Ins 3.40 Coordination of benefits provisions in group and blanket disability insurance policies. (1) PURPOSE. (a) This section establishes authorized coordination of benefits provisions for group and blanket disability insurance policies pursuant to s. 631.23, Stats. It has been found that these clauses are necessary to provide certainty of meaning. Regulation of contract forms will be more effective, and litigation will be substantially reduced if there is uniformity regarding coordination of benefits provisions in health insurance policies.

(b) A Coordination of benefits (COB) provision as defined in sub. (3) (e) avoids claim payment delays be establishing an order in which Plans pay their claims and by providing the 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 this section, a Plan does not have to pay its benefits first.

(c) Coordinating health benefits has been found to be an effective tool in containing health care costs. However, minimum standards of protection and uniformity are needed to protect the insured's and the public's interest.

(2) SCOPE. This section applies to all group and blanket disability insurance policies subject to s. 631.01 (1), Stats., that provide 24-hour continuous coverage for medical or dental care, treatment or expenses due to either injury or sickness that contain a coordination of benefits provision, an "excess," "anti-duplication," "non-profit" or "other insurance" exclusion by whatever name designated under which benefits are reduced because of other insurance, other than an exclusion for expenses covered by worker's compensation, employer's liability insurance, or individual traditional automobile "fault" contracts. Except as permitted under s. 632.32 (4) (b), Stats., this section applies to the medical benefits provisions in an automobile "no fault" type or group or group-type "fault" policy. A policy subject to this section may reduce benefits because of medicare only to the extent permitted by federal law and shall comply with s. 632.755, Stats., when reducing benefits because of coverage by or eligibility for medical assistance.

(3) DEFINITIONS. In this section:

(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 by one or more Plans covering the person for whom the claim is made, except as provided in sub. (4).

(b) "Claim" means a request that benefits of a Plan be provided or paid. The benefits claimed may be in the form of any of the following:

1. Services, including supplies.

2. Payment for all or a portion of the expenses incurred.

3. A combination of subds. 1 and 2.

4. Indemnification.

(c) "Claim determination period" means the period of time over which allowable expenses are compared with total benefits payable in the absence of COB to determine whether overinsurance exists and how much

each Plan will pay or provide. However, it does include any part of a year before the date this COB provision or a similar provision takes effect.

(d) "Complying Plan" means a Plan with order of benefit determination rules which comply with this section.

(e) A "Coordination of benefits (COB) provision" means an insurance contract provision intended to avoid claims payment delays and duplication of benefits when a person is covered by 2, or more plans providing benefits or services for medical, dental or other care or treatment.

(f) "Group-type contracts" means contracts which are not available to the general public and may 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 issuing group-type plans 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 employe, subcriber or member to pay for the coverage is not sufficient, of itself, to make an individual contract part of a group-type plan. Group-type contracts do not include individually underwritten and issued, guaranteed renewable policies that may be purchased through payroll deduction at a premium savings to the insured.

(g) "Hospital indemnity benefits" means benefits for hospital confinement which are not related to expenses incurred but does not include plans that reimburse a person for actual hospital expenses incurred even if the plans are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

(h) "Noncomplying Plan" means a Plan that declares its benefits to be "excess" or "always secondary" or that uses order of benefit determination rules inconsistent with those contained in this section.

(i) "Plan" means a form of coverage providing benefits for medical or dental care, except as limited under sub. (6), with which coordination is allowed.

(j) "Primary Plan" means a health care plan, determined by the order of benefit determination rules, whose benefits shall be determined before those of the other Plan and without taking the existence of any other Plan into consideration.

(k) "Secondary Plan" means a plan which is not a Primary Plan according to the order of benefit determination rules and whose benefits are determined after those of another Plan and may be reduced because of the other plan's benefits.

(l) "This Plan" means the part of the group contract that provides the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other Plans. Any other part of the group contract providing health care benefits is separate from This Plan.

(4) ALLOWABLE EXPENSE USES AND LIMITATIONS. (a) Items of expense under dental care, vision care, prescription drug or hearing aid programs may be excluded from the definition of allowable expense. A Plan which

provides benefits only for these items may limit its definition of allowable expense to these items of expense.

(b) When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be considered as both an allowable expense and a benefit paid.

(c) The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an allowable expense under the above definition unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice or as specifically defined in the Plan.

(d) 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 include the corresponding expenses or services to which COB applies.

(5) CLAIM DETERMINATION PERIOD USES AND LIMITATIONS. (a) A claim determination period may not be less than 12 months and 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.

(b) As each claim is submitted, each Plan shall determine its liability and pay or provide benefits based upon allowable expenses incurred to that point in the claim determination period. However, that determination is subject to adjustment as later allowable expenses are incurred in the same claim determination period.

(6) PLAN USES, LIMITATIONS AND VARIATIONS. (a) The definition of Plan in the group contract shall state the types of coverage which shall be considered in applying the COB provision of that contract. The right to include a type of coverage is limited by the rest of this subsection.

(b) The definition of Plan shown in the model COB provision in APPENDIX A is an example of what may be used. Any definition that satisfies sub. (3) (i) and this subsection may be used.

(c) Notwithstanding the fact that this section uses the term "Plan," a group contract may instead use "Program" or some other term.

(d) "Plan" shall not include individual or family insurance or subscriber contracts or individual or family coverage through health maintenance organizations (HMOs), limited service health organizations (LSHOs), or any other prepayment, group practice or individual practice plan except as provided in pars. (e) and (f).

(e) "Plan" may include: group insurance and group subscriber contracts; uninsured arrangements of group or group-type coverage; group or group-type coverage through HMOs, LSHOs and other prepayment, group practice and individual practice plans; and group-type contracts.

(f) "Plan" may include the medical benefits coverage in group, group-type, and individual automobile "no-fault" contracts; but, as to the traditional automobile "fault" contracts, only the medical benefits written on a group or group-type basis may be included.

(g) If "Plan" includes 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 (Title XIX, Grants to State for Medical Assistance Programs, of the United States Social Security Act as amended from time to time) and shall not include a law or plan whose benefits, by law, are excess to those of any private insurance plan or other non-government plan.

(h) "Plan" shall not include group or group-type hospital indemnity benefits of $100 per day or less but may include the amount by which group or group-type hospital indemnity benefits exceed $100 per day.

(i) "Plan" shall not include 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.

(j) Each contract or other arrangement for coverage is a separate Plan. If an arrangement has 2 parts and COB rules apply only to one of the 2, each of the parts is a separate Plan.

(7) PRIMARY PLAN AND SECONDARY PLAN USES AND LIMITATIONS. (a) The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person.

(b) There may be more than one Primary Plan. A Plan is a Primary Plan if either subd. 1 or 2 is true:

1. The Plan either has no order of benefit determination rules, or it has rules that differ from sub. (11).

2. All plans that cover the person are complying plans and, under sub. (11), the Plan determines its benefits first.

(c) When there are more than 2 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) If a person is covered by more than one Secondary Plan, the order of benefit determination rules of this section decide the order in which the benefits are determined in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under the rules of this section, has its benefits determined before those of that Secondary Plan.

(8) APPLICABILITY. (a) This coordination of benefits (COB) provision applies to This Plan when an employe or the employe's covered dependent has health care coverage under more than one Plan.

(b) If this COB provision applies, the order of benefit determination rules shall be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan.

(c) The benefits of This Plan shall not be reduced when, under the order of benefit determination rules, This Plan is primary and determines its benefits before another Plan.

(d) The benefits of This Plan may be reduced when, under the order of benefit determination rules, another Plan determines its benefits first.

(9) FLEXIBILITY AND CONSISTENCY WITH THIS SECTION. (a) APPENDIX A shall be considered authorized clauses pursuant to s. 631.23, Stats., for use in policy forms subject to this section and shall only be changed as provided in this section.

(b) This section permits but does not require the use of COB or "other insurance" provisions. However, if such provisions are used, they must conform with this section and substantially conform to the clauses contained in APPENDIX A. Liberalization of the prescribed language in APPENDIX A, including rearrangement of the order of the clauses, is permitted provided that the modified language is not less favorable to the insured person.

(c) Policy language which reduces benefits because of other insurance and which is inconsistent with this section violates the criteria of s. 631.20, Stats., and shall not be used.

(d) A Plan that includes a COB provision inconsistent with this section shall not take the benefits of another Plan 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.

(e) A group contract's COB provision does not have to use the words and format contained in APPENDIX A. 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 this section.

(f) A term such as "usual and customary," "usual and prevailing," or "reasonable and customary" may be substituted for the term "necessary, reasonable and customary". Terms such as "medical care" or "dental care" may be substituted for "health care" to describe the coverages to which the COB provisions apply.

(g) A group contract may apply one COB provision to certain of its benefits (such as dental benefits), coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.

(10) PROHIBITED COORDINATION AND BENEFIT DESIGN. (a) A group contract shall not reduce benefits on the basis that:

1. Another Plan exists;

2. Except with respect to Part B of Medicare, that a person is or could have been covered under another Plan; or

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

(b) No contract shall contain a provision that its benefits are "excess" or "always secondary" to any Plan defined in sub. (3) (i), except as permitted under this section.

