211 CMR 38.00: COORDINATION OF BENEFITS (COB)

Section

38.01: Authority

211 CMR 38.00 is promulgated in accordance with the authority granted to the Commissioner of Insurance by M.G.L. Chs. 175, 176A, 176B, 176C, 176D, 176E, 176F, 176G and 176I.

38.02: Purpose and Applicability

The purpose of 211 CMR 38.00 is to establish an order in which ~~plans~~Plans pay their claims when a person is covered by more than one ~~plan~~Plan. Any ~~plan~~Plan which contains a Coordination of Benefits provision must comply with 211 CMR 38.00. A ~~plan~~Plan that does not contain such a provision may not take the benefits of another ~~plan~~Plan into account when determining its benefits.

38.03: Definitions

As used in 211 CMR 38.00, these words and terms shall have the following ~~words shall mean~~meanings, unless the context clearly indicates otherwise:

Allowable Expense~~: 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~~ ,

(1) Except as set forth in 211 CMR 38.03 or elsewhere in this regulation, or where a statute requires a different definition~~. However, items~~, Allowable Expense 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 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.

(3) An expense ~~under coverages such as dental care, vision care, prescription drug or hearing aid programs may be excluded from the definition of allowable~~or a portion of an expense~~. A plan which provides benefits only for any such items of~~ that is not covered by any of the Plans is not an Allowable Expense.

(4) Any expense ~~may limit its definition of allowable expense to like items of 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) When a ~~plan~~Plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an ~~allowable expense~~Allowable Expense and

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a benefit paid.

~~When a plan uses capitation as the method of paying its providers of services, the reasonable value of such services shall be utilized as the basis of determining payment.~~

(6) Expenses that are not Allowable Expenses include, but are not limited to:

(a) ~~The~~ If a person is confined in a private hospital room, the difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an ~~allowable expense under the above definition~~Allowable Expense, unless ~~the patient's stay in a~~one of the Plans provides coverage for private hospital room ~~is medically necessary in terms of generally accepted medical practice~~expenses.

(b) If a person is covered by two (2) or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, then 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 (2) or more Plans that provide benefits or services on the basis of negotiated fees, then any amount in excess of the highest of the negotiated fees is not an Allowable Expense.

(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, then the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, that negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

The~~When COB is restricted in its use to a specific coverage in a contract (for example, major medical or dental), the definition of allowable expense shall clearly identify the corresponding expenses or services to which COB applies.~~

(7) definition of "Allowable Expense" may exclude certain types of coverage or benefits such as dental care, vision care, prescription drug or hearing aids. A plan that limits the application of COB to certain coverages or benefits may limit the definition of Allowable Expense in its contract to expenses that are similar to the expenses that it provides. When COB is restricted to specific coverages or benefits in a contract, the definition of Allowable Expense shall include similar expenses to which COB applies.

(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 has a lower benefit because the covered person did not use a preferred provider.

(9) Nothing in this provision shall be interpreted to require a Plan that makes its provider payments on the basis of capitation or other similar reimbursement methodology to make any reimbursements beyond the negotiated capitation arrangement between the provider and carrier.

Birthday, refers only to month and day in a calendar year and does not include the year in which the individual is born.

Claim~~:~~, a request that benefits of a ~~plan~~Plan be provided or paid. The benefits claimed may be in the form of:

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(a) ~~(a)~~ services (including supplies);
(b) ~~(b)~~ payment for all or a portion of the expenses incurred;
(c) ~~(c)~~ a combination of 211 CMR 38.03: Claim(a) and (b); or
(d) ~~(d)~~ an indemnification.

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~~Claim Determination Period: the 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 COB, to determine whether over-insurance exists and how much each plan will pay or provide. 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.~~

~~As each claim is submitted, each plan is to determine its liability and pay or provide benefits based upon allowable expenses incurred to that point in the claim determination period. That determination is subject to adjustment as later allowable expenses are incurred in the same claim determination period.~~

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Closed Panel Plan, a Health Benefit 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 Health Benefit Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral approved by the Health Benefit Plan.

Consolidated Omnibus Budget Reconciliation Act of 1985 or "COBRA", coverage provided under a right of continuation pursuant to federal law.

