction to dependents. No deduction shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

(7) Medicare eligible individuals. The limitation under this subsection for any month with respect to an individual shall be zero for the first month such individual is entitled to benefits under title XVIII of the Social Security Act [42 USCS §§ 1395 et seq.] and for each month thereafter.

(8) Increase in limit for individuals becoming eligible individuals after the beginning of the year.

(A) In general. For purposes of computing the limitation under paragraph (1) for any taxable year, an individual who is an eligible individual during the last month of such taxable year shall be treated--

(i) as having been an eligible individual during each of the months in such taxable year, and

(ii) as having been enrolled, during each of the months such individual is treated as an eligible individual solely by reason of clause (i), in the same high deductible health plan in which the individual was enrolled for the last month of such taxable year.

(B) Failure to maintain high deductible health plan coverage.

(i) In general. If, at any time during the testing period, the individual is not an eligible individual, then--

(I) gross income of the individual for the taxable year in which occurs the first month in the testing period for which such individual is not an eligible individual is increased by the aggregate amount of all contributions to the health savings account of the individual which could not have been made but for subparagraph (A), and

(II) the tax imposed by this chapter [26 USCS §§ 1 et seq.] for any taxable year on the individual shall be increased by 10 percent of the amount of such increase.

(ii) Exception for disability or death. Subclauses (I) and (II) of clause (i) shall not apply if the individual ceased to be an eligible individual by reason of the death of the individual or the individual becoming disabled (within the meaning of section 72(m)(7) [26 USCS § 72(m)(7)]).

(iii) Testing period. The term "testing period" means the period beginning with the last month of the taxable year referred to in subparagraph (A) and ending on the last day of the 12th month following such month.

(c) Definitions and special rules. For purposes of this section--

(1) Eligible individual.

(A) In general. The term "eligible individual" means, with respect to any month, any individual if--

(i) such individual is covered under a high deductible health plan as of the 1st day of such month, and

(ii) such individual is not, while covered under a high deductible health plan, covered under any health plan--

(I) which is not a high deductible health plan, and

(II) which provides coverage for any benefit which is covered under the high deductible health plan.

(B) Certain coverage disregarded. Subparagraph (A)(ii) shall be applied without regard to--

(i) coverage for any benefit provided by permitted insurance,

(ii) coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care, and

(iii) for taxable years beginning after December 31, 2006, coverage under a health flexible spending arrangement during any period immediately following the end of a plan year of such arrangement during which unused benefits or contributions remaining at the end of such plan year may be paid or reimbursed to plan participants for qualified benefit expenses incurred during such period if--

(I) the balance in such arrangement at the end of such plan year is zero, or

## 26 USCS § 223

(II) the individual is making a qualified HSA distribution (as defined in section 106(e) [26 USCS § 106(e)]) in an amount equal to the remaining balance in such arrangement as of the end of such plan year, in accordance with rules prescribed by the Secretary.

(2) High deductible health plan.

(A) In general [Caution: For calendar year 2008, see § 4 of *Rev. Proc. 2007-36* (note to this section) for inflation adjustments to deductible amounts for purposes of this subparagraph.]. The term "high deductible health plan" means a health plan--

(i) which has an annual deductible which is not less than--

(I) \$ 1,000 for self-only coverage, and

(II) twice the dollar amount in subclause (I) for family coverage, and

(ii) the sum of the annual deductible and the other annual out-of-pocket expenses required to be paid under the plan (other than for premiums) for covered benefits does not exceed--

(I) \$ 5,000 for self-only coverage, and

(II) twice the dollar amount in subclause (I) for family coverage.

(B) Exclusion of certain plans. Such term does not include a health plan if substantially all of its coverage is coverage described in paragraph (1)(B).

(C) Safe harbor for absence of preventive care deductible. A plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for preventive care (within the meaning of section 1871 of the Social Security Act [42 USCS § 1395hh], except as otherwise provided by the Secretary).

(D) Special rules for network plans. In the case of a plan using a network of providers--

(i) Annual out-of-pocket limitation. Such plan shall not fail to be treated as a high deductible health plan by reason of having an out-of-pocket limitation for services provided outside of such network which exceeds the applicable limitation under subparagraph (A)(ii).

