COORDINATION OF BENEFITS STUDY

REPORT TO THE LEGISLATURE

In accordance with the Laws of 2010

Chapter 384, Sec. 102

JANUARY 15, 2010

INTRODUCTION:

This report is in response to Chapter 384, Laws of 2010 which requested the commissioner of commerce, in consultation with the commissioner of health and health plan companies, to consider the appropriateness of adopting the National Association of Insurance Commissioners 2005 Coordination of Benefits Model Regulation. The departments consulted with the Minnesota Council of Health Plans and the National Association of Insurance Commissioners in preparing this report.

The cost to the state of preparing this report is $325. This includes staff time, printing and supplies.

BACKGROUND

Coordination of benefits is a practice which is used to ensure that insurance claims are not paid multiple times when someone is insured under multiple insurance plans. Coordination of benefits prevents overinsurance. If health care benefits are coordinated, the insurance companies share the burden without overpaying, and the insured is fully covered, but not covered in excess so that they profit by having insurance claims.

Coordination of benefits provisions serve to avoid claims payment delays by establishing an order in which plans pay claims and providing authority for the orderly transfer of information needed to pay claims promptly. Under coordination of benefits, one insurer is designated the primary insurer, which means the claims are sent to this company first to pay its normal benefits. If the primary insurer does not pay a claim in full, the claim would be passed to the secondary insurer.

Minnesota Rules Chapters 2742 and 4685 outline the manner in which a determination is made as to which insurance carrier is primary and which is secondary for policies issued in Minnesota. Minnesota Rules Chapter 2742 was effective July 5, 1986 and applies to health insurance companies. Minnesota Rules Chapter 4685 was effective October 9, 1989 and applies to health maintenance organizations.

The National Association of Insurance Commissioners (NAIC) acts as a forum for the creation of model laws and regulations. Each state decides whether to pass each NAIC model law or regulation. Minnesota follows NAIC models in many areas of insurance regulation to provide uniformity with other states. This uniformity allows for a standard of best practices in insurance regulation and makes it easier for insurance companies to comply with the laws and regulations in all states in which they do business.

ANALYSIS

This report called for the departments and insurance companies to specifically look at adoption of the NAIC 2005 Coordination of Benefits Model Regulation. The Minnesota Council of Health Plans compiled a comparison chart to outline the differences between the NAIC 2005 Coordination of Benefits model and Minnesota's two rules chapters dealing with coordination of benefits in health plans. This document is included at the end of this report.

While this chart reflects a comparison between Minnesota rules and the NAIC 2005 Coordination of Benefits Model regulation, the model itself has become out of date. Under the Affordable Care Act, enacted March 2010, new federal eligibility requirements are placed on health plans. For example, effective with plan years beginning on or after September 23, 2010, health policies that cover children are required to include children up to age 26, regardless of marital, financial dependency or student status. The addition of this new class of dependents poses a need for the NAIC to revisit the 2005 regulation. Previous model law requirements did not, for example, anticipate married adult children being covered by their parent's plan as well as their spouse's plan. The NAIC has indicated in response to an inquiry from the Minnesota Department of Commerce that it will be beginning to draft a new model coordination of benefit regulation in 2011 that will address the new ACA requirements.

Since, in coordinating benefits, there is a high likelihood that the plans being coordinated are issued in different states or that the Minnesota plan could be coordinating with a self-funded employer plan regulated by the U.S. Department of Labor, it is not advisable that Minnesota create its own rules to attempt to address the new classes of dependents covered as a result of the Affordable Care Act. Proceeding without a coordinated effort through the NAIC could result in Minnesota policyholders with coordination of benefits requirements in direct conflict with the requirements of a plan issued elsewhere with both carriers claiming a position as the secondary payor.

If the departments and the health plans were to proceed and implement the 2005 NAIC Coordination of Benefits model regulation now and then implement a 2011 version of the same model in the next legislative session, both the state and the health plans would encounter duplicate administrative expenses. For the state, there would be duplicate expenses associated with rulemaking and legislation, issuance of updated requirements to health plans, review of associated form filings, etc. For the health plans there would be duplicate expenses associated with form filings, updating systems, printing and distribution of plan changes to policyholders. Additionally, since each model would be phased in as plans are issued and renewed, yearly changes in the same plan provision would contribute to confusion for all parties, most importantly consumers.

RECOMMENDATIONS

The Minnesota Department of Commerce, after consulting with the Minnesota Department of Health and the Minnesota Council of Health Plans, recommends waiting to adopt the NAIC Coordination of Benefits Model until it has been updated to comply with the Affordable Care Act. It would not be advisable either from a standpoint of administrative cost or consumer understanding for Minnesota to adopt an obsolete NAIC model and then follow with adoption of another model in the next year.

As with all NAIC Model Acts and Regulations, the Minnesota Department of Commerce should continue to follow development of the revised NAIC Coordination of Benefits Model Regulation and consult with the Minnesota Department of Health, Minnesota Council of Health Plans and legislators regarding implementation of the new model is adopted.

Questions

Any Questions regarding this report may be directed to Tina Armstrong, *Acting Director of Health Policy,* Minnesota Department of Commerce at Tina.Armstrong@state.mn.us or (651) 296-8305.