Coordination of Benefits or ("COB~~");~~"), a provision establishing an order in which ~~plans pay their claims~~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.

Custodial Parent, the parent awarded custody of a child by a court decree. In the absence of a court decree, the parent with whom the child resides more than one half of the calendar year, without regard to any temporary visitation, is the Custodial Parent.

Group-type Contract~~:~~, a contract for coverage which is 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~~a connection with a particular organization or group, including blanket coverage. A Group-type Contract does not include an individually underwritten and issued guaranteed renewable policy even if the policy is purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.

~~Hospital Indemnity Benefits: benefits provided during hospital confinement on other than an expense incurred basis.~~

~~Plan:~~Health Benefit Plan, a policy, contract, certificate or agreement entered into, offered or issued to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. For the purposes of 211 CMR 38.00, Medical Payments Coverage and Personal Injury Protection shall not be considered a "Health Benefit Plan."

High-deductible Health Plan, has 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.

Hospital Indemnity Benefits, insurance policies offered as independent, non-coordinated benefits which for the purposes of 211 CMR 38.00 shall mean policies issued under M.G.L. c. 175 which provide a benefit to be paid to an insured or a dependent, including the spouse of an insured, on the basis of a hospitalization of the insured or a dependent, that are sold as a supplement and not as a substitute for a health benefit plan.

Medical Payments Coverage, medical coverage that may be purchased by a person pursuant to M.G.L. c. 175, § 113C in conjunction with the purchase of a Massachusetts motor vehicle insurance policy.

Personal Injury Protection ("PIP"), The coverage included in a Massachusetts motor vehicle liability policy as set forth and defined by M.G.L. c. 90, §§ 34A and 34M.

Plan, a form of coverage with which coordination is allowed. ~~The definition of plan in the~~ 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. If a Plan coordinates benefits, its contract must state the types of coverage which will be considered in applying the COB provision of that contract. ~~Plan shall include:~~

(1) ~~(a)~~ Plan shall include:

(a) group and nongroup insurance contracts and group and nongroup subscriber contracts;

~~(b)~~ uninsured arrangements of group coverage~~;~~

(b) ~~(c)~~ or group ~~coverage through HMOs and other prepayment, group practice and individual practice plans~~ type coverage;

~~(d) group-type contracts may be included in the definition of plan at the option of the~~

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~~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 coverage is designated;~~

~~(e) the amount by which hospital indemnity benefits exceed $100 per day; and~~

(c) ~~(f)~~ 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;

(f) the medical benefits coverage in automobile ~~policies~~ "no fault" and traditional automobile "fault" type contracts, to the extent permitted by law~~.~~;

~~Plan shall not include:~~

~~(a) nongroup coverage except for coverage described in 211 CMR 38.03: Plan(d) through (f) above, or when a nongroup plan chooses to coordinate with other nongroup plans;~~

(g) ~~(b)~~ Medicare or other governmental benefits, as permitted by law, except as provided in Paragraph (2)(h) below. That part of the definition of Plan may be limited to the hospital, medical and surgical benefits ~~except to~~of the ~~extent permitted by law~~governmental program;

~~(c) student accident coverages, Qualifying Student Health Insurance Programs ("QSHIPs") or other student health plans when designated as "excess only" or "always secondary plan"; and~~

(h) ~~(d) a~~ Group and nongroup insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care; and

(i) Group and nongroup insurance contracts and subscriber contracts that pay or reimburse for the cost of vision care.

(2) Plan shall not include:

(a) Hospital Indemnity Benefits coverage or other fixed indemnity coverage;

(b) Accident only coverage;

(c) Specified disease or specified accident coverage;

(d) Insured contracts that pay a fixed daily benefit without regard to which expenses are incurred or services received;

(e) Medicare Supplement policies;

(f) School accident-type coverages that cover students for accidents only, including those contracts covering students for accidents or athletic injuries, either on a twenty-four hour basis or on a "to and from school" basis;

(g) Benefits provided in long-term care insurance policies for non-medical services or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;

(h) A state plan under Medicaid~~,~~; or ~~any other~~

(i) A governmental plan when, by law, its benefits are ~~secondary to or~~ in excess of those of any private insurance plan or other nongovernmental plan.

