TITLE 760 DEPARTMENT OF INSURANCE

Final Rule
LSA Document #05-265(F)

DIGEST

Amends 760 IAC 1-38.1 regarding definitions, order of benefits, terms of policies, medical expenses, and to update the rule consistent with the most recent model adopted by the National Association of Insurance Commissioners. Effective 30 days after filing with the Publisher.

760 IAC 1-38.1-2; 760 IAC 1-38.1-2.5; 760 IAC 1-38.1-3; 760 IAC 1-38.1-4; 760 IAC 1-38.1-4.3; 760 IAC 1-38.1-4.7; 760 IAC 1-38.1-5; 760 IAC 1-38.1-5.2; 760 IAC 1-38.1-5.6; 760 IAC 1-38.1-5.8; 760 IAC 1-38.1-7; 760 IAC 1-38.1-7.5; 760 IAC 1-38.1-8; 760 IAC 1-38.1-9; 760 IAC 1-38.1-10; 760 IAC 1-38.1-11; 760 IAC 1-38.1-12; 760 IAC 1-38.1-13; 760 IAC 1-38.1-14; 760 IAC 1-38.1-15; 760 IAC 1-38.1-15.5; 760 IAC 1-38.1-16; 760 IAC 1-38.1-17; 760 IAC 1-38.1-19; 760 IAC 1-38.1-20; 760 IAC 1-38.1-21.2; 760 IAC 1-38.1-21.6

SECTION 1. 760 IAC 1-38.1-2 IS AMENDED TO READ AS FOLLOWS:

760 IAC 1-38.1-2 "Allowable expenses" defined

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 2. (a) As used in this rule, "allowable expenses" means ~~the necessary, reasonable, and customary item of expense for~~ **any** health care ~~when the item of~~ expense, **including:**

(1) coinsurance or copayments; and

(2) without reduction for any applicable deductible;

that is covered at least in part under any of the plans ~~involved,~~ **covering the person,** except where a statute requires a different definition.

(b) If:

(1) a plan is advised by a covered person that all plans covering the person are high-deductible health plans; and

(2) 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.

(c) An expense or a portion of an expense that is not covered by any of the plans is not an allowable expense.

(d) Any expense that a provider:

(1) by law; or

(2) in accordance with a contractual agreement;

is prohibited from charging a covered person is not an allowable expense.

~~(b)~~ **(e)** Notwithstanding subsection (a), items of expense under coverages, such as dental care, vision care, prescription drug, or hearing aid programs, may be excluded from the definition of allowable expense. A plan ~~which provides~~ **that limits the application of coordination of** benefits ~~only for any such items of expense~~ **to certain coverages or benefits** may limit ~~its~~ definition of allowable **in its contract to** expenses **that are similar to the expenses that it provides. When coordination of benefits is restricted** to ~~like items~~ **specific coverages or benefits in a contract, the definition** of **allowable expense shall include similar** expense **to which coordination of benefits applies.**

~~(c)~~ **(f)** When a plan provides benefits in the form of service, the reasonable cash value of each service will be considered as both **of the following:**

(1) An allowable expense. ~~and~~
(2) A benefit paid.

~~(d)~~ **(g)** The difference between the cost of a:
(1) private hospital room; and ~~the cost of a~~
(2) semiprivate room;
is not considered an allowable expense under subsection (a) unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice.

~~(e) When coordination of benefits is restricted in its use to specific coverage in a contract, for example, major medical or dental, the definition of "allowable expense" must include the corresponding expenses or services to which coordination of benefits applies.~~

~~(f)~~ **(h)** When benefits are reduced under a primary plan because a covered person does not comply with the plan provisions ~~the amount of such reduction will not be considered an allowable expense. Examples of such provisions are those~~ related to:
(1) second surgical opinions;
(2) precertification of admissions or services; and
(3) preferred provider arrangements;
the amount of the reduction will not be considered an allowable expense.

~~(g) Only benefit reductions based upon provisions similar in purpose to those described in subsection (f) and which are contained in the primary plan may be excluded from allowable expenses. The provisions of subsection (f) shall not be used by a secondary plan to refuse to pay benefits because a health maintenance organization (HMO) member has elected to have health care services provided by a nonHMO provider and the HMO, pursuant to its contract, is not obligated to pay for providing those services.~~

(i) If a person is covered as follows by two (2) or more plans that:
(1) Compute their benefits payments on the basis of:
(A) usual and customary fees;
(B) relative value schedule reimbursement; or
(C) other similar reimbursement methodology;
any amount charged by the provider in excess of the highest reimbursement amount for a specified benefit is not an allowable expense.
(2) Provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.

(j) If a person is covered by:
(1) one (1) plan that calculates its benefits or services on the basis of:
(A) usual and customary fees;
(B) relative value schedule reimbursement; or
(C) other similar reimbursement methodology; and
(2) another plan that provides its benefits or services on the basis of negotiated fees;
the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, that negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

(Department of Insurance; 760 IAC 1-38.1-2; filed Feb 14, 1990, 3:30 p.m.: 13 IR 1169; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Sep 15, 2006, 2:02 p.m.: 20061011-IR-760050265FRA)

SECTION 2. 760 IAC 1-38.1-2.5 IS ADDED TO READ AS FOLLOWS:

760 IAC 1-38.1-2.5 "Birthday" defined

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 2.5. As used in this rule, "birthday" refers only to the month and day in a calendar year. The term does not include the year in which the individual is born.

(Department of Insurance; 760 IAC 1-38.1-2.5; filed Sep 15, 2006, 2:02 p.m.: 20061011-IR-760050265FRA)

SECTION 3. 760 IAC 1-38.1-3 IS AMENDED TO READ AS FOLLOWS:

760 IAC 1-38.1-3 "Claim" defined

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 3. As used in this rule, "claim" means a request that benefits of a plan be provided or paid. A claim may be for **any of the following:**

(1) Services (including supplies).
(2) Payment for all or a portion of the expenses incurred.
(3) A combination of subdivisions (1) ~~through~~ **and** (2). ~~or~~
(4) An indemnification.

(Department of Insurance; 760 IAC 1-38.1-3; filed Feb 14, 1990, 3:30 p.m.: 13 IR 1170; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Sep 15, 2006, 2:02 p.m.: 20061011-IR-760050265FRA)

SECTION 4. 760 IAC 1-38.1-4.3 IS ADDED TO READ AS FOLLOWS:

760 IAC 1-38.1-4.3 "Closed panel plan" defined

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 4.3. As used in this rule, "closed panel plan" means a plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have been contracted with or are employed by the plan. The term excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

(Department of Insurance; 760 IAC 1-38.1-4.3; filed Sep 15, 2006, 2:02 p.m.: 20061011-IR-760050265FRA)

SECTION 5. 760 IAC 1-38.1-4.7 IS ADDED TO READ AS FOLLOWS:

760 IAC 1-38.1-4.7 "Consolidated Omnibus Budget Reconciliation Act of 1985" or "COBRA" defined

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 4.7. As used in this rule, "Consolidated Omnibus Budget Reconciliation Act of 1985" or "COBRA" means coverage provided under a right of continuation pursuant to federal law.

(Department of Insurance; 760 IAC 1-38.1-4.7; filed Sep 15, 2006, 2:02 p.m.: 20061011-IR-760050265FRA)

SECTION 6. 760 IAC 1-38.1-5 IS AMENDED TO READ AS FOLLOWS:

760 IAC 1-38.1-5 "Coordination of benefits" or "COB" defined

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 5. As used in this rule, "coordination of benefits" **or "COB"** means a provision:
(1) establishing an order in which plans pay their claims; **and**
(2) permitting secondary plans to reduce their benefits so that the combined benefits do not exceed the total allowable expenses.

