

WEST VIRGINIA
SECRETARY OF STATE
KEN HECHLER
ADMINISTRATIVE LAW DIVISION

Form #6

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**OFFICE OF WEST VIRGINIA
SECRETARY OF STATE**

**NOTICE OF FINAL FILING AND ADOPTION OF A LEGISLATIVE RULE AUTHORIZED
BY THE WEST VIRGINIA LEGISLATURE.**

AGENCY: Insurance Commissioner TITLE NUMBER: 114

AMENDMENT TO AN EXISTING RULE: YES X, NO _____

IF YES, SERIES NUMBER OF RULE BEING AMENDED: Series 28

TITLE OF RULE BEING AMENDED: Group Coordination of Benefits

IF NO, SERIES NUMBER OF NEW RULE BEING PROPOSED: _____

TITLE OF RULE BEING PROPOSED: _____

THE ABOVE RULE HAS BEEN AUTHORIZED BY THE WEST VIRGINIA LEGISLATURE.

AUTHORIZATION IS CITED IN (house or senate bill number) House Bill 100

SECTION 64-7-2(r), PASSED ON May 26, 1993

THIS RULE IS FILED WITH THE SECRETARY OF STATE. THIS RULE BECOMES EFFECTIVE ON
THE FOLLOWING DATE: June 18, 1993


Hanley C. Clark
Insurance Commissioner

6.00

119 hundred ninety-two, relating to the insurance commis-
 120 sioner (regulation of credit life insurance and credit
 121 accident and sickness insurance), are authorized.

122 (q) The legislative rules filed in the state register on
 123 the eighteenth day of September, one thousand nine
 124 hundred ninety-two, modified by the insurance commis-
 125 sioner to meet the objections of the legislative rule-
 126 making review committee and refiled in the state
 127 register on the tenth day of December, one thousand
 128 nine hundred ninety-two, relating to the insurance
 129 commissioner (filing fees for purchasing groups and for
 130 risk retention groups not chartered in this state), are
 131 authorized.

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132 (r) The legislative rules filed in the state register on
 133 the fourteenth day of October, one thousand nine
 134 hundred ninety-two, relating to the insurance commis-
 135 sioner (group coordination of benefits), are authorized
 136 with the amendments set forth below:

Adm.

137 "On page six, subsection 2.1.9., after the words 'If a
 138 person is covered by more than one employer group
 139 minimum benefits plan, the order of benefits determi-
 140 nation rules of this regulation decide the order in which
 141 their benefits are determined in relation to each other'
 142 by inserting a colon and the words 'Provided, That
 143 under the provisions of West Virginia Code §5-16-12(a),
 144 coverage issued pursuant to the Public Employees
 145 Insurance Act is secondary to an employer group
 146 minimum benefits plan and any other applicable health
 147 insurance coverage.'"

148 (s) The legislative rules filed in the state register on
 149 the eighteenth day of September, one thousand nine
 150 hundred ninety-two, modified by the insurance commis-
 151 sioner to meet the objections of the legislative rule-
 152 making review committee and refiled in the state
 153 register on the fifteenth day of January, one thousand
 154 nine hundred ninety-three, relating to the insurance
 155 commissioner (permanent regulations on medicare
 156 supplement insurance), are authorized.

157 (t) The legislative rules filed in the state register on
 158 the eighteenth day of September, one thousand nine

Adm.

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TITLE 114
LEGISLATIVE RULE
INSURANCE COMMISSIONER

OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

SERIES 28
GROUP COORDINATION OF BENEFITS

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- §114-28-2. Definitions.
- §114-28-3. Model COB Contract Provision.
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APPENDIX A

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TITLE 114
LEGISLATIVE RULE
INSURANCE COMMISSIONER

OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

SERIES 28
GROUP COORDINATION OF BENEFITS

§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:

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

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

1.2. Purpose. -- The purpose of this regulation is to:

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

1.2.2. Establish an order in which plans pay their claims;

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

1.2.4. Reduce duplication of benefits by permitting a reduction of the benefits paid by a plan when the plan, pursuant to rules established by regulation, does not have to pay its benefits first;

1.2.5. Reduce claims payment delays; and

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

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

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1.4 Filing Date. --

1.5 Effective Date. --

§114-28-2. Definitions.