Policyholder, the primary insured named in a nongroup insurance policy.

Primary Plan~~:~~, a ~~plan~~Plan whose benefits for a person's health care coverage must be determined without taking the existence of any other ~~plan~~Plan into consideration. ~~A plan~~Except as otherwise provided in 211 CMR 38.00, a Plan is a ~~primary plan~~Primary Plan if either:

(a) ~~(a)~~ the ~~plan~~Plan either has no order of benefit determination rules, or it has rules which differ from those permitted by 211 CMR 38.00 ~~(There may be more than one primary plan.);~~ or

(b) ~~(b)~~ all ~~plans~~Plans which cover the person use the order of benefit determination rules required by 211 CMR 38.00, and under those rules the ~~plan~~Plan determines its benefits first.

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~~Secondary Plan: a plan which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules of 211 CMR 38.00 decide the order in which their benefits are determined in relation to each other. The benefits of each secondary plan may take into consideration the benefits of the primary plan or plans and the benefits of any other plan which, under the rules of 211 CMR 38.00, has its benefits determined before those of that secondary plan.~~

~~Qualifying Student Health Insurance Programs ("QSHIPs"): student health programs established pursuant to St. 1988, c. 23, § 22 and complying with guidelines or regulations issued by the Department of Medical Security.~~

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Secondary Plan, a Plan which is not a Primary Plan.

38.04: COB Contract ~~Provision~~Provisions

(1) Any ~~plan~~Plan which contains a ~~Coordination of Benefits~~COB provision must provide information to persons covered under the ~~plan~~Plan about its COB provision and the rules used to determine ~~primary and secondary coverage~~ whether it is a Primary Plan or Secondary Plan and to determine and calculate ~~allowable expense~~Allowable Expense.

(2) A COB provision may not be used that permits a Plan to reduce its benefits on the basis that:

(a) Another Plan exists and the covered person did not enroll in that Plan;

(b) A person is or could have been covered under another Plan, except with respect to Part B of Medicare; or

(c) A person has elected an option under another Plan providing a lower level of benefits than another option that could have been elected.

(3) No Plan may contain a COB provision that its benefits are "always excess" or "always secondary" except in accordance with the rules permitted by 211 CMR 38.00.

(4) 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 211 CMR 38.03.

38.05: Rules for Coordination of Benefits

(1) ~~(1)~~ When a person is covered by two (2) or more Plans, the rules for determining the order of benefit payments are as follows:

(a) The ~~primary plan~~Primary Plan must pay or provide its benefits as if the ~~secondary plan~~Secondary Plan or ~~plans~~Plans did not exist. ~~A plan that does not include a coordination of~~

(b) If the Primary Plan is a Closed Panel Plan and the Secondary Plan is not a Closed Panel Plan, the Secondary Plan shall pay or provide benefits ~~provision may not take the benefits of another plan into account~~as if it were the Primary Plan when ~~it determines~~a covered person uses the services of a health care provider that is not within the Primary Plan's Closed Panel provider network, except for emergency services or authorized referrals that are paid or provided by the Primary Plan.

(c) If the Primary Plan is not a Closed Panel Plan and the Secondary Plan is a Closed Panel Plan, and the covered person uses the services of a health care provider that is not within the Secondary Plan's provider network, then the Secondary Plan is not required to pay or provide benefits, except for emergency services or authorized referrals that are paid or provided by the Primary Plan.

(d) When multiple contracts providing coordinated coverage are treated as a single Plan under 211 CMR 38.00, this section applies only to the Plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the Plan, the carrier designated as primary within the Plan shall be responsible for the Plan's compliance with 211 CMR 38.00.

(e) If a person is covered by more than one Secondary Plan, the order of benefit determination rules of 211 CMR 38.00 decide the order in which Secondary Plans benefits are determined in relation to each other. Each Secondary Plan shall take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan, which, under the rules of 211 CMR 38.00, has its benefits~~. There is one exception: a contract holder's coverage that is~~ determined before those of that Secondary Plan.