(11) ORDER OF BENEFIT DETERMINATION RULES. (a) 1. The Primary Plan shall pay or provide its benefits as if the Secondary Plan or Plans did not exist.

2. A Secondary Plan may take the benefits of another Plan into account only when, under the rules in par. (b), it is secondary to that other Plan.

(b) When there is a basis for a claim under This Plan and another Plan, This Plan determines its order of benefits using the first of the following rules which applies:

1. No rule in another plan. If the other Plan does not have rules coordinating its benefits with those of This Plan, the benefits of the other Plan are determined first.

2. Non-dependent or dependent. The benefits of the Plan that covers the person as an employe, member or subscriber are determined before those of the Plan that covers the person as a dependent of an employe, member or subscriber.

3. Dependent child-parents not separated or divorced. Except as stated in subpar. c., 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.

c. However, if the other Plan does not have the rule described in subpar. a., 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 shall determine the order of benefits.

d. In this subdivision, the word "birthday" refers only to month and day in a calendar year, not the year in which the person was born.

4. Dependent child-separated or divorced parents. If 2 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

c. Finally, the Plan of the parent not having custody of the child.

d. 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 the Plan of the responsible parent are determined first. This subparagraph 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.

e. If the specific terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility for the child's health care expenses or if the court decree states that both parents shall be responsible for the health care needs of the child but gives physical custody of the child to one parent, and the entities obligated to pay or provide the benefits of the respective parents' Plans have actual knowledge of those terms, benefits for the dependent child shall be determined according to subd. 3.

5. Active or inactive employe. The benefits of a Plan which covers a person as an employe who is neither laid off or retired, or as that employe's dependent, are determined before those of a Plan which covers that person as a laid off or retired employe, or as that employe's dependent. If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

5m. Continuation coverage. a. If a person has continuation coverage under federal law or s. 632.897 (3) (a), Stats., and is also covered under another Plan, the following shall determine the order of benefits:

i. First, the benefits of a Plan covering the person as an employe, member or subscriber or as a dependent of an employe, member or subscriber.

ii. Second, the benefits under the continuation coverage.

b. If the other Plan does not have the rule described in subpar. a. and if, as a result, the Plans do not agree on the order of benefits, this subdivision is ignored.

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 covered an employe, member or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

b. To determine the length of time a person has been covered under a Plan, 2 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:

1) A change in the amount or scope of a Plan's benefits;

2) A change in the entity which 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 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.

(c) If a dependent is a medicare beneficiary and if, under the social security act of 1965 as amended, medicare is secondary to the Plan covering the person as a dependent of an active employe, the federal medicare regulations shall supersede this subsection.

(12) PAYMENT AS A SECONDARY PLAN. (a) In accordance with order of benefit determination rules under sub. (11), when This Plan is a second-

ary Plan as to one or more other Plans, the benefits of This Plan may be reduced as provided in par. (b). The other Plan or Plans are referred to as "the other Plans" in par. (b).

(b) 1. The benefits of This Plan shall be reduced when the sum of the following exceeds the allowable expenses in a claim determination period:

a. The benefits that would be payable for the allowable expenses under This Plan in the absence of this COB provision, and

b. 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.

2. If subd. 1 applies, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not equal more than the total allowable expenses. When the benefits of This Plan are reduced as described, each benefit is reduced in proportion and is then charged against any applicable benefit limit of This Plan.

(c) If the benefits of This Plan are reduced under par. (b), a Secondary Plan may reduce its benefits so that the total benefits paid or provided by all Plans during a claim determination period are not more than the total allowable expenses. The amount by which the Secondary Plan's benefits are reduced shall be used by the Secondary Plan to pay allowable expenses not otherwise paid, which were incurred during the claim determination period by the person for whom the claim is made. As each claim is submitted, the Secondary Plan determines its obligation to pay for allowable expenses based on all claims which were submitted up to that point in time during the claim determination period.

(14) RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION. An insurer has the right to decide the facts it needs to apply the COB rules. It may get needed facts from or give them to any other organization or person without the consent of the insured but only as needed to apply the provisions of this section. This subsection does not relieve the insurer of the requirements of s. 146.82, Stats. Each person claiming benefits under This Plan shall give the insurer any facts it needs to pay the claim.

(15) 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 insurer responsible for payment 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 insurer will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

(16) RIGHT OF RECOVERY. If the amount of the payments made by the insurer responsible for payment, including the reasonable cash value of any benefits provided in the form of services, is more than it should have paid under a 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.