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

2.1.1. Allowable Expenses.

2.1.1.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.

2.1.1.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.

2.1.1.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.

2.1.1.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.

2.1.1.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 corresponding expenses or services to which COB applies.

2.1.1.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.

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2.1.1.f.1. 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.

2.1.1.f.2. 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.

2.1.2. Claim - A request that benefits of a plan be provided or paid is a claim. The benefits claimed may be in the form of:

2.1.2.a. Services (including supplies);

2.1.2.b. Payment for all or a portion of the expenses incurred;

2.1.3.c. A combination of (1) and (2) above; or

2.1.3.d. An indemnification.

2.1.4. 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.

2.1.4.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.

2.1.4.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.

2.1.5. Coordination of Benefits - This is a provision establishing an order in which plans pay their claims.

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2.1.6. Hospital Indemnity Benefits - These are benefits not related to expenses incurred. The term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

2.1.7. 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.

2.1.7.a. The definition of "Plan" shown in the Model COB Provision, attached to this rule as Appendix A, is an example of what may be used. Any definition that satisfies this subsection may be used.

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

2.1.7.c. Plan may include:

2.1.7.c.1. Group insurance and group subscriber contracts;

2.1.7.c.2. Uninsured arrangements of group or group-type coverage;

2.1.7.c.3. Group or group-type coverage through HMOs and other prepayment, group practice and individual practice plans;

2.1.7.c.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

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right to maintain or renew the policy independently of continued employment with the employer.

2.1.7.c.5. The amount by which group or group-type hospital indemnity benefits exceed \$100 per day;

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

2.1.7.c.7. Medicare or other governmental benefits, except as provided in 2.1.7.d.7. below. That part of the definition of "Plan" may be limited to the hospital, medical and surgical benefits of the governmental program.

2.1.7.d. Plan shall not include:

2.1.7.d.1. Individual or family insurance contracts;

2.1.7.d.2. Individual or family subscriber contracts;

2.1.7.d.3. Individual or family coverage through Health Maintenance Organizations (HMOs);

2.1.7.d.4. Individual or family coverage under other prepayment, group practice and individual practice plans;

2.1.7.d.5. Group or group-type hospital indemnity benefits of \$100 per day or less;

2.1.7.d.6. School accident-type coverages. These contracts cover grammar, high school and college students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a "to and from school" basis; and

2.1.7.d.7. 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.

2.1.8. Primary Plan - A Primary Plan is a plan whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration.

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A plan is a Primary Plan if either of the following conditions is true:

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

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

2.1.9. Secondary Plan - A Secondary Plan is 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. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or plans and the benefits of any other plan which, under the rules of this regulation, has its benefits determined before those of that Secondary Plan.

2.1.10. 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 3.2 and 3.3 below and to the provisions of Section 5.

3.2. Flexibility. A group contract's COB provision does not have to use the words and format shown at Appendix A. Changes may be made to fit the language and style of the rest of the group

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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:

3.3.1.a. Another plan exists;

3.3.1.b. A person is or could have been covered under another plan, except with respect to Part B of Medicare; or

3.3.1.c. A person has elected an option under another plan providing a lower level of benefits than another option which could have been elected.

3.3.2. No contract may contain a provision that its benefits are "excess" or "always secondary" to any plan as defined in this regulation, except in accord with the rules permitted by this regulation.

§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 order of benefits is as follows:

4.1.1.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.

4.1.1.b. A Secondary Plan may take the benefits of another plan into account only when, under these rules, it is secondary to that other plan.

4.1.1.c. The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as

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a dependent) are determined before those of the plan which covers the person as a dependent.