(ii) Annual deductible. Such plan's annual deductible for services provided outside of such network shall not be taken into account for purposes of subsection (b)(2).

(3) Permitted insurance. The term "permitted insurance" means--

(A) insurance if substantially all of the coverage provided under such insurance relates to--

(i) liabilities incurred under workers' compensation laws,

(ii) tort liabilities,

(iii) liabilities relating to ownership or use of property, or

(iv) such other similar liabilities as the Secretary may specify by regulations,

(B) insurance for a specified disease or illness, and

(C) insurance paying a fixed amount per day (or other period) of hospitalization.

(4) Family coverage. The term "family coverage" means any coverage other than self-only coverage.

(5) Archer MSA. The term "Archer MSA" has the meaning given such term in section 220(d) [26 USCS § 220(d)].

(d) Health savings account. For purposes of this section--

(1) In general. The term "health savings account" means a trust created or organized in the United States as a health savings account exclusively for the purpose of paying the qualified medical expenses of the account beneficiary, but only if the written governing instrument creating the trust meets the following requirements:

(A) Except in the case of a rollover contribution described in subsection (f)(5) or section 220(f)(5) [26 USCS § 220(f)(5)], no contribution will be accepted--

(i) unless it is in cash, or

(ii) to the extent such contribution, when added to previous contributions to the trust for the calendar year, exceeds the sum of--

(I) the dollar amount in effect under subsection (b)(2)(B), and

(II) the dollar amount in effect under subsection (b)(3)(B).

(B) The trustee is a bank (as defined in section 408(n) [26 USCS § 408(n)]), an insurance company (as defined in section 816 [26 USCS § 816]), or another person who demonstrates to the satisfaction of the Secretary that the manner in which such person will administer the trust will be consistent with the requirements of this section.

(C) No part of the trust assets will be invested in life insurance contracts.

(D) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

(E) The interest of an individual in the balance in his account is nonforfeitable.

(2) Qualified medical expenses.

(A) In general. The term "qualified medical expenses" means, with respect to an account beneficiary, amounts paid by such beneficiary for medical care (as defined in section 213(d) [26 USCS § 213(d)] for such individual, the spouse of

## 26 USCS § 223

such individual, and any dependent (as defined in section 152 [26 USCS § 152], determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof) of such individual, but only to the extent such amounts are not compensated for by insurance or otherwise.

(B) Health insurance may not be purchased from account. Subparagraph (A) shall not apply to any payment for insurance.

(C) Exceptions. Subparagraph (B) shall not apply to any expense for coverage under--

(i) a health plan during any period of continuation coverage required under any Federal law,

(ii) a qualified long-term care insurance contract (as defined in section 7702B(b) [26 USCS § 7702B(b)]),

(iii) a health plan during a period in which the individual is receiving unemployment compensation under any Federal or State law, or

(iv) in the case of an account beneficiary who has attained the age specified in section 1811 of the Social Security Act [42 USCS § 1395c], any health insurance other than a medicare supplemental policy (as defined in section 1882 of the Social Security Act [42 USCS § 1395ss]).

(3) Account beneficiary. The term "account beneficiary" means the individual on whose behalf the health savings account was established.

(4) Certain rules to apply. Rules similar to the following rules shall apply for purposes of this section:

(A) Section 219(d)(2) [26 USCS § 219(d)(2)] (relating to no deduction for rollovers).

(B) Section 219(f)(3) [26 USCS § 219(f)(3)] (relating to time when contributions deemed made).

(C) Except as provided in section 106(d) [26 USCS § 106(d)], section 219(f)(5) [26 USCS § 219(f)(5)] (relating to employer payments).

(D) Section 408(g) [26 USCS § 408(g)] (relating to community property laws).

(E) Section 408(h) [26 USCS § 408(h)] (relating to custodial accounts).

(e) Tax treatment of accounts.

(1) In general. A health savings account is exempt from taxation under this subtitle [26 USCS §§ 1 et seq.] unless such account has ceased to be a health savings account. Notwithstanding the preceding sentence, any such account is subject to the taxes imposed by section 511 [26 USCS § 511] (relating to imposition of tax on unrelated business income of charitable, etc. organizations).