Comparison NAIC Coordination of Benefits Model to MN Rules Chapters 2742 and 4685

2005 NAIC Coordination of Benefits Model Regulation	**MN Rules Chapter 2742 (Commerce)**	**MN Rules Chapter 4685 (MDH)**
Section 1. Authority This regulation is adopted and promulgated by the Commissioner of Insurance pursuant to Section [insert section] of the Insurance Code.		
Sec 2. Purpose The purpose of this regulation is to: A. Establish a uniform order of benefit determination under which plans pay claims; B. Reduce duplication of benefits by permitting a reduction of the benefits to be paid by plans that, pursuant to rules established by this regulation, do not have to pay their benefits first; and C. Provide greater efficiency in the processing of claims when a person is covered under more than one plan.	**2742.0100 PURPOSE AND SCOPE.** Subpart 1. **Generally.** Parts 2742.0100 to 2742.0400 are intended to establish uniformity in the permissive use of overinsurance provisions and to avoid claim delays and misunderstandings that could otherwise result from the use of inconsistent or incompatible provisions among plans. Subp. 2. **Description.** A coordination of benefits provision is one that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental, or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay claims and providing authority for the orderly transfer of information needed to pay claims promptly. It avoids duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by parts 2742.0100 to 2742.0400, it does not have to	**4685.0905 PURPOSE AND APPLICABILITY.** The purpose of parts 4685.0905 to 4685.0950 is to: A. permit, but not require, plans to include a coordination of benefits provision; B. establish the order in which plans pay claims; C. provide the authority for the orderly transfer of information needed to pay claims promptly; D. reduce duplication of benefits by permitting a reduction of the benefits paid by a plan when the plan does not have to pay its benefits first; E. reduce delays in payment of claims; and F. make all contracts that contain a coordination of benefits provision consistent with this regulation.

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	pay its benefits first. Subp. 3. **Rules permissive.** Parts 2742.0100 to 2742.0400 permit, but do not require, plans to include coordination of benefits provisions. Subp. 4. **Effect.** If a group contract includes a coordination of benefits provision, it must be consistent with parts 2742.0100 to 2742.0400. A plan that does not include such a provision may not take the benefits of another plan as defined in part 2742.0200 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.	
Sec 3. Definitions As used in this regulation, these words and terms have the following meanings, unless the context clearly indicates otherwise: A. (1) "Allowable expense," except as set forth below or where a statute requires a different definition, means any health care expense, including coinsurance or copayments and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering the person. (2) If a plan is advised by a covered person that all plans covering the person are high-deductible health plans and the person intends	**2742.0200 DEFINITIONS.** Subpart 1. **Scope.** For the purposes of parts 2742.0100 to 2742.0400, the terms in this part have the meanings given them. Subp. 7. **Allowable expense.** "Allowable expense" is 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. However, items of expense under coverages such as dental care, vision care, prescription drugs, or hearing aid programs may be excluded from the definition of allowable	**4685.0910 DEFINITIONS.** Subpart 1. **Scope.** The following words and terms, when used in parts 4685.0905 to 4685.0950, have the following meanings unless the context clearly indicates otherwise. Subp. 2. **Allowable expense.** 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. B. Notwithstanding this definition, items of expense under coverages such as dental care, vision care, or prescription drug or hearing aid

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to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan's deductible is not an allowable expense, except for any health care expense incurred that may not be subject to the deductible as described in Section 223(c)(2) (C) of the Internal Revenue Code of 1986.[i] (3)An expense or a portion of an expense that is not covered by any of the plans is not an allowable expense. (4) 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. (5) The following are examples of expenses that are not allowable expenses: (a) If a person is confined in a private hospital room, the difference between the cost of a semiprivate 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; (b) If a person is covered by two or more plans that compute the person's 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; (c) If a person is covered by two or more plans that provide benefits or services on the	expense. A plan which provides benefits only for any items of expense may limit its definition of allowable expenses to like items of expense. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid. When coordination of benefits is restricted in its use to a 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 coordination of benefits applies.	programs may be excluded from the definition of allowable expense. A plan that provides benefits only for such items of expense may limit its definition of allowable expenses to those items of expense. C. When a plan provides benefits in the form of service, the reasonable cash value of each service is both an allowable expense and a benefit paid. D. The difference between the cost of a private hospital room and the cost of a semiprivate hospital room is not an allowable expense under this definition unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice. E. When coordination of benefits is restricted 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 coordination of benefits 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. (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

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basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense; and (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 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 is 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 is the allowable expense used by the secondary plan to determine its benefits. (6) The definition of "allowable expense" may exclude certain types of coverage or benefits such as dental care, visions care, prescription drug or hearing aids. A plan that limits the application of COB to certain coverage 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. (7) When a plan provides benefits in the form of services, the reasonable cash value of each		allowable expenses. (2) This provision shall not be used by a secondary plan to refuse to pay benefits because a health maintenance organization enrollee has elected to have health care services provided by a nonhealth maintenance organization provider and the health maintenance organization, pursuant to its contract is not obligated to pay for providing those services.

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service will be considered an allowable expense and a benefit paid. (8) The amount of the reduction may be excluded from allowable expense when a covered person's benefits are reduced under a primary plan: (a) Because the covered person does not comply with the plan provisions concerning second surgical opinions or precertification of admissions or services; or (b) Because the covered person had a lower benefit because the covered person did not use a preferred provider. B. "Birthday" refers only to month and day in a calendar year and does not include the year in which the individual is born. C. "Claim" means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of: (1) Services (including supplies); (2) Payment for all or a portion of the expenses incurred; (3) A combination of Paragraphs (1) and (2); or (4) An indemnification. D. "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	Subp. 8. **Claim.** "Claim" means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of services, (including supplies); payment for all or a portion of the expenses incurred; a combination of services and payment for expenses incurred; or an indemnification.	Subp. 3. **Claim.** "Claim" means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of: A. services, including supplies; B. payment for all or a portion of the expenses incurred; C. a combination of items A and B; or D. an indemnification.

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providers, except in cases of emergency or referral by a panel member. E. “Consolidated Omnibus Budget Reconciliation Act of 1985” or “COBRA” means coverage provided under a right of continuation pursuant to federal law. F. “Coordination of benefits” or “COB” means a provision establishing an order in which plans pay their claims, and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses. G. “Custodial parent” means: (1) The parent awarded custody of a child by a court decree; or (2) In the absence of a court decrees, the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation. H. (1) “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. (2) “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		Subp. 5. **Coordination of benefits.** "Coordination of benefits" means a provision establishing the order in which plans pay their claims.

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insured would have the right to maintain or renew the policy independently of continued employment with the employer. I. “High-deductible health plan” had the meaning given 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. J. "Hospital indemnity benefits" 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. K. (1) "Plan" means a form of coverage with which coordination is allowed. 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. (2) If a plan coordinates benefits, its contract must 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" in the	Subp. 3. **Hospital indemnity benefits.** "Hospital indemnity benefits" are those 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. Subp. 2. **Plan.** "Plan" is 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 coordination of benefits provision of that contract. The right to include a type of coverage is limited by the rest of this subpart. The definition in part 2742.0300 is an example of what may be used. Any definition that satisfies this subpart may be used. Parts 2742.0100 to 2742.0400 use the term "plan." However, a group contract may, instead, use "program" or some other term. The term "plan" does not include individual or family:	Subp. 6. **Hospital indemnity benefits.** "Hospital indemnity benefits" are 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. Subp. 7. **Plan.** "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 that will be considered in applying the coordination of benefits provision of that contract. The right to include a type of coverage is limited by the rest of this definition. A. The definition shown in the Model Coordination of Benefits Provisions in part 4685.0950 is an example of what may be used. Any definition that satisfies this subpart may be used. B. Instead of "plan," a group contract may use "program" or some other term. C. Plan includes:

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model COB provision in section 62A.73 is an example. (3) "Plan" includes: (a) group and nongroup insurance contracts and subscriber contracts; (b) uninsured arrangements of group or group-type coverage; (c) group and nongroup coverage through closed panel plans; (d) group-type contracts; (e) the medical care components of long-term care contracts, such as skilled nursing care; and (f) Medicare or other governmental benefits, as permitted by law, except as provided in Paragraph (4)(h). That part of the definition of plan may be limited to the hospital, medical, and surgical benefits of the governmental program. (4) "Plan" does not include: (a) hospital indemnity coverage benefits or other fixed indemnity coverage; (b) accident-only coverage; (c) specified disease or specified accident coverage; (d) limited benefit health coverage; (e) school accident-type coverages that cover students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis; (f) benefits provided in long-term care insurance policies for nonmedical services, for example, personal care, adult day care, homemaker services, assistance with activities	A. insurance contracts; B. subscriber contracts; C. coverage through health maintenance organizations; or D. coverage under other prepayment, group practice, and individual practice plans; except as otherwise provided in this part. "Plan" includes: group insurance and group subscriber contracts; uninsured arrangements of group or group-type coverage; group or group-type coverage through health maintenance organizations and other prepayment, group practice, and individual practice plans; and 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 its 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"). The use of payroll deductions by the employee, subscriber, or member to pay for the coverage is not sufficient, of itself, to make an individual contract part of a group-type plan. This description of group-type contracts is not intended to include individually underwritten and issued, guaranteed renewable policies that	(1) Group insurance and group subscriber contracts. (2) Uninsured arrangements of group or group-type coverage. (3) Group or group-type coverage through health maintenance organizations and other prepayment, group practice, and individual practice plans. (4) Group-type contracts. Group-type contracts are contracts that 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 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 are not 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. (5) The amount by which group or group-type hospital indemnity benefits exceed $100 a day. (6) The medical benefits coverage in group, group-type, and individual automobile no-fault and traditional automobile fault-type contracts.

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of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; (g) Medicare supplement policies; (h) a state plan under Medicaid; or (i) a governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.	may be purchased through payroll deduction at a premium savings to the insured. "Plan" may include the medical benefits coverage in group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts. "Plan" may include Medicare or other governmental benefits. That part of the definition of "plan" may be limited to the hospital, medical, and surgical benefits of the governmental program. However, "plan" shall not include a state plan under Medicaid, and shall not include a law or plan when, by law, its benefits are excess to those of any private insurance plan or other nongovernmental plan. The term "plan" shall not be construed to include group or group-type hospital indemnity benefits of $100 per day or less, but may be construed to include the amount by which group or group-type hospital indemnity benefits exceed $100 per day. "Plan" shall not include school accident-type coverages. These cover grammar, high school, and college students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis.	(7) Medicare or other governmental benefits, except as provided in item D, subitem (7). That part of the definition of plan may be limited to the hospital, medical, and surgical benefits of the governmental program. D. Plan does not include: (1) individual or family insurance contracts; (2) individual or family subscriber contracts; (3) individual or family coverage through health maintenance organizations; (4) individual or family coverage under other prepayment, group practice, and individual practice plans; (5) group or group-type hospital indemnity benefits of $100 a day or less; (6) school accident-type coverages that cover grammar, high school, and college students for accidents only, including athletic injuries, either on a 24-hour basis or on a to and from school basis; and (7) a state plan under Medicaid, or a law or plan when, by law, its benefits are in excess of those of any private insurance plan or other nongovernmental plan.
L. "Policyholder" means the primary insured named in a nongroup insurance policy.		
M. "Primary plan" 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.	Subp. 5. **Primary plan.** A primary plan is one whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into	Subp. 8. **Primary plan.** "Primary plan" means a plan that requires benefits for a person's health care coverage to be determined without taking into consideration the existence of any