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:

4.1.2.a. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year;

4.1.2.b. If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time;

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

4.1.2.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."

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

4.1.3.a. First, the plan of the parent with custody of the child;

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4.1.3.b. Then, the plan of the spouse of the parent with the custody of the child; and

4.1.3.c. Finally, the plan of the parent not having custody of the child.

4.1.3.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 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.

4.1.3.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. Active/Inactive Employee. The benefits of a plan which covers a person as 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). 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.

4.1.5. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the plan which covered that person for the shorter term.

4.1.5.a. To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the claimant was eligible under the second within twenty-four hours after the first ended.

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

4.1.5.b.1. A change in the amount or scope of a plan's benefits;

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4.1.5.b.2. A change in the entity which pays, provides or administers the plan's benefits; or

4.1.5.b.3. A change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).

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

§114-28-5. Procedure to be Followed by Secondary Plan.

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 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.

5.1.2.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.

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5.1.2.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.

§114-28-6. Miscellaneous Provisions.

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

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

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

6.2.2.b. If the Complying Plan is the Secondary Plan, it shall, nevertheless, pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the Complying Plan were the Secondary Plan. In such a situation, such payment shall be the limit of the Complying Plan's liability; and

6.2.2.c. If the Noncomplying Plan does not provide the information needed by the Complying Plan to determine its benefits within a reasonable time after it is requested to do so, the Complying Plan shall assume that the benefits of the

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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.

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

However, 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. In consideration of such advance, the Complying Plan shall be subrogated to all rights of the employee, subscriber or member against the Noncomplying Plan. Such advance by the Complying Plan shall also be without prejudice to any claim it may have against the Noncomplying Plan in the absence of such subrogation.

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. 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.

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

7.1. 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.

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8.1. 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 CONTRACT'S BENEFITS WITH OTHER BENEFITS

I. APPLICABILITY

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

II. DEFINITIONS

A. "Plan" is any of these which provides benefits or services for, or because of, medical or dental care or treatment:

(1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

(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

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Programs, of the United States Social Security Act, as amended from time to time).

B. "This Plan" is the part of the group contract that provides benefits for health care expenses.

C. "Primary Plan/Secondary Plan:" The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person.

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

When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

D. "Allowable Expense" means 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.

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 either in terms of generally accepted medical practice, or as specifically defined in the plan.

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.

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.

E. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a

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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.

III. ORDER OF BENEFIT DETERMINATION RULES

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.

B. Rules. This Plan determines its order of benefits using the first of the following rules which applies:

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

(2) Dependent Child/Parents not Separated or Divorced. 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:"

(a) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

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

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.

(3) Dependent Child/Separated or Divorced Parents. If two or more plans cover a person as a dependent child of

Insurance Commission
Legislative Rule
Title 114, Series 28

divorced or separated parents, benefits for the child are determined in this order:

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

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

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

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

(4) Joint Custody. If the specific terms of a 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 Paragraph III B(2).

(5) Active/Inactive Employee. The benefits of a plan which covers a person as 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). 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) is ignored.

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

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

Insurance Commission
Legislative Rule
Title 114, Series 28

Determination Rules," This Plan is a Secondary Plan as to one or more other plans. In that event the benefits of This Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in B immediately below.

B. 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.

V. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these COB rules. [Insurer] has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person to the extent reasonably necessary to apply these rules. 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 must give [insurer] any facts it reasonably needs to pay the claim.

VI. FACILITY OF PAYMENT

A payment made under another plan may include an amount which should have been paid under This Plan. If it does, [insurer] may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. [Insurer] 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] is more than it should have paid under this COB provision, it may recover the excess from one or more of:

- 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.



KEN HECHLER
Secretary of State

MARY P. RATLIFF
Deputy Secretary of State

A. RENEE COE
Deputy Secretary of State

CATHERINE FREROTTE
Executive Assistant

Telephone: (304) 558-6000
Corporations: (304) 558-8000

WILLIAM H. HARRINGTON
Chief of Staff

JUDY COOPER
Director, Administrative Law

DONALD R. WILKES
Director, Corporations

(Plus all the volunteer
help we can get)

FAX: (304) 558-0900

STATE OF WEST VIRGINIA

SECRETARY OF STATE

Building 1, Suite 157-K
1900 Kanawha Blvd., East
Charleston, WV 25305-0770

RECEIVED

JUL 28 1993

LEGAL DIVISION
W. VA. INS. DEPT.

TO: Linda Gay

AGENCY: Insurance Commission

FROM: JUDY COOPER, DIRECTOR, ADMINISTRATIVE LAW DIVISION

DATE: July 26, 1993

THE ATTACHED RULE FILED BY YOUR AGENCY HAS BEEN ENTERED INTO OUR COMPUTER SYSTEM. PLEASE REVIEW, PROOF AND RETURN IT WITH ANY CORRECTIONS. IF THERE ARE NO CORRECTIONS, PLEASE SIGN THIS MEMO AND RETURN IT TO THIS OFFICE. YOU WILL BE SENT A FINAL VERSION OF THE RULE FOR YOUR RECORDS.

PLEASE RETURN EITHER THE CORRECTED RULE OR THIS FORM WITHIN TEN (10) WORKING DAYS OF THE DATE YOU RECEIVED THIS REQUEST. CALL IF YOU HAVE ANY QUESTIONS.

SERIES: 28 TITLE: 114 Insurance Commission

* THE ATTACHED RULE HAS BEEN REVIEWED AND IS CORRECT.

SIGNED: _____

TITLE OF PERSON SIGNING: _____

DATE: _____

* THE ATTACHED RULE HAS BEEN REVIEWED AND NEEDS CORRECTING. THE CORRECTIONS HAVE BEEN MARKED.

SIGNED: Linda Gay

TITLE OF PERSON SIGNING: Assoc. Counsel, WV Insurance Comm'r

DATE: August 19, 1993

NOTE: IF YOU ARE NOT THE PERSON WHO HANDLES THIS RULE, PLEASE FORWARD TO THE CORRECT PERSON.

** Be sure to type the footnote on page 4 into this rule, along with other changes marked.*

OFFICE OF THE SECRETARY OF STATE
SEP 1 2 01 PM '93

FILED

SENATE BILL NO. 216

(By Senator Manchin)

[Introduced March 1, 1993; referred to the
Committee on Banking and Insurance; and then
to the Committee on the Judiciary.

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9
10 A BILL to amend and reenact section two, article seven, chapter
11 sixty-four of the code of West Virginia, one thousand nine
12 hundred thirty-one, as amended, relating to authorizing the
13 insurance commissioner to promulgate legislative rules
14 relating to the group coordination of benefits.

15 Be it enacted by the Legislature of West Virginia:

16 That section two, article seven, chapter sixty-four of the
17 code of West Virginia, one thousand nine hundred thirty-one, as
18 amended, be amended and reenacted, to read as follows:

19 ARTICLE 7. AUTHORIZATION FOR DEPARTMENT OF TAX AND REVENUE TO
20 PROMULGATE LEGISLATIVE RULES.

21 §64-7-2. ~~Agency of insurance~~ Insurance commissioner.

22 (a) The legislative rules filed in the state register on the
23 eighteenth day of October, one thousand nine hundred

1 eighty-three, relating to the insurance commissioner (excess line
2 brokers), are authorized.

3 (b) The legislative rules filed in the state register on the
4 eighteenth day of August, one thousand nine hundred eighty-six,
5 modified by the insurance commissioner to meet the objections of
6 the legislative rule-making review committee and refiled in the
7 state register on the twelfth day of December, one thousand nine
8 hundred eighty-six, relating to the insurance commissioner
9 (examiners' compensation, qualification and classification), are
10 authorized.

11 (c) The legislative rules filed in the state register on the
12 twentieth day of February, one thousand nine hundred
13 eighty-seven, relating to the insurance commissioner (West
14 Virginia essential property insurance association), are
15 authorized.

16 (d) The legislative rules filed in the state register on the
17 twenty-ninth day of May, one thousand nine hundred eighty-seven,
18 relating to the insurance commissioner (medical malpractice
19 annual reporting requirements), are authorized.

20 (e) The legislative rules filed in the state register on the
21 thirty-first day of July, one thousand nine hundred eighty-seven,
22 modified by the insurance commissioner to meet the objections of
23 the legislative rule-making review committee and refiled in the
24 state register on the seventh day of November, one thousand nine
25 hundred eighty-seven, relating to the insurance commissioner

1 (medical malpractice loss experience and loss expense reporting
2 requirements), are authorized.

3 (f) The legislative rules filed in the state register on the
4 thirtieth day of November, one thousand nine hundred
5 eighty-eight, modified by the insurance commissioner to meet the
6 objections of the legislative rule-making review committee and
7 refiled in the state register on the twenty-first day of
8 February, one thousand nine hundred eighty-nine, relating to the
9 insurance commissioner (transitional requirements for the
10 conversion of Medicare supplement insurance benefits and premiums
11 to conform to Medicare program revisions), are authorized.

12 (g) The legislative rules filed in the state register on the
13 twenty-sixth day of May, one thousand nine hundred eighty-nine,
14 modified by the insurance commissioner to meet the objections of
15 the legislative rule-making review committee and refiled in the
16 state register on the twenty-eighth day of September, one
17 thousand nine hundred eighty-nine, relating to the insurance
18 commissioner (insurance adjusters), are authorized.

19 (h) The legislative rules filed in the state register on the
20 second day of February, one thousand nine hundred ninety,
21 modified by the insurance commissioner to meet the objections of
22 the legislative rule-making review committee and refiled in the
23 state register on the twenty-ninth day of May, one thousand nine
24 hundred ninety, relating to the insurance commissioner (accident
25 and sickness rate filing), are authorized.

1 (i) The legislative rules filed in the state register on the
2 tenth day of August, one thousand nine hundred ninety, modified
3 by the insurance commissioner to meet the objections of the
4 legislative rule-making review committee and refiled in the state
5 register on the ninth day of October, one thousand nine hundred
6 ninety, relating to the insurance commissioner (group
7 coordination of benefits), are authorized.

8 (j) The legislative rules filed in the state register on the
9 tenth day of August, one thousand nine hundred ninety, modified
10 by the insurance commissioner to meet the objections of the
11 legislative rule-making review committee and refiled in the state
12 register on the seventeenth day of January, one thousand nine
13 hundred ninety-one, relating to the insurance commissioner (AIDS
14 regulations), are authorized.

15 (k) The legislative rules filed in the state register on the
16 third day of December, one thousand nine hundred ninety, relating
17 to the insurance commissioner (health insurance benefits for
18 temporomandibular and craniomandibular disorders), are
19 authorized.

20 (l) The legislative rules filed in the state register on the
21 twelfth day of August, one thousand nine hundred ninety-one,
22 modified by the insurance commissioner to meet the objections of
23 the legislative rule-making review committee and refiled in the
24 state register on the thirteenth day of January, one thousand
25 nine hundred ninety-two, relating to the insurance commissioner

1 (guaranteed loss ratios as applied to individual sickness and
2 accident insurance policies), are authorized.

3 (m) The legislative rules filed in the state register on the
4 ninth day of August, one thousand nine hundred ninety-one,
5 modified by the insurance commissioner to meet the objections of
6 the legislative rule-making review committee and refiled in the
7 state register on the thirteenth day of January, one thousand
8 nine hundred ninety-two, relating to the insurance commissioner
9 (examiners' compensation, qualifications and classification), are
10 authorized.

