WAC 284-51-255 Appendix A—Model COB contract provisions.

COORDINATION OF THIS CONTRACT'S BENEFITS
WITH OTHER BENEFITS

The coordination of benefits (COB) provision applies when a person has health care coverage under more than one **plan**. **Plan** is defined below.

The order of benefit determination rules govern the order in which each **plan** will pay a claim for benefits. The **plan** that pays first is called the **primary plan**. The **primary plan** must pay benefits according to its policy terms without regard to the possibility that another **plan** may cover some expenses. The **plan** that pays after the **primary plan** is the **secondary plan**. The **secondary plan** may reduce the benefits it pays so that payments from all **plans** do not exceed 100% of the total **allowable expense**.

DEFINITIONS

A. A **plan** is any of the following that provides benefits or services for 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. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate plan.

(1) **Plan** includes: Group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), closed panel plans or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and medicare or any other federal governmental plan, as permitted by law.

(2) **Plan** does not include: Hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for nonmedical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; medicare supplement policies; medicaid coverage; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate **plan**. If a **plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **plan**.

B. **This plan** means, in a **COB** provision, the part of the 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 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. The order of benefit determination rules determine whether **this plan** is a **primary plan** or **secondary plan** when the person has health care coverage under more than one **plan**.

When **this plan** is primary, it determines payment for its benefits first before those of any other **plan** without considering any other

plan's benefits. When **this plan** is secondary, it determines its benefits after those of another **plan** and must make payment in an 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 equal 100% of the **total allowable expense** for that claim. This means that when this **plan** is **secondary**, it must pay the amount which, when combined with what the **primary plan** paid, totals 100% of the highest **allowable expense**. In addition, if this **plan** is **secondary**, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the **primary plan**) and record these savings as a benefit reserve for the covered person. This reserve must be used to pay any expenses during that calendar year, whether or not they are an **allowable expense** under this **plan**. If this **plan** is **secondary**, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

D. **Allowable expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any **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**.

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

(1) The difference between the cost of a semi-private hospital room and a private hospital 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 or more **plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an **allowable expense**.

(3) If a person is covered by two or more **plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **allowable expense**.

E. **Closed panel plan** is a **plan** that provides health care benefits to covered persons in the form of services through a panel of providers who are primarily 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.

ORDER OF BENEFIT DETERMINATION RULES

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

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

B. (1) Except as provided in subsection (2), a **plan** that does not contain a coordination of benefits provision that is consistent with this chapter 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 is excess to any other parts of the **plan** provided by the contract holder. Examples include major medical coverages that are superimposed over hospital and surgical benefits, and insurance type coverages that are written in connection with a **closed panel plan** to provide out-of-network benefits.

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

D. Each **plan** determines its order of benefits using the first of the following rules that apply:

(1) Nondependent or dependent. The **plan** that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber 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) Dependent child covered under more than one plan. 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:

• The **plan** of the parent whose birthday falls earlier in the calendar year is the **primary plan**; or

• If both parents have the same birthday, the **plan** that has covered the parent the longest is the **primary plan.**

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

(i) If a court decree states that one of the parents is responsible for the 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. This rule applies to claim determination periods commencing after the **plan** is given notice of the court decree;

(ii) If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;

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

(iv) 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 child, the provisions of subsection (a) above determine the order of benefits; or

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

• The **plan** covering the **custodial parent**, first;
• The **plan** covering the spouse of the **custodial parent**, second;
• The **plan** covering the **noncustodial parent**, third; and then
• The **plan** covering the spouse of the **noncustodial parent**, last

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

(3) Active employee or retired or laid-off employee. The **plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, 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 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 under section D(1) can determine the order of benefits.

(4) COBRA or state continuation coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another **plan**, the **plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **primary plan** and the COBRA or state or other federal continuation coverage is the **secondary plan**. If the other **plan** does not have this rule, and as a result, the **plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under section D(1) can determine the order of benefits.

(5) Longer or shorter length of coverage. The **plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **primary plan** and the **plan** that covered the person the shorter period of time is the **secondary plan**.

(6) If the preceding rules do not determine the order of benefits, the **allowable expenses** must 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**.

EFFECT ON THE BENEFITS 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 claim determination period are not more than the total **allowable expenses.** In determining the amount to be paid for any claim, the **secondary plan** must make payment in an 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 equal one hundred percent of the total **allowable expense** for that claim **total allowable expense** is the highest **allowable expense** of the **primary plan** or the **secondary plan**. In addition, the **secondary plan** must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **this plan** and other **plans**. [Organization responsibility for **COB** administration] may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **this plan** and other **plans** covering the person claiming benefits. [Organization responsibility for **COB** administration] need not tell, or get the consent of, any person to do this. Each person claiming benefits under **this plan** must give [organization

responsibility for **COB** administration] any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

If payments that should have been made under **this plan** are made by another **plan**, the issuer has the right, at its discretion, to remit to the other **plan** the amount it determines appropriate to satisfy the intent of this provision. The amounts paid to the other **plan** are considered benefits paid under **this plan**. To the extent of such payments, the issuer is fully discharged from liability under **this plan**.

RIGHT OF RECOVERY

The issuer has the right to recover excess payment whenever it has paid allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. The issuer may recover excess payment from any person to whom or for whom payment was made or any other issuers or plans.

Questions about Coordination of Benefits?
Contact Your State Insurance Department

[Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200. WSR 07-13-008 (Matter No. R 2005-07), § 284-51-255, filed 6/8/07, effective 7/9/07.]

Reviser's note: The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency.