28 CA ADC § 1300.67.13

Term

28 CCR § 1300.67.13

Cal. Admin. Code tit. 28, § 1300.67.13

BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS
TITLE 28. MANAGED HEALTH CARE
DIVISION 1. THE DEPARTMENT OF MANAGED HEALTH CARE
CHAPTER 2. HEALTH CARE SERVICE PLANS
ARTICLE 7. STANDARDS
This database is current through 5/23/08, Register 2008, No. 21

§ 1300.67.13. Coordination of Benefits ("COB").

(a)(1) This rule does not require the use of COB provisions in plan contracts. If a contract contains a COB provision, the provision must be consistent with the standard provision set forth in subdivision (b), as interpreted by the "Instructions" set forth in that subdivision. COB provisions, or provisions for the reduction of benefits otherwise payable because of other coverage by whatever name designated, which are not consistent with the standard provision set forth in subdivision (b), may not be used, except that plans of coverage designed to be supplementary over the subscriber's or enrollee's underlying basic plan of coverage may provide that coverage shall be excess to that specific subscriber's or enrollee's plan of basic coverage from whatever source provided.

(2) A COB provision may not relieve a plan of a duty otherwise arising from a plan contract to deliver any health care service to any subscriber or enrollee because the subscriber or enrollee may be or is entitled to coverage for the service by any other plan or insurer.

(3) A COB provision may not result in a delay in furnishing any reasonably necessary health care service to any subscriber or enrollee pursuant to a plan contract.

(b) Standard COB Provision:

(1) Benefits Subject to This Provision

All of the benefits provided under this Plan contract are subject to this provision.

Instructions

When the contract provides both integrated Major Medical Expense Benefits and the Basic Benefits, but the COB provision applies to all or some of the benefits, use appropriate alternate wording such as: "Only the Major Medical Expense Benefits provided under this contract are subject to this provision."

(2) Definitions

(A) "Plan" means any plan providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided by (i) group, blanket or franchise insurance coverage, (ii) service plan contracts, group practice, individual practice and other prepayment coverage, (iii) any coverage

under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans, and (iv) any coverage under governmental programs, and any coverage required or provided by any statute.

The term "Plan" shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

(B) "This Plan" means that portion of this contract which provides the benefits that are subject to this provision.

(C) "Allowable Expense" means any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the Plans covering the person for whom claim is made. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

(D) "Claim Determination Period" means a calendar year.

Instructions

The definition of a "Plan" within the COB provision of group contracts enumerates the types of coverage which the Plan may consider in determining whether other coverage exists with respect to a specific claim. The definition:

1. May not include individual or family policies, or individual or family subscriber contracts, except as otherwise provided in this special instruction.

2. May include all group policies, group subscriber contracts, selected group disability insurance contracts issued pursuant to section 10270.97 of the Insurance Code and blanket insurance contracts, except blanket insurance contracts issued pursuant to section 10270.2(b) or (e) which contain nonduplication of benefits or excess policy provisions.

3. May not include any entitlements to Medi-Cal benefits under chapter 7 (commencing with section 14000) or chapter 8 (commencing with section 14500) of part 3 of division 9 of the Welfare and Institutions Code, or benefits under the California Crippled Children Services program under section 10020 of the Welfare and Institutions Code or any other coverage provided for or required by law when, by law, its benefits are excess to any private insurance or other non-governmental program.

4. May not include the medical payment benefits customarily included in the traditional automobile contracts.

5. May include "Medicare" or any other similar governmental benefits so long as it does not expand the definition of "Allowable Expenses" beyond the hospital, medical and surgical benefits as may be provided by the government program and so long as such benefits are not by law excess to this Plan.

(3) Effect on Benefits

(A) This provision shall apply in determining the benefits as to a person covered under this Plan for any Claim Determination Period if, for the Allowable Expenses incurred as to such person during such period, the sum of:

(i) the value of the benefits that would be provided by this Plan in the absence of this provision, and

(ii) the benefits that would be payable under all other plans in the absence therein of provisions of similar purpose to this provision would exceed such Allowable Expenses.

(B) As to any Claim Determination Period to which this provision is applicable, the benefits that would be provided under this Plan in the absence of this provision for the Allowable Expenses incurred as to such person during such Claim Determination Period shall be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such Allowable Expenses under all other Plans, except as provided in paragraph (3)C., shall not exceed the total of such Allowable Expenses. Benefits payable under another Plan include the benefits that would have been payable had claim been made therefor.

(C) If

(i) another Plan which is involved in paragraph (3)B. and which contains a provision coordinating its benefits with those of this Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined, and

(ii) the rules set forth in paragraph (4) would require this Plan to determine its benefits before such other Plan, then the benefits of such other Plan will be ignored for the purposes of determining the benefits under this Plan.

(4) For the purposes of paragraph (3), use the first of the following rules establishing the order of determination which applies:

(A) The benefits of a Plan which covers the person on whose expenses claim is based other than as a dependent shall be determined before the benefits of a Plan which covers such person as a dependent, except that, if the person is also a Medicare beneficiary and as a result of the rules established by Title XVIII of the Social Security Act (42 USC 1395 et seq.) 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), then the benefits of the Plan covering the person as a dependent are determined before those of the Plan covering that person as other than a dependent.

(B) Except for cases of a person for whom claim is made as a dependent child whose parents are separated or divorced, the benefits of a Plan which covers the person on whose expenses claim is based as a dependent of a person whose date of birth, excluding year of birth, occurs earlier in a calendar year, shall be determined before the benefits of a Plan which covers such person as a dependent of a person whose date of birth, excluding year of birth, occurs later in a calendar year. If either Plan does not have the provisions of this subparagraph regarding dependents, which results either in each Plan determining its benefits before the other or in each Plan determining its benefits after the other, the provisions of this subparagraph shall not apply, and the rule set forth in the Plan which does not have the provisions of this subparagraph shall determine the order of the benefits.