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A plan is a primary plan if: (1) the plan either has no order of benefit determination rules, or its rules differ from those permitted by this regulation; or (2) All plans that cover the person use the order of benefit determination rules required by this regulation, and under those rules the plan determines its benefits first.	consideration. A plan is a primary plan if either item A or B is true. A. The plan either has no order of benefit determination rules, or it has rules which differ from those permitted by parts 2742.0100 to 2742.0400. B. All plans which cover the person use the order of benefit determination rules required by parts 2742.0100 to 2742.0400 and under those rules the plan determines its benefits first. There may be more than one primary plan (for example, two plans which have no order of benefit determination rules).	other plan. A plan is a primary plan if either of the following is true: A. The plan either has no order of benefit determination rules or it has provisions that differ from those permitted by parts 4685.0905 to 4685.0950. There may be more than one primary plan. B. All plans that cover the person use the order of benefit determination rules required by parts 4685.0905 to 4685.0950 and, under those rules, the plan determines its benefits first.
N. "Secondary plan" means a plan that is not a primary plan.	Subp. 6. **Secondary plan.** A secondary plan is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules of parts 2742.0100 to 2742.0400 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 parts 2742.0100 to 2742.0400, has its benefits determined before those of that secondary plan.	Subp. 9. **Secondary plan.** "Secondary plan" means a plan that is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules in parts 4685.0905 to 4685.0950 determine 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 these rules has its benefits determined before those of that secondary plan.
	Subp. 4. **This plan.** In a coordination of benefits provision, this term refers to the part of the group contract providing the health care benefits to which the coordination of benefits provision applies and which may be reduced	Subp. 10. **This plan.** In a coordination of benefits provision, "this plan" refers to the part of the group contract providing the health care benefits to which the coordination of benefits provision applies and that may be

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	on account 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 coordination of benefits provision to certain of its benefits (such as dental benefits), coordinating only with like benefits, and may apply other separate coordination of benefits provisions to coordinate other benefits. Subp. 9. **Claim determination period.** "Claim determination period" means a period of time, which must not be less than 12 consecutive months, over which allowable expenses are compared with total benefits payable in the absence of coordination of benefits, to determine whether overinsurance exists; and how much each plan will pay or provide. Claim determination period does not mean the period of time in which a plan may take to pay. A claim determination period usually is 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 that claim determination period. 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. A determination is	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 coordination of benefits provision to certain of its benefits, such as dental benefits, coordinating only with like benefits, and may apply other separate coordination of benefits provisions to coordinate other benefits. Subp. 4. **Claim determination period.** A. "Claim determination period" means the period of time over which allowable expenses are compared with total benefits payable in the absence of coordination of benefits, to determine whether overinsurance exists and how much each plan will pay or provide. The claim determination period must not be less than 12 consecutive months. B. 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. C. As each claim is submitted, each plan must determine its liability and pay or provide benefits based upon allowable expenses incurred to that point in the claim determination period. The determination may be adjusted as allowable expenses are incurred later in the same claim determination period.

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	subject to adjustment as later allowable expenses are incurred in the same claim determination period.	
Sec 4. Applicability and Scope This regulation applies to all plans that are issued on or after the effective date of this regulation, which is [insert date].		
Sec. 5. Use of Model COB Contract Provision A. Appendix A contains a model COB provision for use in contracts. The use of this model COB provision is subject to the provisions of Subsections B, C, and D and to the provisions of Section 6 of this regulation. B. 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. C. The COB provision contained in Appendix A and the plain language explanation in Appendix B do not have to use the specific words and format shown in Appendix A or Appendix B. Changes may be made to fit the language and style of the rest of the contract or to reflect differences among plans that	**2742.0300 MODEL COORDINATION OF BENEFITS CONTRACT PROVISION.** Subpart 1. **General.** Subpart 4 contains a model coordination of benefits provision for use in group contracts. That use is subject to parts 2742.0200, subpart 2, items B and C and 2742.0400. Subp. 2. **Flexibility.** A group contract's coordination of benefits provision does not have to use the words and format shown in parts 2742.0100 to 2742.0400. Changes may be made to fit the language and style of the rest of the group contract or to reflect the differences among plans which provide services, which pay benefits for expenses incurred, and which indemnify. Substantive changes are allowed only as set forth in parts 2742.0100 to 2742.0400. Subp. 3. **Prohibited coordination and benefit design.** A group contract may not reduce benefits on the basis that another plan exists; except with respect to Part B of Medicare, that a person is or could have been covered under another plan; or a person has	**4685.0940 MODEL COORDINATION OF BENEFITS CONTRACT PROVISION.** Subpart 1. **General.** Use of the model coordination of benefits provision for group contracts in part 4685.0950 is subject to subparts 2 and 3 and part 4685.0915. Subp. 2. **Flexibility.** A group contract's coordination provision does not have to use the words and format shown in part 4685.0950. Changes may be made to fit the language and style of the rest of the group contract or to reflect the difference among plans that provide services, that pay benefits for expenses incurred, and that indemnify. No other substantive changes are allowed. Subp. 3. **Prohibited coordination and benefit design.** A. A group contract may not reduce benefits on the basis that: (1) another plan exists; (2) a person is or could have been covered

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provide services, that pay benefits for expenses incurred, and that indemnify. No substantive changes are permitted. D. A COB provision may not be used that permits a plan to reduce its benefits on the basis that: (1) Another plan exists and the covered person did not enroll in that plan; (2) A person is or could have been covered under another plan, except with respect to Part B of Medicare; or (3) A person has elected an option under another plan providing a lower level of benefits than another option that could have been elected.	elected an option under another plan providing a lower level of benefits than another option which could have been elected.	under another plan, except with respect to Part B of Medicare; or (3) a person has elected an option under another plan providing a lower level of benefits than another option that could have been elected.
E. No plan may contain a provision that its benefits are "always excess" or "always secondary" except in accordance with the rules permitted by this regulation. F. 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	No contract may contain a provision that its benefits are "excess" or "always secondary" to any plan defined in part 2742.0200, subpart 2, except in accord with the rules permitted by parts 2742.0100 to 2742.0400.	B. No contract may contain a provision that its benefits are excess or always secondary to any plan, except as allowed in parts 4685.0905 to 4685.0950.