(2) (a) Except as otherwise provided in 211 CMR 38.00, a Plan that does not contain order of benefit determination provisions that are consistent with 211 CMR 38.00 is always the Primary Plan unless the provisions of both Plans, regardless of the provisions of this paragraph, state that the complying Plan is primary.

(b) Coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the ~~plan~~Plan provided by the contract holder.

(3) ~~(2)~~ A ~~plan~~Plan may take the benefits ~~of~~ paid or provided by another ~~plan~~Plan into account

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only when, under ~~these~~the rules of 211 CMR 38.00, it is secondary to that other ~~plan~~Plan.

~~(3) The~~

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38.06: Order of Benefit Determination

Each Plan determines its order of benefits using the first of the ~~plan which~~following rules that applies:

(1) Medical Payments Coverage and PIP Coverage in Motor Vehicle Insurance Policies

(a) If a person who has a Health Benefit Plan and a motor vehicle insurance policy incurs expenses or requires services as a result of an accident with a motor vehicle:

i. Personal Injury Protection, as defined by M.G.L. c. 90, § 34A, shall always be primary and pay the first $2,000 of expenses as allowed under said statute. PIP shall thereafter be secondary to any such Health Benefit Plan(s) and shall coordinate with the Health Benefit Plan(s) pursuant to the rules set forth by M.G.L. c. 90, § 34A and M.G.L. c. 90, § 34M.

(b) Medical Payments Coverage under a motor vehicle insurance policy shall always be secondary to and in excess of any Health Benefit Plan or Personal Injury Protection, as defined under 211 CMR 38.00.

(2) Non-Dependent or Dependent

(a) Subject to the provisions of 211 CMR 38.06(2)(b), the Plan that covers the person other than as a dependent - for example, as an employee, member ~~or~~, subscriber (that is, other than as a dependent~~) are determined before those of the plan which~~), Policyholder or retiree - is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan.

(b) ~~(4) If two or more plans cover~~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:

a. Secondary to the Plan covering the person as dependent; and

b. Primary to the Plan covering the person as other than a dependent (*e.g.*, retired employee),

ii. Then the order of benefits is reversed so that the Plan covering the person as an employee, member, subscriber, policyholder or retiree is the Secondary Plan and the other Plan covering the person as a dependent is the Primary Plan.

(3) 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) If two or more Plans cover a dependent child whose parents are married or are living together, whether or not ~~separated or divorced, the order of payment is:~~they have ever been married, then,:

i. ~~(a)~~ The ~~benefits of the plan~~Plan of the parent whose ~~birthday~~Birthday falls earlier in ~~a~~the calendar year ~~are determined before those of the plan of the parent whose birthday falls later in that year.~~is the Primary Plan;

ii. ~~(b)~~ If both parents have the same ~~birthday~~Birthday, the ~~benefits of the plan which~~Plan that has covered the parent ~~longer~~ the longest is the Primary Plan.

(b) For a dependent child whose parents are divorced or separated or are ~~determined before those of the plan which covered the parent for a shorter period of time.~~not living together, whether or not they have ever been married:

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

~~(d) If the other plan does not have the rule described 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 birthday rule will determine the order of benefits.~~

~~(5) (a) If two or more plans cover a dependent child whose parents are divorced or separated, the order of payment is:~~

~~1. the plan of the parent with custody of the child;~~

~~2. the plan of the spouse of the parent with the custody of the child; and~~

~~3. the plan of the parent not having custody of the child.~~

~~(b)~~

i. If the specific terms of a court decree state that one of the parents is responsible for the dependent child's health care expenses ~~of the child, and the entity obligated to pay or provide the benefits of the plan~~or health care coverage and the Plan of that parent has actual knowledge of those terms, ~~the benefits of that plan are determined first. 211 CMR 38.05(5)(b)~~that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care

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expenses, but that parent's spouse does, that parent's spouse's Plan is the Primary Plan. This subsection 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 the actual knowledge~~.~~ of the court decree provisions;

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ii. ~~(c)~~ 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 211 CMR 38.06(3)(a) shall determine the order of benefits;

iii. 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 or health care coverage of the dependent child, the ~~plans covering the child~~provisions of 211 CMR 38.06(3)(a) shall ~~follow~~determine the order of ~~benefit determination rules outlined in 211 CMR 38.05(4).~~benefits; or

iv. ~~(6)~~ 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 ~~benefits of~~Plan covering the Custodial Parent;

II. The Plan covering the Custodial Parent's spouse;

III. The Plan covering the non-Custodial Parent; and then

IV. The Plan covering the non-Custodial 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 211 CMR 38.06(3)(a) or (b) as if those individuals were parents of the child.