(17) REASONABLE CASH VALUE OF SERVICES. A Secondary Plan which provides benefits in the form of services may recover the reasonable cash value of providing the services from the Primary Plan, to the extent that benefits for the services are covered by the Primary Plan and have not already been paid or provided by the Primary Plan. Nothing in this provision shall be interpreted to require a Plan to reimburse a covered person in cash for the value of services provided by a Plan which provides benefits in the form of services.

(18) COORDINATION WITH NONCOMPLYING PLANS. Except for expenses covered by worker's compensation, employer's liability insurance, medicare, medical assistance, or traditional automobile "fault" contracts, a Complying Plan may coordinate its benefits with a Noncomplying Plan that may not be subject to insurance regulation 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 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, the payment shall be the limit of 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 assume that the benefits of the Noncomplying Plan are identical to its own and shall pay its benefits accordingly. However, the Complying Plan shall adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the Noncomplying Plan.

(d) The Complying Plan shall advance to or on behalf of the employe, subscriber, or member an amount equal to the difference if the Noncomplying Plan reduces its benefits so that the employe, 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.

(e) 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 employe, subscriber, or member against the Noncomplying Plan. Such advance by the Complying Plan shall also be without prejudice to any claim it may have against the Noncomplying Plan in the absence of such subrogation.

Note: In sub. (18) if the Noncomplying Plan is unwilling to provide the Complying Plan with the necessary information, the Complying Plan should assume the primary position in order to avoid undue claim delays and hardship to the insured. The Complying Plan may, through its subrogation rights, seek reimbursement for such payments. Undue delay in paying the claim may subject the Complying Plan to a violation of s. Ins 6.11.

(19) SUBROGATION. The COB concept differs from that of subrogation. Provision for one may be included in health care benefits contracts without compelling the inclusion or exclusion of the other.

Applicability. 1) Except as provided in 2), the treatment of s. Ins 3.40 (2), (12) and (13) by this October, 1991 rule revision first applies to a group contract providing health care benefits:

a) For group contracts that are issued or renewed on January 1, 1992, on the effective date of this rule.

b) For group contracts that are issued or renewed after January 1, 1992, on the date of issuance or the first anniversary or renewal date following the effective date of this rule.

2) If a group contract providing health care benefits is written pursuant to a collectively bargained agreement, the treatment of s. Ins 3.40 (2), (12) and (13) by this October, 1991 rule revision first applies on whichever of the following occurs later:

a) January 1, 1992.

b) The expiration date of the collectively bargained agreement pursuant to which the group contract was written if the agreement prohibits changes to the health care benefits prior to its expiration date.

History: Cr. Register, July, 1980, No. 295, eff. 9-1-80; am. (2), Register, Janaury, 1981, No. 301, eff. 2-1-81; r. and recr. (7) (d) and (e), r. (19) under s. 13.93 (2m) (b) 16, Stats., renum. (8) to (18) to be (9) to (19), am. (20), Register, July, 1985, No. 355, eff. 8-1-85; r. and recr. Register, December 1986, No. 372, eff. 1-1-87; am. (2), (6) (d) and (f), (18) (b) (intro.) and Appendix A, cr. (11) (b) 4. e., Register, August, 1989, No. 404, eff. 9-1-89; am. (2), (3) (b), (c) and (k), (6) (b) and (c), (7) (b), (11) (b) 2., (12) (a) and (b), (14) and Appendix A, r. (12) (b) (intro.), (c) and (d), (13) (b) to (f), (18) (a) and (20), cr. (11) (b) 5m., and (c), renum. (13) (a) and (18) (b) to be (12) (c) and (18) and am. (12) (c) and (18) (intro.), Register, October, 1991, No. 430, eff. 1-1-92.

INS 3.40 APPENDIX A

Model COB Provision

This appendix provides model COB provision language. The terms and conditions of all insurance contracts containing a COB provision must comply with Ins 3.40.

COORDINATION OF THE GROUP CONTRACT'S BENEFITS WITH OTHER BENEFITS

(I) APPLICABILITY.

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

(B) If this COB provision applies, the order of benefit determination rules shall be looked at first. The 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. This reduction is described in Section (IV) Effect on the Benefits of This Plan.

(II) DEFINITIONS.

(A) *"Allowable Expense"* means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense 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 shall be considered both an Allowable Expense and a benefit paid.

(B) *"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.

(C) *"Plan"* means any of the following 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, that includes continuous 24-hour coverage. 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 coverage that is 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 whose benefits, by law, are excess to those of any private insurance program or other non-governmental program.