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been covered by both plans. Then the secondary plan shall use the provisions of Section 7 of this regulation to determine the amount it should pay for the benefit. G. 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 Section 3K of this regulation.		
Section 6. Rules for Coordination of Benefits When a person is covered by two (2) or more plans, the rules for determining the order of benefit payments are as follows: A. (1) The primary plan shall pay or provide its benefits as if the secondary plan or plans did not exist. (2) 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 nonpanel provider, except for emergency services or authorized referrals that are paid or provided by the primary plan. (3) When multiple contracts providing coordinated coverage are treated as a single plan under this regulation, this section applies only to the plan as a whole, and coordination among the component contracts is governed	**2742.0400 RULES FOR COORDINATION OF BENEFITS.** Subpart 1. **General.** The primary plan must pay or provide its benefits as if the secondary plan or plans did not exist. A secondary plan may take the benefits of another plan into account only when, under this part, it is secondary to that other plan.	**4685.0915 COORDINATION OF BENEFITS; PROCEDURES.** Subpart 1. **General.** The general order of benefits is as follows: A. The primary plan must pay or provide its benefits as if the secondary plan or plans do not exist. A plan that does not include a coordination provision may not take into account the benefits of another plan as defined in part 4685.0910 when it determines its benefits. The one exception is that a contract holder's coverage 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. A secondary plan may take the benefits of another plan into account only when, under this part, it is secondary to that other plan. C. The benefits of the plan that covers the person as an employee, member, or subscriber, that is, other than as a dependent,

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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 is responsible for the plan's compliance with this regulation. (4) 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 secondary plans benefits are determined in relation to each other. Each secondary plan must 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. B. (1) Except as provided in Paragraph (2), a plan that does not contain order of benefit determination provisions that are consistent with this regulation is always the primary plan unless the provisions of both plans, regardless of the provisions of this subdivision, state that the complying plan is primary. (2) 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 is 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		are determined before those of the plan that covers the person as a dependent.

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coverages that are written in connection with a closed panel plan to provide out-of-network benefits. C. A plan may take into consideration the benefits paid or provided by another plan only when, under the rules of this regulation, it is secondary to that other plan. D. Order of Benefit Determination Each plan determines its order of benefits using the first of the following rules that applies: **(1) Non-Dependent or Dependent** (a) Subject to Subparagraph (b) of this paragraph, the plan that covers the person other than as a dependent, for example as an employee, member, subscriber, policyholder, or retiree, is the primary plan and the plan that covers the person as a dependent is the secondary plan. (b) (i) If the person is a Medicare beneficiary, and, as a result of the provisions of title XVIII of the Social Security Act and implementing regulations, Medicare is: (I) Secondary to the plan covering the person as a dependent; and (ii) Primary to the plan covering the person as other than a dependent (e.g. a retired employee) (iii) 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		

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plan covering the person as a dependent is the primary plan.[ii] **(2) 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: (a) For a dependent child whose parents are married or are living together, whether or not they have ever been married: (i) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or (ii) If both parents have the same birthday, the plan that has covered the parent longest is the primary plan. (b) For a dependent child whose parents are divorced or separated or are 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. 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 clause does not apply with respect to any plan year during which benefits are paid or provided before the entity has	Subp. 2. **Dependent child/parents not separated or divorced.** The word "birthday" in the wording shown in subsection (4)(d)(III)(B)(ii) of part 2742.0300, subpart 4 refers only to month and day in a calendar year, not the year in which the person was born. A group contract which includes coordination of benefits and which is issued or renewed, or which has an anniversary date of July 5, 1986, shall include the substance of the provision in subsection (4)(d)(III)(B)(ii) of part 2742.0300, subpart 4. That provision shall become effective July 5, 1987. Until that provision becomes effective, the group contract shall, instead, use wording like this: "(ii) ... Except as stated in (iii) ....., 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."	Subp. 2. **Dependent child: parents not separated or divorced.** Benefits for a dependent child when the parents are not separated or divorced must be coordinated according to the procedures in items A to E. 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. B. If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter time. 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 that includes coordination of benefits and is issued or renewed or that has an anniversary date on or after 60 days after October 9, 1989, must include the substance of the provisions in items A to C. Until October 9, 1989, the group contract may contain wording such as: "Except as stated in subpart 3, the benefits of a plan that covers a person as a dependent of a male are determined before those of a plan that covers the person as a dependent of a female." E. If one parent's plan contains the coordination plan described in items A to C, and the other parent's plan contains the