(Department of Insurance; 760 IAC 1-38.1-5; filed Feb 14, 1990, 3:30 p.m.: 13 IR 1170; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Sep 15, 2006, 2:02 p.m.: 20061011-IR-760050265FRA)

SECTION 7. 760 IAC 1-38.1-5.2 IS ADDED TO READ AS FOLLOWS:

760 IAC 1-38.1-5.2 "Custodial parent" defined

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 5.2. As used in this rule, "custodial parent" means:
(1) the parent awarded custody of a child for more than one-half (½) of the calendar year by a court decree; or
(2) in the absence of a court decree, the parent with whom the child resides more than one-half (½) of the calendar year without regard to any temporary visitation.

(Department of Insurance; 760 IAC 1-38.1-5.2; filed Sep 15, 2006, 2:02 p.m.: 20061011-IR-760050265FRA)

SECTION 8. 760 IAC 1-38.1-5.6 IS ADDED TO READ AS FOLLOWS:

760 IAC 1-38.1-5.6 "Group-type contract" defined

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 5.6. As used in this rule, "group-type contract" means a contract that is:
(1) not available to the general public; and
(2) obtained and maintained only because of:
(A) membership in; or
(B) a connection with;
a particular organization or group, including blanket coverage.
The term does not include any 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.

(Department of Insurance; 760 IAC 1-38.1-5.6; filed Sep 15, 2006, 2:02 p.m.: 20061011-IR-760050265FRA)

SECTION 9. 760 IAC 1-38.1-5.8 IS ADDED TO READ AS FOLLOWS:

760 IAC 1-38.1-5.8 "High-deductible health plan" defined

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 5.8. As used in this rule, "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.

(Department of Insurance; 760 IAC 1-38.1-5.8; filed Sep 15, 2006, 2:02 p.m.: 20061011-IR-760050265FRA)

SECTION 10. 760 IAC 1-38.1-7 IS AMENDED TO READ AS FOLLOWS:

760 IAC 1-38.1-7 "Plan" defined

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 7. (a) As used in this rule, "plan" means a form of coverage with which coordination is allowed. **Separate parts of a plan for members of a group that are:**

(1) provided through alternative contracts; and

(2) intended to be part of a coordinated package of benefits;

are considered one (1) plan, and there is no COB among the separate parts of the plan. If a plan coordinates benefits, the definition of plan in the group contract must state the types of coverage ~~which~~ **that** will be considered in applying the coordination of benefits provision of that contract. The right to include a type of coverage is limited by subsections (b) through (d).

(b) This rule uses the term "plan". However, a group contract may instead use "program" or some other term.

(c) A plan may include the following:

(1) Group **and nongroup** insurance **contracts** and ~~group~~ subscriber contracts.

(2) Uninsured arrangements of group or group-type coverage.

(3) Group or ~~group-type~~ **nongroup** coverage through ~~health maintenance organizations (HMOs) and other prepayment, group practice, and individual practice~~ **closed panel** plans.

(4) Group-type contracts. ~~which are contracts not available to the general public and which can be obtained and maintained only because of membership in or connection with a particular organization or group. Group-type contracts answering this description may be included in the definition of plan, at the option of the insurer or the service provider and the contract client whether or not uninsured arrangements or individual contract forms are used and regardless of how the group-type coverage is designated, for example, "franchise" or "blanket". Individually underwritten and issued guaranteed renewable policies would not be considered "group-type" even though purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.~~

(5) The ~~amount by which group or group-type hospital indemnity benefits exceed one hundred dollars ($100) per day.~~ **medical care components of long term care contracts, such as skilled nursing care.**

(6) The medical benefits coverage in: ~~group, group-type, and individual~~

(A) automobile "no fault"; and

(B) traditional automobile "fault";

type contracts.

(7) Medicare or other governmental benefits, except as provided in subsection (d)(7). That part of the definition of plan may be limited to the hospital, medical, and surgical benefits of the governmental program.