11 (n) The legislative rules filed in the state register on the
12 seventeenth day of July, one thousand nine hundred ninety-one,
13 modified by the insurance commissioner to meet the objections of
14 the legislative rule-making review committee and refiled in the
15 state register on the thirteenth day of January, one thousand
16 nine hundred ninety-two, relating to the insurance commissioner
17 (permanent regulations on Medicare supplement insurance), are
18 authorized.

19 (o) The legislative rules filed in the state register on the
20 twelfth day of August, one thousand nine hundred ninety-one,
21 modified by the insurance commissioner to meet the objections of
22 the legislative rule-making review committee and refiled in the
23 state register on the thirteenth day of January, one thousand
24 nine hundred ninety-two, relating to the insurance commissioner

1 ("tail" malpractice insurance covering certain medical and allied
2 health care providers), are authorized.

3 (p) The legislative rules filed in the state register on the
4 fourteenth day of October, one thousand nine hundred ninety-two,
5 relating to the insurance commissioner (group coordination of
6 benefits), are authorized.

7

8 NOTE: The purpose of this bill is to authorize the Insurance
9 Commissioner to promulgate legislative rules relating to the
10 group coordination of benefits.

11

12 Strike-throughs indicate language that would be stricken from
13 the present law, and underscoring indicates new language that
14 would be added.

KEN HECHLER
Secretary of State

MARY P. RATLIFF
Deputy Secretary of State

A. RENEE COE
Deputy Secretary of State

CATHERINE FREROTTE
Executive Assistant

Telephone: (304) 558-8000
Corporations: (304) 558-8000



STATE OF WEST VIRGINIA

SECRETARY OF STATE

Building 1, Suite 157-K
1900 Kanawha Blvd., East
Charleston, WV 25305-0770

WILLIAM H. HARRINGTON
Chief of Staff

JUDY COOPER
Director, Administrative Law

DONALD R. WILKES
Director, Corporations

(Plus all the volunteer
help we can get)

FAX: (304) 558-0900

May 28, 1993

Linda Gay
Insurance Commission
2019 Washington St., E
Charleston, WV 25305

HB 100 authorizing, **Title 114, Series 28, Group Coordination of Benefits**, passed the Legislature on **May 26, 1993**. It is now awaiting the Governor's signature.

You have sixty (60) days after the Governor signs HB 100, to final file the legislative rule with the Secretary of State's office. To final file your legislative rule, fill in the blanks on the enclosed form #6, the "Final Filing" form and file the form with our office. Authorization for your legislative rule is cited in **HB 100** section **64-7-2(r)**. The agency may set the effective date of the legislative rule up to ninety (90) days from the date the legislative rule is final filed with the Secretary of State's office. Please have an authorized signature on the bottom line.

*****IMPORTANT: IF YOUR AGENCY HAS COMPLETED THE LEGISLATIVE RULE ON A COMPUTER SYSTEM THAT USES A 3 1/2" OR 5 1/4" DISK, PLEASE SUBMIT A CLEAN COPY, WITH ALL UNDERLINING AND STRIKE-THROUGHS TAKEN OUT, TO OUR OFFICE WHEN FINAL FILING THE RULE. STATE ON THE DISK THE FORMAT THE RULE IS IN AND THE TITLE IT IS FILED UNDER. THIS WILL MAKE IT QUICKER FOR US TO ENTER YOUR RULES ON THE LEGISLATIVE DATA BASE. REMEMBER THE TEXT OF THE COMPUTER FILED RULE MUST BE IDENTICAL - WORD FOR WORD, COMMA FOR COMMA, WITH ALL UNDERLINING AND STRIKE-THROUGHS TAKEN OUT, AS THE HARD COPY AUTHORIZED BY THE LEGISLATURE.**

After the final rule is entered into the legislative data base, the rule will be sent to the agency for review and proofing. Following confirmation or corrections, as the case may be, the Secretary of State shall submit to the agency a final version of the rule for their records.

If you have any questions or need any assistance, please do not hesitate to call our office.

Thank You
Administrative Law Division