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actual knowledge of the court decree provision; (ii) 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; (iii) 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 Subparagraph (a) of this paragraph shall determine the order of benefits; or (iv) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows: (I) The plan covering the custodial parent; (II) The plan covering the custodial parent's spouse; (III) The plan covering the noncustodial parent; and then (IV) the plan covering the noncustodial parent's spouse. (c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under Subparagraph (a) or (b) of this paragraph as if those individuals were parents of the child.		coordination plan based on the gender of the parent, and if, as a result, the parents' plans do not agree on the coordination of benefits, the coordination plan based on the gender of the parent determines the order of benefits. Subp. 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 coordinated according to this subpart. If a court orders one of the parents to pay the health care expenses of the child, and the entity that pays or provides the parent's plan knows of the order, the benefits of that parent's plan are determined first. The plan of the other parent is the secondary plan. This paragraph does not apply to any claim determination period or plan year during which benefits are actually paid or provided before the entity knows of the order. If a court order does not require one of the parents to pay the child's health care expenses, benefits are coordinated according to items A to C. A. The benefits of the plan of the parent with custody of the child are determined first. B. The benefits of the plan of the spouse of the parent with the custody of the child are determined second. C. The benefits of the plan of the parent without custody of the child are determined last. D. In the case of joint custody, the primary plan will be determined according to subpart 2.

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(3) Active Employee or Retired or Laid-Off Employee (a) The plan that covers a person as an active employee, that is an employee who is neither laid off nor retired, or as a dependent of an active employee 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. (b) 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. (c) This rule does not apply if the rule in Paragraph (1) can determine the order of benefits. **(4) COBRA or State Continuation Coverage** (a) 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. (b) 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.		Subp. 4. **Active/inactive employee.** The benefits of a plan that covers a person as an employee, who is neither laid off nor retired, or as a dependent of that employee are determined before benefits of a plan that covers that person as a laid-off or retired employee or as a dependent of that 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 does not apply.

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(c) This rule does not apply if the rule in Paragraph (1) can determine the order of benefits.		
(5) Longer or Shorter Length of Coverage (a) If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan. (b) To determine the length of time a person has been covered under a plan, two successive plans must be treated as one if the covered person was eligible under the second plan within twenty-four (24) hours after coverage under the first plan ended. (c) The start of a new plan does not include: (i) A change in the amount or scope of a plan's benefits; (ii) A change in the entity that pays, provides, or administers the plan's benefits; or (iii) A change from one type of plan to another, such as, from a single-employer plan to a multiple-employer plan. (d) The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group must be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.	Subp. 3. **Longer/shorter length of coverage.** 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 24 hours after the first ended. Thus, the start of a new plan does not include a change in the amount or scope of a plan's benefits; a change in the entity which pays, provides, or administers the plan's benefits; or a change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan). 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.	Subp. 5. **Longer/shorter length of coverage.** If none of these rules determines the order of benefits, the benefits of the plan that covered an employee, member, or subscriber longer are determined before those of the plan that covered that person for the shorter term. A. To determine the length of time a person has been covered under a plan, two plans are treated as one if the claimant was eligible under the second plan within 24 hours after the first ended. B. The start of a new plan does not include: (1) a change in the amount of scope of a plan's benefits; (2) a change in the entity that pays, provides, or administers the plan's benefits; or (3) a change from one type of plan to another, such as from a single employer plan to that of a multiple employer plan. 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 is the date used to determine the length of time the claimant's coverage under the present plan has been in force.

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(6) If none of the preceding rules determines the order of benefits, the allowable expenses must be shared equally between the plans.		
Section 7. Procedure to be Followed by Secondary Plan to Calculate Benefits and Pay a Claim 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 100 percent 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.		**4685.0925 PROCEDURE TO BE FOLLOWED BY SECONDARY PLAN.** Subpart 1. **Total allowable expenses.** When a plan is a secondary plan under part 4685.0915, its benefits may be reduced so that the total benefits paid or provided by all plans during a claim determination period are not more than total allowable expenses. 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, that 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 that were submitted up to that time during the claim determination period. Subp. 2. **Reducing benefits of a secondary plan.** The benefits of the secondary plan shall be reduced when the sum of the benefits that would be payable for the allowable expenses under the secondary plan in the absence of coordination of benefits provisions in parts 4685.0905 to 4685.0950 and the benefits that would be payable for the allowable expenses under the other plans, in the absence of coordination of benefits provisions in parts

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		4685.0905 to 4685.0950, whether or not claim is made, exceeds those allowable expenses in a claim determination period. In that case, the benefits of the secondary plan shall be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses. 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. Item A may be omitted if the plan provides only one benefit, or may be altered to suit the coverage provided.
Section 8. 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."		
Section 9. Miscellaneous Provisions A. A secondary plan that provides benefits in the form of services may recover the reasonable cash value of 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. This provision does not require a plan to reimburse a covered person in cash for the value of services provided by a plan that provides benefits in the form of services.	**2742.0400 RULES FOR COORDINATION OF BENEFITS.**	**4685.0930 MISCELLANEOUS PROVISIONS.** Subpart 1. **Reasonable cash values of services.** A secondary plan that provides benefits in the form of services may recover the reasonable cash value of providing the services from the primary plan, if 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 subpart shall be interpreted to require a plan to reimburse a covered person in cash for the value of