(d) A plan shall not include the following:

(1) ~~Individual or family insurance contracts.~~ **Accident only coverage.**

(2) ~~Individual~~ **Specified disease** or ~~family subscriber contracts.~~ **specified accident coverage.**

(3) ~~Individual or family~~ **Limited health benefit** coverage. ~~through health maintenance organizations.~~

(4) ~~Individual or family coverage under other prepayment, group practice, and individual practice plans~~ **Benefits provided in long term care insurance policies for either of the following:**

(A) Nonmedical services, such as the following:

(i) Personal care.

(ii) Adult day care.

(iii) Homemaker services.

(iv) Assistance with activities of daily living.

(v) Respite care and custodial care.

(B) Contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services.

(5) ~~Group or group-type~~ Hospital indemnity **coverage** benefits ~~of one hundred dollars ($100) per day~~ or ~~less.~~ **other fixed indemnity coverage.**

(6) School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a:

(A) twenty-four (24) hour; ~~basis~~ or ~~on a~~

(B) "to and from school";
basis.
(7) A state plan under Medicaid ~~and shall not include a law~~ or **a government** plan ~~when,~~ **that,** by law, ~~its~~ **provides** benefits **that** are in excess of those of any:
(A) private insurance plan; or
(B) other nongovernmental plan.
(8) Medicare supplement policies.

(Department of Insurance; 760 IAC 1-38.1-7; filed Feb 14, 1990, 3:30 p.m.: 13 IR 1170; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Sep 15, 2006, 2:02 p.m.: 20061011-IR-760050265FRA)

SECTION 11. 760 IAC 1-38.1-7.5 IS ADDED TO READ AS FOLLOWS:

760 IAC 1-38.1-7.5 "Policyholder" defined

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 7.5. As used in this rule, "policyholder" means the primary insured named in a nongroup insurance policy.

(Department of Insurance; 760 IAC 1-38.1-7.5; filed Sep 15, 2006, 2:02 p.m.: 20061011-IR-760050265FRA)

SECTION 12. 760 IAC 1-38.1-8 IS AMENDED TO READ AS FOLLOWS:

760 IAC 1-38.1-8 "Primary plan" defined

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 8. As used in this rule, "primary plan" means a plan whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration. A plan is a primary plan if either of the following conditions are true:
(1) The plan either has:
(A) no order of benefit determination rules; or ~~it has~~
(B) rules ~~which~~ **that** differ from those permitted by this rule. ~~There may be more than one (1) primary plan.~~
(2) All plans ~~which~~ **that** cover the person use the order of benefit determination provisions of this rule, and under this rule the plan determines its benefits first.

(Department of Insurance; 760 IAC 1-38.1-8; filed Feb 14, 1990, 3:30 p.m.: 13 IR 1171; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Sep 15, 2006, 2:02 p.m.: 20061011-IR-760050265FRA)

SECTION 13. 760 IAC 1-38.1-9 IS AMENDED TO READ AS FOLLOWS:

760 IAC 1-38.1-9 "Secondary plan" defined

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 9. As used in this rule, "secondary plan" means a plan ~~which~~ **that** is not a primary plan. ~~If a person is covered by more than one (1) secondary plan, the order of benefit determination rules 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 these rules, has its benefits determined before those of that secondary plan.~~

(Department of Insurance; 760 IAC 1-38.1-9; filed Feb 14, 1990, 3:30 p.m.: 13 IR 1171; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Sep 15, 2006, 2:02 p.m.: 20061011-IR-760050265FRA)

SECTION 14. 760 IAC 1-38.1-11 IS AMENDED TO READ AS FOLLOWS:

760 IAC 1-38.1-11 Model coordination of benefits provision; prohibited coordination; benefit design

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 11. (a) A model coordination of benefits provision for use in group contracts, contained as Appendix A to the Group Coordination of Benefits Model Regulation as adopted and amended in ~~December, 1988,~~ **April 2005,** by the National Association of Insurance Commissioners (NAIC) (~~1989~~ **(2005** Proc. I), appearing in the NAIC Model Insurance Laws, Regulations and Guidelines, Vol. I, pages ~~120-9~~ **120-14** through ~~120-13,~~ **120-19,** is hereby adopted by reference, as if fully set out in this rule.