(d) i. For a dependent child who has coverage under either or both parents' Plans and also has his or her own coverage as a dependent under a spouse's Plan, the rule in 211 CMR 38.06(6) applies.

ii. In the event the dependent child's coverage under the spouse's plan ~~which~~ began on the same date as the dependent child's coverage under either or both parents' Plans, the order of benefits shall be determined by applying the birthday rule in 211 CMR 38.06(3)(a) to the dependent child's parent(s) and the dependent's spouse.

(4) 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 ~~that employee's~~ a dependent~~) are determined before those~~ of ~~a plan which covers that~~an active employee is the Primary Plan. The Plan covering that same person as a laid-off or retired employee ~~(~~or as ~~that employee's~~a dependent~~).~~ of a laid-off or retired employee is the Secondary Plan.

(b) If the other ~~plan~~Plan does not have this rule, and if, as a result, the ~~plans~~Plans do not agree on the order of benefits, this rule is ignored.

(c)~~(7)~~ This rule does not apply if the rule in 211 CMR 38.06(2) can determine the order of benefits.

(5) 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.

(c) This rule does not apply if the rule in 211 CMR 38.06(2) can determine the order of benefits.

(6) Longer or Shorter Length of Coverage

(a) If none of the above rules determines the order of benefits, the ~~benefits of the plan which~~Plan that covered ~~a~~the person for a longer ~~are determined before those~~period of time is the ~~plan which~~Primary Plan and the Plan that covered ~~a~~the person for the shorter ~~term~~period of time is the Secondary Plan.

(b) ~~(a)~~ To determine the length of time a person has been covered under a ~~plan~~Plan, two ~~plans~~successive Plans shall be treated as one if the ~~claimant~~covered person was eligible under the second Plan within 24 hours after coverage under the first Plan ended.

(c) ~~(b)~~ The start of a new ~~plan~~Plan does not include:

i. ~~1. a~~A change in the amount or scope of a ~~plan's~~Plan's benefits;

ii. ~~2. a~~A change in the entity which pays, provides or administers the ~~plan's~~Plan's benefits;

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

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

~~38.06: Prohibited Coordination and Benefit Design~~

~~(1) A group contract may not reduce benefits on the basis that:~~
~~(a) another plan exists;~~
~~(b) a person is or could have been covered under another plan;~~
~~(c) a person has elected an option under another plan providing a lower level of benefits than another option which could have been elected; or~~
~~(d) a person did not follow a provision found in a primary plan.~~

~~(2) No contract may contain a provision that its benefits are "excess" or "always secondary" to any plan as defined in 211 CMR 38.00, except in accord with the rules permitted by 211 CMR 38.00.~~

(7) If none of the preceding rules determines the order of benefits, the Allowable Expenses shall be shared equally between the Plans.

38.07: Procedure to be Followed by Secondary Plan to Calculate Benefits and Pay a Claim

(1) ~~A secondary plan~~ 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 ~~benefits~~payments by an amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the Claim do not exceed 100 percent of the total Allowable Expenses for the Claim. In addition, the Secondary Plan shall credit toward its Plan deductible the amounts it would have credited to its deductible in the absence of other health care coverage.

38.08: ~~plans during a claim determination period~~Notice to Covered Persons

A Plan shall, in its explanation of benefits provided to covered persons, include the following language: "If you are ~~not~~covered by 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, which were incurred during the claim determination period by the person for whom the~~ one health benefit plan, you should file all your claims ~~are made. As~~with each ~~claim is submitted, the secondary plan determines its obligation to pay for allowable expenses based on all claims which were submitted up to that point in time during the claim determination period.~~plan."