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		services provided by a plan that provides benefits in the form of services.
B. (1) A plan with order of benefit determination rules that comply with this regulation (complying plan) may coordinate its benefits with a plan that is "excess" or "always secondary" or that uses order of benefit determination rules that are inconsistent with those contained in this regulation (non-complying plan) on the following basis: (a) If the complying plan is the primary plan, it shall pay or provide its benefits first; (b) If the complying plan is the secondary plan, it shall pay or provide its benefits first, but the amount of the benefits payable must be determined as if the complying plan were the secondary plan. In such a situation, the payment must be the limit of the complying plan's liability; and (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 noncomplying plan are identical to its own, and shall pay its benefits accordingly. If, within two years of payment, the complying plan receives information as to the actual benefits of the noncomplying plan, it shall adjust payments accordingly. (2) If the noncomplying plan reduces its	Subp. 6. **Excess and other nonconforming provisions.** Some plans have order of benefit determination rules not consistent with parts 2742.0100 to 2742.0400 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 some group contracts have not yet been conformed with parts 2742.0100 to 2742.0400 pursuant to the effective date provisions of these rules. A plan with order of benefit determination rules which comply with parts 2742.0100 to 2742.0400 (herein called a 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 parts 2742.0100 to 2742.0400 (herein called a noncomplying plan) on the following basis: A. If the complying plan is the primary plan, it shall pay or provide its benefits on a primary basis. 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, payment shall be the limit of the complying plan's liability.	Subp. 2. **Coordination of benefits with a noncomplying plan.** Some plans contain a coordination provision that violates parts 4685.0905 to 4685.0950 by declaring that the plan's coverage is excess to all others, or is always secondary. This occurs because certain plans may not be subject to insurance regulation, or because some group contracts have not yet been conformed with this regulation under part 4685.0905. A plan may coordinate its benefits with a plan that does not comply with parts 4685.0905 to 4685.0950 according to items A to D. A. If the complying plan is the primary plan, it must pay or provide its benefits on a primary basis. B. If the complying plan is the secondary plan, it must pay or provide its benefits first, but the benefits payable are determined as if the complying plan is the secondary plan, and are limited to the complying plan's liability. 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 pay benefits as if the benefits of the noncomplying plan are identical to its own. However, the complying plan must adjust its payments when it receives information on the actual benefits of the

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benefits so that the covered person receives less in benefits than 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 covered person an amount equal to the difference. (3) 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 the advance, the complying plan is subrogated to all rights of the covered person against the noncomplying plan. The advance by the complying plan is without prejudice to any claim it may have against a noncomplying plan in the absence of subrogation.	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 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. D. 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 in subpart 8; then the complying plan shall advance to or on behalf of the employee, subscriber, or member an amount equal to the 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. An advance by the complying plan shall also be without prejudice to any claim it may have against the noncomplying plan in the absence of	noncomplying plan. D. If the noncomplying plan reduces its benefits so that the member receives less in benefits than the member would have received had the complying plan paid benefits as the secondary plan and the noncomplying plan paid benefits as the primary plan, and governing state law allows the right of subrogation set forth below, then the complying plan shall pay to or on behalf of the member an amount equal to the difference. The complying plan shall not pay more than the complying plan would have paid had it been the primary plan less any amount it previously paid. The complying plan is subrogated to all rights of the member against the noncomplying plan. A payment by the complying plan under this item does not prejudice any claim against the noncomplying plan in the absence of subrogation.

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	subrogation.	
C. COB differs from subrogation. Provisions for one may be included in health care benefits contracts without compelling the inclusion or exclusion of the other.	Subp. 8. **Subrogation.** The coordination of benefits 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.	Subp. 4. **Subrogation.** Provisions for coordination or subrogation may be included in health care benefits contracts without compelling the inclusion or exclusion of the other.
D. 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 is required to pay more than it would have paid had it been the primary plan.		
	Subp. 7. **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 coordination of benefits provisions apply.	Subp. 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," or "customary." A term such as "medical care" or "dental care" may be substituted for "health care" to describe the coverages to which the coordination provisions apply.
Section 10. Effective Date for Existing Contracts A. A contract that provides health care benefits and that was issued before the effective date of this regulation shall be	**2742.0500 EFFECTIVE DATE.** Parts 2742.0100 to 2742.0400 are effective July 5, 1986. Parts 2742.0100 to 2742.0400 apply to every group contract which provides health care	**4685.0935 EFFECTIVE DATE; EXISTING CONTRACTS.** Subpart 1. **Applicability of coordination rules.** Coordination requirements in parts 4685.0905 to 4685.0950 apply to every group

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brought into compliance with this regulation by: (1) The later of: (a) The next anniversary date or renewal date of the contract; or (b) Twelve months following [insert date that the amended regulation is adopted]; or (2) The expiration of any applicable collectively bargained contract pursuant to which it was written. B. For the transition period between the adoption of this regulation and the timeframe for which plans are to be in compliance pursuant to Subsection A, a plan that is subject to the prior COB requirements shall not be considered a non-complying plan by a plan subject to the new COB requirements and if there is a conflict between the prior COB requirements under the prior regulation and the new COB requirements under the amended regulation, the prior COB requirements shall apply.	benefits and is issued on or after that date. A group contract which provides health care benefits and was issued before that date shall be brought into compliance with parts 2742.0100 to 2742.0400 by the later of the next anniversary date or renewal date of the group contract; or the expiration of any applicable collectively bargained contract pursuant to which it was written.	contract that provides health care benefits issued on or after October 9, 1989. Subp. 2. [Repealed, 31 SR 35]
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	**2742.0300** Subp. 4. **Text of model coordination of benefits provision.** COORDINATION OF THE GROUP CONTRACT'S BENEFITS WITH OTHER BENEFITS (I) APPLICABILITY. (A) This coordination of benefits provision applies to this plan when an employee or the employee's covered dependent has health care coverage under more than one plan. "Plan"	**4685.0950 TEXT OF MODEL COORDINATION OF BENEFITS PROVISIONS FOR GROUP CONTRACTS.** Group contracts must contain language on coordination of benefits that is substantially similar to the following model provisions. COORDINATION OF THE GROUP CONTRACT'S BENEFITS WITH OTHER BENEFITS I. APPLICABILITY.