(2) Account terminations. Rules similar to the rules of paragraphs (2) and (4) of section 408(e) [26 USCS § 408(e)] shall apply to health savings accounts, and any amount treated as distributed under such rules shall be treated as not used to pay qualified medical expenses.

(f) Tax treatment of distributions.

(1) Amounts used for qualified medical expenses. Any amount paid or distributed out of a health savings account which is used exclusively to pay qualified medical expenses of any account beneficiary shall not be includible in gross income.

(2) Inclusion of amounts not used for qualified medical expenses. Any amount paid or distributed out of a health savings account which is not used exclusively to pay the qualified medical expenses of the account beneficiary shall be included in the gross income of such beneficiary.

(3) Excess contributions returned before due date of return.

(A) In general. If any excess contribution is contributed for a taxable year to any health savings account of an individual, paragraph (2) shall not apply to distributions from the health savings accounts of such individual (to the extent such distributions do not exceed the aggregate excess contributions to all such accounts of such individual for such year) if--

(i) such distribution is received by the individual on or before the last day prescribed by law (including extensions of time) for filing such individual's return for such taxable year, and

(ii) such distribution is accompanied by the amount of net income attributable to such excess contribution.

Any net income described in clause (ii) shall be included in the gross income of the individual for the taxable year in which it is received.

(B) Excess contribution. For purposes of subparagraph (A), the term "excess contribution" means any contribution (other than a rollover contribution described in paragraph (5) or section 220(f)(5) [26 USCS § 220(f)(5)]) which is neither excludable from gross income under section 106(d) [26 USCS § 106(d)] nor deductible under this section.

(4) Additional tax on distributions not used for qualified medical expenses.

(A) In general. The tax imposed by this chapter [26 USCS §§ 1 et seq.] on the account beneficiary for any taxable year in which there is a payment or distribution from a health savings account of such beneficiary which is includible in gross income under paragraph (2) shall be increased by 10 percent of the amount which is so includible.

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(B) Exception for disability or death. Subparagraph (A) shall not apply if the payment or distribution is made after the account beneficiary becomes disabled within the meaning of section 72(m)(7) [26 USCS § 72(m)(7)] or dies.

(C) Exception for distributions after medicare eligibility. Subparagraph (A) shall not apply to any payment or distribution after the date on which the account beneficiary attains the age specified in section 1811 of the Social Security Act [42 USCS § 1395c].

(5) Rollover contribution. An amount is described in this paragraph as a rollover contribution if it meets the requirements of subparagraphs (A) and (B).

(A) In general. Paragraph (2) shall not apply to any amount paid or distributed from a health savings account to the account beneficiary to the extent the amount received is paid into a health savings account for the benefit of such beneficiary not later than the 60th day after the day on which the beneficiary receives the payment or distribution.

(B) Limitation. This paragraph shall not apply to any amount described in subparagraph (A) received by an individual from a health savings account if, at any time during the 1-year period ending on the day of such receipt, such individual received any other amount described in subparagraph (A) from a health savings account which was not includible in the individual's gross income because of the application of this paragraph.

(6) Coordination with medical expense deduction. For purposes of determining the amount of the deduction under section 213 [26 USCS § 213], any payment or distribution out of a health savings account for qualified medical expenses shall not be treated as an expense paid for medical care.

(7) Transfer of account incident to divorce. The transfer of an individual's interest in a health savings account to an individual's spouse or former spouse under a divorce or separation instrument described in subparagraph (A) of section 71(b)(2) [26 USCS § 71(b)(2)] shall not be considered a taxable transfer made by such individual notwithstanding any other provision of this subtitle [26 USCS §§ 1 et seq.], and such interest shall, after such transfer, be treated as a health savings account with respect to which such spouse is the account beneficiary.

(8) Treatment after death of account beneficiary.

(A) Treatment if designated beneficiary is spouse. If the account beneficiary's surviving spouse acquires such beneficiary's interest in a health savings account by reason of being the designated beneficiary of such account at the death of the account beneficiary, such health savings account shall be treated as if the spouse were the account beneficiary.