(C) Except as provided in subparagraph (E), in the case of a person for whom claim is made as a dependent child whose parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a Plan which covers the child as a dependent of the parent without custody.

(D) Except as provided in subparagraph (E), in the case of a person for whom claim is made as a dependent child whose parents are divorced and the parent with custody of the child has remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a Plan which covers that child as a dependent of the stepparent, and the benefits of a Plan which covers that child as a dependent of the stepparent will be determined before the benefits of a Plan which covers that child as a dependent of the parent without custody.

(E) In the case of a person for whom claim is made as a dependent child whose parents are separated or divorced, where there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, then, notwithstanding subparagraphs (C) and (D), the benefits of a Plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan which covers the child as a dependent child.

(F) Except as provided in subparagraph (G), the benefits of a Plan covering the person for whose expenses claim is based as a laid-off or retired employee, or dependent of such person, shall be determined after the benefits of any other Plan covering such person as an employee, other than a laid-off or retired employee, or dependent of such person;

(G) If either Plan does not have a provision regarding laid-off or retired employees, which results in each Plan determining its benefits after the other, then the rule under subparagraph (F) shall not apply;

(H) If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:

(1) First, the benefits of a Plan covering the person as an employee, member, or subscriber, or as that person's dependent;

(2) Second, the benefits under continuation coverage. If the other Plan does not have the rules described above, and if, as a result, the Plans do not agree on the order of benefits, the rule under this subparagraph is ignored.

(I) When subparagraphs (A) through (H) do not establish an order of benefit determination, the benefits of a Plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a Plan which has covered such person the shorter period of time.

(5) When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during any Claim Determination Period, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of this Plan.

Instructions

1. When a claim under a Plan with a COB provision involves another Plan which also has a COB provision, the carriers involved shall use the above rules to decide the order in which the benefits payable under the respective Plans will be determined.

2. In determining the length of time an individual has been covered under a given Plan, two successive Plans of a given group shall be deemed to be one continuous Plan so long as the claimant concerned was eligible for coverage within 24 hours after the prior Plan terminated. Thus, neither a change in the amount or scope of benefits provided by a Plan, a change in the carrier insuring the Plan, nor a change from one type of Plan to another (e.g., single employer to multiple employer Plan, or vice versa, or single employer to a Taft-Hartley Welfare Plan) would constitute the start of a new Plan for purposes of this instruction.

3. If a claimant's effective date of coverage under a given Plan is subsequent to the date the carrier first contracted to provide the Plan for the

group concerned (employer, union, association, etc.), then, in the absence of specific information to the contrary, the carrier shall assume, for purposes of this instruction, that the claimant's length of time covered under that Plan shall be measured from claimant's effective date coverage. If a claimant's effective date of coverage under a given Plan is the same as the date the carrier first contracted to provide the Plan for the group concerned, then the carrier shall require the group concerned to furnish the date the claimant first became covered under the earliest of any prior Plans the group may have had. If such 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 his coverage under that Plan has been in force.

4. It is recognized that there may be existing group plans containing provisions under which the coverage is declared to be "excess" to all other coverages, or other COB provisions not consistent with this rule. In such cases, plans are urged to use the following claims administration procedures: A group plan should pay first if it would be primary under the COB order of benefits determination. In those cases where a group plan would normally be considered secondary, the plan should make every effort to coordinate in a secondary position with benefits available through any such "excess" plans. The plan should

try to secure the necessary information from the "excess" plan.

(6) Right to Receive and Release Necessary Information. For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provision of similar purpose of any other Plan, the Plan may release to or obtain from any insurance company or other organization or person any information, with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish such information as may be necessary to implement this provision.

(7) Facility of Payment. Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other Plans, the Plan shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, the Plan shall be fully discharged from liability under this Plan.

(8) Right of Recovery. Whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Plan shall have the right to recover such payments, to the extent of such excess, from one or more of the following, as the Plan shall determine: any persons to or for or with respect to whom such payments were made, any insurers, service plans or any other organizations.

(c) Contracts in force on the effective date of this rule which contain an "excess" clause, "anti-duplication" provision, or any other provision by whatever name designated under which benefits would be reduced because of other existing coverages, shall be brought into compliance with this rule by the later of the next anniversary or renewal date of the group policy or contract, or the expiration of the applicable collectively bargained contract pursuant to which they are written, if any.

<General Materials (GM) - References, Annotations, or Tables>

Note: Authority cited: Section 1344, Health and Safety Code. Reference: Section 10270.98, Insurance Code.

HISTORY

1. New section filed 5-9-80; effective thirtieth day thereafter (Register 80, No. 19).

2. Repealer of former COB regulation section 1300.67.13 and adoption of new COB regulation section 1300.67.13 filed 3-9-87; effective upon filing pursuant to Government Code section 11346.2(d). Regulation approved for consistency with CCR, title 10, sections 2232.50 through 2232.59, as required by Insurance Code section 10270.98 (Register 87, No. 11).

3. Editorial correction of printing error restoring correct wording of subsection (8) of Instructions (Register 91, No. 33).

4. Amendment of subsections (b)(4)-(b)(4)(E), new subsections (b)(4)(F)-(b)(4)(H)(2), subsection relettering, and amendment of newly designated subsection (b)(4)(I) filed 8-6-93; operative 9-7-93 (Register 93, No. 32).

5. Editorial correction of printing error in History 2 (Register 93, No. 32).

28 CCR § 1300.67.13, 28 **CA ADC § 1300.67.13**
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28 **CA ADC § 1300.67.13**

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Term

Cite List Docs In Sequence Table of Contents