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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 to that payments from all **Plans** does not exceed 100 percent 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. (1) **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); medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted. (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, as defined by state law; school accident-type coverage; benefits for nonmedical components of long-term care policies; Medicare supplement policies;	and "this plan" are defined below. (B) If this coordination of benefits 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: (i) shall not be reduced when, under the order of benefit determination rules, this plan determines its benefits before another plan; but (ii) 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) A "plan" is any of these which provides benefits or services for, or because of, medical or dental care or treatment: (i) 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. (ii) Coverage under a governmental plan or 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). It also does not include any plan when, by law, its benefits are excess to those of any private insurance program or other nongovernmental	(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 coordination of benefits 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 benefits determination rules, another plan determines its benefits first. The above reduction is described in section IV. 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 Programs, of the United States

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Medicaid policies; 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 may reduce the benefits it pays so that all **Plan** benefits do not exceed 100 percent of the total **Allowable expense**. D. **Allowable expense** is a health care expense, including deductibles, coinsurance, and copayments, that is covered at least in	program. Each contract or other arrangement for coverage under (i) or (ii) is a separate plan. Also, if an arrangement has two parts and coordination of benefits rules apply only to one of the two, each of the parts is a separate plan. (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 semiprivate	Social Security Act, as amended from time to time). Each contract or other arrangement for coverage under (1) or (2) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan. 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 semiprivate

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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**. 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**. The following are examples of expenses that are not **Allowable expenses**: (1) The difference between the cost of a semiprivate 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 methodology or other similar reimbursement methodology, 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**. (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	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. (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 coordination of benefits 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: (i) the other plan has rules coordinating its benefits with those of this plan; and (ii) both those rules and this plan's rules, in subparagraph (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: (i) Nondependent/dependent. The benefits of	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 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

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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. (5) The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements. 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	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. (ii) Dependent child/parents not separated or divorced. Except as stated in subparagraph (B)(iii) 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 the 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. 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. (iii) 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: a. first, the plan of the parent with custody of the child; b. then, the plan of the spouse of the parent with custody of the child; and	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) Nondependent/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 on 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. If

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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 of coverage under any other **Plan**. B. (1) Except as provided in paragraph (2), a **Plan** that does not contain a coordination of benefits provision that is consistent with this regulation 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 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	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. 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. (iv) 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, (iv) is ignored. (v) 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 time. (IV) EFFECT ON THE BENEFITS OF THIS PLAN. (A) When this section applies. This section	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: (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 expense 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 follow the order of benefit determination rules outlined in Paragraph 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

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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	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) below. (B) Reduction in this plan's benefits. The benefits of this plan will be reduced when the sum of: (i) the benefits that would be payable for the allowable expenses under this plan in the absence of this coordination of benefits provision; and (ii) 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 coordination of benefits provision, whether or not claim is made; exceeds those allowable expenses 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 allowable expenses. 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 coordination of benefits rules. [The XYZ Company] has the right to decide which facts it needs. It may get needed facts from or give	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 (4) is ignored. (6) 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. 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. 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, exceeds those Allowable

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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 plan years commencing after the **Plan** is given notice of the court decree; (ii) 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 shall determine the order of benefits; (iii) 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 subparagraph (a) above shall determine the order of benefits; or (iv) 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**; • The **Plan** covering the spouse of the **Custodial parent**; • The **Plan** covering the **noncustodial parent**; and then • The **Plan** covering the spouse of the	them to any other organization or person. [The XYZ Company] need not tell, or get the consent of, any person to do this unless applicable federal or state law prevents disclosure of the information without the consent of the patient or the patient's representative. Each person claiming benefits under this plan must give [The XYZ Company] any facts it 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, [The XYZ Company] 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. [The XYZ Company] 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 [The XYZ Company] is more than it should have paid under this coordination of benefits 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	Expenses 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 Allowable Expenses. 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. [health maintenance organization] has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. [health maintenance organization] need not tell, or get the consent of, any person to do this. Unless applicable federal or state law prevents disclosure of the information without the consent of the patient or the patient's representative, each person claiming benefits under This Plan must give [health maintenance organization] any facts it 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, [health maintenance organization] 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. [health maintenance organization] will not

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noncustodial parent. (c) For a dependent child covered under more than one **Plan** of individuals who are the parents of the child, the provisions of subparagraph (a) or (b) above shall 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 labeled D(1) 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 **Plan** does not have this rule, and	the reasonable cash value of any benefits provided in the form of services.	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 [health maintenance organization] 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.

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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) 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** 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**. **EFFECT ON THE BENEFITS OF THIS PLAN** A. 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 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 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**		

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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. B. If a covered person is enrolled in two or more **Closed panel plans** and if, for any reason, including the provision of service by a nonpanel provider, benefits are not payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other **Closed panel plans**. **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 befits 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** A payment made under another **Plan** may include an amount that should have been paid		

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under **This plan**. If it does, [Organization responsibility for **COB** administration] may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under **This plan**. [Organization responsibility 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 the reasonable cash value of the benefits provided in the form of services. **RIGHT OF RECOVERY** If the amount of the payments made by [Organization responsibility 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. 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,**		

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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		

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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: **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		

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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 healthcare expense covered by one of the plans, including copayments, 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		

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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 precertification, 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**		

[i] Language regarding High Deductible Health Plans was adopted in Laws of 2010, Chapter 384. Refer to Minn. Stat. 62A.046 Subd. 7

[ii] Language regarding Medicare Secondary Payor provisions of federal law was adopted in Laws of 2010, Chapter 384. Refer to Minn. Stat. 62A.046 Subd. 6