(B) Other cases.

(i) In general. If, by reason of the death of the account beneficiary, any person acquires the account beneficiary's interest in a health savings account in a case to which subparagraph (A) does not apply--

(I) such account shall cease to be a health savings account as of the date of death, and

(II) an amount equal to the fair market value of the assets in such account on such date shall be includible if such person is not the estate of such beneficiary, in such person's gross income for the taxable year which includes such date, or if such person is the estate of such beneficiary, in such beneficiary's gross income for the last taxable year of such beneficiary.

(ii) Special rules.

(I) Reduction of inclusion for predeath expenses. The amount includible in gross income under clause (i) by any person (other than the estate) shall be reduced by the amount of qualified medical expenses which were incurred by the decedent before the date of the decedent's death and paid by such person within 1 year after such date.

(II) Deduction for estate taxes. An appropriate deduction shall be allowed under section 691(c) to any person (other than the decedent or the decedent's spouse) with respect to amounts included in gross income under clause (i) by such person.

(g) Cost-of-living adjustment.

(1) In general. Each dollar amount in subsections (b)(2) and (c)(2)(A) shall be increased by an amount equal to--

(A) such dollar amount, multiplied by

(B) the cost-of-living adjustment determined under section 1(f)(3) [26 USCS § 1(f)(3)] for the calendar year in which such taxable year begins determined by substituting for "calendar year 1992" in subparagraph (B) thereof--

(i) except as provided in clause (ii), "calendar year 1997", and

(ii) in the case of each dollar amount in subsection (c)(2)(A), "calendar year 2003".

In the case of adjustments made for any taxable year beginning after 2007, section 1(f)(4) shall be applied for purposes of this paragraph by substituting "March 31" for "August 31", and the Secretary shall publish the adjusted amounts under subsections (b)(2) and (c)(2)(A) for taxable years beginning in any calendar year no later than June 1 of the preceding calendar year.

(2) Rounding. If any increase under paragraph (1) is not a multiple of \$ 50, such increase shall be rounded to the nearest multiple of \$ 50.

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(h) Reports. The Secretary may require--

(1) the trustee of a health savings account to make such reports regarding such account to the Secretary and to the account beneficiary with respect to contributions, distributions, the return of excess contributions, and such other matters as the Secretary determines appropriate, and

(2) any person who provides an individual with a high deductible health plan to make such reports to the Secretary and to the account beneficiary with respect to such plan as the Secretary determines appropriate.

The reports required by this subsection shall be filed at such time and in such manner and furnished to such individuals at such time and in such manner as may be required by the Secretary.

**HISTORY:**

(Added Dec. 8, 2003, P.L. 108-173, Title XII, § 1201(a), 117 Stat. 2469; Dec. 21, 2005, P.L. 109-135, Title IV, Subtitle A, § 404(c), 119 Stat. 2634; Dec. 20, 2006, P.L. 109-432, Div A, Title III, §§ 302(b), 303(a), (b), 304, 305(a), 307(b), 120 Stat. 2949, 2950, 2953.)

**HISTORY; ANCILLARY LAWS AND DIRECTIVES****Explanatory notes:**

A prior § 223 was transferred to 26 USCS § 224.

**Amendments:**

In 2006, P.L. 109-432, Sec. 302(b) (effective on 12/20/2006, as provided by Sec. 302(c)(2) of P.L. 109-432, which appears as a note to this section), amended subsec. (c)(1)(B) by deleting "and" at the end of cl. (i), substituting ", and" for a concluding period in cl. (ii), and adding cl. (iii).

--P.L. 109-432, Sec. 303(a), (b) (applicable to taxable years beginning after 12/31/2006, as provided by Sec. 303(c) of P.L. 109-432, which appears as a note to this section), amended subsec. (b)(2), in subpara. (A), by substituting "\$ 2,250." for "the lesser of--

"(i) the annual deductible under such coverage, or

"(ii) \$ 2,250, or"

and, in subpara. (B), by substituting "\$ 4,500." for "the lesser of--

"(i) the annual deductible under such coverage, or

"(ii) \$ 4,500.";

and amended subsec. (d)(1)(A)(ii)(I) by substituting "subsection (b)(2)(B)" for "subsection (b)(2)(B)(ii)".