Each contract or other arrangement for coverage under (i) or (ii) is a separate Plan. If an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

(D) *"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 Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

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 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.

(E) *"This Plan"* means the part of the group contract that provides benefits for health care expenses.

(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 described in subparagraph (B) 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) *Non-dependent/Dependent.* The benefits of the Plan which covers the person as an employee, member or subscriber are determined before those of the Plan which covers the person as a dependent of an employee, member or subscriber.

(ii) *Dependent Child/Parents Not Separated or Divorced.* Except as stated in subparagraph (B) (iii), 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 the calendar year are determined before those of the Plan of the parent whose birthday falls later in that calendar 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. 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 shall 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 the custody of the child; and

c. finally, the Plan of the parent not having custody of the child.

Also, if the specfic terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility for the child's health care expenses or if the court decree states that both parents shall be responsible for the health care needs of the child but gives physical custody of the child to one parent, and the entities obligated to pay or provide the benefits of the respective parents' Plans have actual knowledge of those terms, benefits for the dependent child shall be determined according to (III) (B) (ii).

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, this rule (iv) is ignored.

Note: If a dependent is a Medicare beneficiary and if, under the Social Security Act of 1965 as amended, Medicare is secondary to the plan covering the person as a dependent of an active employee, the federal Medicare regulations shall supersede this paragraph (iv).

(v) *Continuation coverage.* a. If a person has continuation coverage under federal or state law and is also covered under another plan, the following shall determine the order of benefits:

i. First, the benefits of a plan covering the person as an employee, member or subscriber or as a dependent of an employee, member or subscriber.

ii. Second, the benefits under the continuation coverage.

b. If the other plan does not have the rule described in subparagraph a., and if, as a result, the plans do not agree on the order of benefits, this paragraph (v) is ignored.

(vi) *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 (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).

(B) *Reduction in This Plan's Benefits.* The benefits of This Plan will be reduced when the sum of the following exceeds the Allowable Expenses in a Claim Determination Period:

(i) the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB 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 COB provision, whether or not claim is made. Under this provision, 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.

Note: The last paragraph may be omitted if the Plan provides only one benefit or may be altered to suit the coverage provided.

(V) RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

The [name of insurance company] has the right to decide the facts it needs to apply these COB rules. It may get needed facts from or give them to any other organization or person without the consent of the insured but only as needed to apply these COB rules. Medical records remain confidential as provided by state law. Each person claiming benefits under This Plan must give the [name of insurance 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 [name of insurance 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 [name of insurance company] will not have to pay that amount again. The term "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 [name of insurance company] 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.

Ins 3.41 Individual conversion policies. (1) REASONABLY SIMILAR COVERAGE. An insurer provides reasonably similar coverage under s. 632.897 (4), Stats., to a terminated insured as defined in s. 632.897 (1) (f), Stats., if a person is offered individual coverage substantially identical to the terminated coverage under the group policy or individual policy, or is offered his or her choice of the 3 plans described in s. Ins 3.42, or is offered a high limit comprehensive plan of benefits approved for the purpose of conversion by the commissioner as meeting the standards described in s. Ins 3.43. Individual conversion policies must include benefits required for individual disability insurance policies by subch. VI, ch. 632, Stats. This subsection does not apply to a long-term care policy as defined under s. Ins 3.46 (3) (e).

(2) RENEWABILITY. (a) Except as provided in par. (b), individual conversion policies shall be renewable at the option of the insured unless the insured fails to make timely payment of a required premium amount, there is over-insurance as provided by s. 632.897 (4) (d), Stats., or there was fraud or material misrepresentation in applying for any benefit under the policy.

(b) Conversion policies issued to a former spouse under s. 632.897 (9) (b), Stats., must include renewal provisions at least as favorable to the insured as did the previous coverage.

(3) PREMIUM RATES. (a) In determining the rates for the class of risks to be covered under individual conversion policies, the premium and loss experience of policies issued to meet the requirements of s. 632.897 (4), Stats., may be considered in determining the table of premium rates applicable to the age and class of risks of each person to be covered under the policy and to the type and amount of coverage provided.

(b) Except as provided in par. (c), conditions pertaining to health shall not be an acceptable basis for classification of risks.

(c) A conversion policy issued to a former spouse under s. 632.897 (9) (b), Stats., may be rated on the basis of a health condition if a similar rating had been previously applied to the prior individual coverage due to the same condition.

History: Cr. Register, April, 1981, No. 304, eff. 5-1-81; am. (1), Register, April, 1991, No. 424, eff. 6-1-91.

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