~~(2) The benefits of the secondary plan will be reduced when the sum of the benefits that would be payable for the allowable expenses under the secondary plan in the absence of 211 CMR 38.07 and the benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of 211 CMR 38.07, whether or not claim is made, exceeds those allowable expenses in a claim determination period. In that case, the benefits of the secondary plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses.~~

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~~38.07: continued~~

~~(a) When the benefits of the secondary plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of the plan.~~
~~(b) 211 CMR 38.07(2)(a) may be omitted if the plan provides only one benefit or benefits in the form of services.~~

38.09:

~~38.08:~~ Miscellaneous Provisions

(1) ~~(1) A secondary plan which~~A Secondary Plan that provides benefits in the form of services may recover the reasonable value of the services from the ~~primary plan, subject~~Primary Plan, to the ~~provisions governing allowable expense~~extent that benefits for the services are covered by the Primary Plan and ~~claim determination period.~~have not already been paid or provided by the Primary Plan. Nothing in this provision shall be interpreted to require a ~~plan~~Plan to reimburse a covered person in cash for the value of services provided by a ~~plan~~Plan which provides benefits in the form of services.

(2)

~~(2) A plan which pays for or provides more benefits than it should have under 211 CMR 38.00 may recover the excess from one or more of:~~
~~(a) the person it has paid;~~
~~(b) insurance companies; or~~
~~(c) other organizations.~~

(a)~~(3) A plan~~ A Plan with order of benefit determination rules which comply with 211 CMR 38.00 ("complying plan") may coordinate its benefits with a ~~plan~~Plan which is "excess" or "always secondary" or which uses order of benefit determination rules which are inconsistent with those contained in 211 CMR 38.00 ("~~noncomplying~~non-complying plan") on the following basis:

i. ~~(a) if~~If the complying plan is the ~~primary plan~~Primary Plan, it shall pay or provide its benefits ~~on a primary basis~~first;

ii. ~~(b) if~~ If the complying plan is the ~~secondary plan~~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.~~Secondary Plan. In such a situation, such payment shall be the limit of the complying plan's liability; and

iii. ~~(c) if~~If the ~~noncomplying~~non-complying 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 ~~non~~complying~~non-complying~~ plan are identical to its own, and shall pay its benefits accordingly. ~~However~~If, within two (2) years of payment, the complying plan ~~must adjust any payments it makes based on such assumption whenever~~receives information ~~becomes available~~ as to the actual benefits of the ~~noncomplying~~non-complying plan, it shall adjust payments accordingly.

(b) If the non-complying plan reduces its 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 non-complying 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.

(c) 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 shall be subrogated to all rights of the covered person against the non-complying plan. The advance by the complying plan shall also be without prejudice to any Claim it may have against a non-complying plan in the absence of subrogation.

(3) COB differs from subrogation. Provisions for one may be included in health care benefits contracts without compelling the inclusion or exclusion of the other.

(4) If the Plans cannot agree on the order of benefits within thirty (30) calendar days after the Plans have received all of the information needed to pay the Claim, the Plans shall immediately pay the Claim in equal shares and determine their relative liabilities following payment, except that no Plan shall be required to pay more than it would have paid had it been the Primary Plan.

38.~~09~~10: Effective Date

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211 CMR 38.00 is applicable to any plan contract covering residents of the Commonwealth which is issued or renewed within or without the Commonwealth on or after the effective date of 211 CMR 38.00.

(1) A ~~plan~~Plan contract ~~which~~that provides health care benefits and that was issued before the effective date of 211 CMR 38.00 shall be brought into compliance with 211 CMR 38.00 by the later of:

(a) ~~(1) the~~The next anniversary date or renewal date of the ~~group~~ contract; or

(b) ~~(2) the~~Twelve (12) months following the adoption of 211 CMR 38.00; or

(2) The expiration of any applicable collectively bargained contract pursuant to which it was written.

38.~~10~~11: Severability

If any provision of 211 CMR 38.00 or the applicability thereof to any person, entity or circumstance is held invalid by a court, the remainder of 211 CMR 38.00 or the applicability of such provision to other persons, entities or circumstances shall not be affected thereby.

REGULATORY AUTHORITY

211 CMR 38.00: M.G.L. chs. 175, 176A, 176B, 176C, 176D, 176E, 176F, 176G and 176I.

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