--P.L. 109-432, Sec. 304, amended subsec. (g)(1) by adding the concluding matter.

--P.L. 109-432, Sec. 305(a) (applicable to taxable years beginning after 12/31/2006, as provided by Sec. 305(b) of P.L. 109-432, which appears as a note to this section), amended subsec. (b) by adding para. (8).

--P.L. 109-432, Sec. 307(b) (applicable to taxable years beginning after 12/31/2006, as provided by Sec. 307(c) of P.L. 109-432, which appears as a note to this section), amended subsec. (b)(4) by deleting "and" at the end of subpara. (A), substituting ", and" for a concluding period in subpara. (B), and inserting subpara. (C).

In 2005, P.L. 109-135, Sec. 404(c) (effective as if included in the provisions of P.L. 108-311 to which it relates, as provided by Sec. 404(d) of P.L. 109-135, which appears as a note to Code Sec. 21), amended subsec. (d)(2)(A) by inserting ", determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof".

In 2003, P.L. 108-173, Sec. 1201(a) (applicable to taxable years beginning after 12/31/2003, as provided by Sec. 1201(k) of P.L. 108-173, which appears as a note to Code Sec. 62), added Code Sec. 223.

## Other provisions:

**Applicability of section.** This section applies to taxable years beginning after December 31, 2003, as provided by § 1201(k) of Act Dec. 8, 2003, P.L. 108-173, which appears as 26 USCS § 62 note.

**Effective date of amendments made by § 302(b) of Act Dec. 20, 2006.** Act Dec. 20, 2006, P.L. 109-432, Div A, Title III, § 302(c)(2), 120 Stat. 2949, provides: "The amendment made by subsection (b) [amending subsec. (c)(1)(B) of this section] shall take effect on the date of the enactment of this Act."

**Applicability of amendments made by § 303 of Act Dec. 20, 2006.** Act Dec. 20, 2006, P.L. 109-432, Div A, Title III, § 303(c), 120 Stat. 2950, provides: "The amendments made by this section [amending subsecs. (b)(2) and (d)(1)(A)(ii)(I) of this section] shall apply to taxable years beginning after December 31, 2006."

**Applicability of amendment made by § 305 of Act Dec. 20, 2006.** Act Dec. 20, 2006, P.L. 109-432, Div A, Title III, § 305(b), 120 Stat. 2951, provides: "The amendments made by this section [adding subsec. (b)(8) of this section] shall apply to taxable years beginning after December 31, 2006."

**Applicability of amendments made by § 307 of Act Dec. 20, 2006.** Act Dec. 20, 2006, P.L. 109-432, Div A, Title III, § 307(c), 120 Stat. 2953, provides: "The amendments made by this section [adding 26 USCS §§ 223(b)(4)(C) and 408(d)(9)] shall apply to taxable years beginning after December 31, 2006."

**Revenue Procedure 2007-36.** *Rev. Proc. 2007-36* of May 11, 2007 (2007 IRB LEXIS 446; 2007-22 I.R.B. 1335), provides:

## "SECTION 1. PURPOSE

"This revenue procedure modifies and supersedes section 3.24(1) of *Rev. Proc. 2006-53, 2006-48 I.R.B. 996*, which provides inflation adjusted items for 2007 for Health Savings Accounts (HSAs) under § 223 of the *Internal Revenue Code*. This revenue procedure also provides inflation adjusted items for HSAs for 2008.

## "SECTION 2. BACKGROUND

"Section 303 of the Health Opportunity Patient Empowerment Act of 2006, Title III of the Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, 120 Stat. 2922 (2006) (the Act), changes the maximum annual contribution for HSAs. Under prior law, the maximum annual HSA contribution was the lesser of the deductible of the high deductible health plan or the indexed statutory amount. For taxable years beginning after December 31, 2006, § 303 of the Act amends § 223(b) to provide that the maximum annual HSA contribution is the indexed statutory amount, without reference to the deductible of the high deductible health plan.

"Section 304 of the Act amends the rules for calculating cost-of-living adjustments for HSA amounts in § 223. Section 304 of the Act amends § 223(g) to provide that, for cost-of-living adjustments made for taxable years beginning after 2007, § 1(f)(4) is applied using March 31 instead of August 31 as the close of the 12-month period described in § 1(f)(4). Section 223(g) also provides that the adjusted amounts under § 223 will be published no later than June 1 of the preceding calendar year.

## "SECTION 3. MODIFICATION OF SECTION 3.24(1) OF REV. PROC. 2006-53

"Section 3.24(1) of *Rev. Proc. 2006-53* is modified to read as follows:

"(1) Annual contribution limitation. For calendar year 2007, the limitation on deductions under § 223(b)(2)(A) for an individual with self-only coverage under a high deductible health plan is \$ 2,850. For calendar year 2007, the limitation on deductions under § 223(b)(2)(B) for an individual with family coverage under a high deductible health plan is \$ 5,650.

## "SECTION 4. INFLATION ADJUSTED ITEMS FOR HSAs FOR 2008

"Annual contribution limitation. For calendar year 2008, the limitation on deductions under § 223(b)(2)(A) for an individual with self-only coverage under a high deductible health plan is \$ 2,900. For calendar year 2008, the limitation on deductions under § 223(b)(2)(B) for an individual with family coverage under a high deductible health plan is \$ 5,800.

"High deductible health plan. For calendar year 2008, a "high deductible health plan" is defined under § 223(c)(2)(A) as a health plan with an annual deductible that is not less than \$ 1,100 for self-only coverage or \$ 2,200 for family coverage, and the annual out-of-pocket expenses (deductibles, co-payments, and other amounts, but not premiums) do not exceed \$ 5,600 for self-only coverage or \$ 11,200 for family coverage.

## "SECTION 5. EFFECT ON OTHER DOCUMENTS

"Section 3.24(1) of *Rev. Proc. 2006-53* is modified and superseded.

## "SECTION 6. EFFECTIVE DATES

"Section 3 of this revenue procedure is effective for calendar year 2007. Section 4 of this revenue procedure is effective for calendar year 2008.

## "SECTION 7. DRAFTING INFORMATION

"The principal author of this revenue procedure is Marnette M. Myers of the Office of Associate Chief Counsel (Income Tax & Accounting). For further information regarding this revenue procedure contact Marnette M. Myers at (202) 622-4920 (not a toll free call)."

**NOTES:****Related Statutes & Rules:**

This section is referred to in 26 USCS §§ 26, 35, 62, 106, 220, 848, 4973, 4975, 6051, 6693.

**Research Guide:****Am Jur:**

33A Am Jur 2d, *Federal Taxation* (2008) §§ 8651, 8652, 8654-8657, 8659-8661, 8663.

34 Am Jur 2d, *Federal Taxation* (2008) § 60235.

**Emerging Issues Analysis**

1. *FSAs, HRAs and HSAs all provide for health care expense reimbursement.*

HSAs are the newest addition to the panoply of health reimbursement arrangements. HSAs are available only to taxpayers covered by a high-deductible health plan (\$1,100 for self-only coverage and \$2,200 for family coverage for 2008) and are subject to annual contribution limits. HSAs can be included in an employer's cafeteria plan and can accept both employee and employer contributions.

2. *Levinson on final IRS regulations on the HSA conundrum*

A Health Savings Account allows an eligible individual to put money aside to cover future medical expenses in a tax-advantaged way. The IRS recently issued final regulations to provide guidance to employers who make contributions to an HSA to ensure that such contributions are comparable for all employees.

**Interpretive Notes and Decisions:**

If individual is covered by both high deductible health plan (HDHP) that does not cover prescription drugs and by separate prescription drug plan (or rider) that provides benefits before minimum annual deductible of HDHP has been satisfied, that individual is not eligible individual under 26 USCS § 223(c)(1)(A) and may not make contributions to Health Savings Account. Rev Rul 2004-38 (2004) 2004-15 IRB 717.