(b) A group contract's coordination of benefits provision does not have to use the words and format shown in the model provision adopted by reference in subsection (a). Changes may be made to:

(1) fit the language and style of the rest of the group contract; or ~~to~~

(2) reflect the difference among plans ~~which~~ **that:**

(A) provide services; ~~which~~

(B) pay benefits for expenses incurred; and ~~which~~

(C) indemnify.

No ~~other~~ substantive changes are allowed.

(c) A ~~group contract~~ **COB provision** may not **be used that permits a plan to** reduce **its** benefits on the basis that:

(1) another plan exists **and the covered person did not enroll in that plan; or**

(2) a person:

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

~~(3) a person~~ **(B)** has elected an option under another plan providing a lower level of benefits than another option ~~which~~ **that** could have been elected.

(d) No contract may contain a provision that its benefits are **"always** excess" or "always secondary" to any plan as defined in section 7 of this rule, except in compliance with ~~these rules.~~ **this rule.**

(e) Under the terms of a closed panel plan, benefits are not payable if the covered person does not use the services of a closed panel provider. In most instances, COB does not occur if a covered person:

(1) is enrolled in two (2) or more closed panel plans; and

(2) obtains services from a provider in one (1) of the closed panel plans because the other closed panel plan (the one (1) whose providers were not used) has no liability.

However, COB may occur during the plan year when the covered person receives emergency services that would have been covered by both plans. The secondary plan shall use the provisions of section 17 of this rule to determine the amount to pay for the benefit.

(f) 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 as defined by section 7 of this rule.

(Department of Insurance; 760 IAC 1-38.1-11; filed Feb 14, 1990, 3:30 p.m.: 13 IR 1172; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Sep 15, 2006, 2:02 p.m.: 20061011-IR-760050265FRA)

SECTION 15. 760 IAC 1-38.1-12 IS AMENDED TO READ AS FOLLOWS:

760 IAC 1-38.1-12 Order of benefits; general and nondependent/dependent

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 12. (a) **When a person is covered by two (2) or more plans,** the primary plan must pay or provide its benefits as if the secondary plan or plans did not exist. **The following apply:**

(1) If the:

(A) primary plan is a closed panel plan; and

(B) secondary plan is not a closed panel plan;

the secondary plan shall pay or provide benefits as if it were the primary plan when a covered person uses a nonpanel provider, except for emergency services or authorized referrals that are paid or provided by the primary plan.

(2) When multiple contracts providing coordinated coverage are treated as a single plan under this rule:

(A) this section applies only to the plan as a whole; and

(B) coordination among the component contracts is governed by the terms of the contracts.

If more than one (1) 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 this rule.

(3) If a person is covered by more than one (1) secondary plan, the order of benefits determination rules of this rule 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:

(A) the primary plan or plans; and

(B) any other plan that under the rules of this rule has its benefits determined before those of that secondary plan.

(b) A plan that does not include a coordination of benefits provision ~~may not take the benefits of another plan as defined in section 7 of~~ **consistent with** this rule ~~into account when it determines its benefits. One (1) exception is that a contract holder's~~ **is always the primary plan unless the provisions of both plans state that the complying plan is primary. However,** coverage ~~which~~ **that** is **obtained by virtue of membership in a group** 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. **The following are examples:**

(1) Major medical coverages that are superimposed over base plan hospital and surgical benefits.

(2) Insurance type coverages that are written in connection with a closed panel plan to provide out of network benefits.

~~(b)~~ **(c)** A ~~secondary~~ plan may take the benefits of another plan into account only when, under this rule, it is secondary to that other plan. **Each plan determines its order of benefits using the first of the rules in sections 12 through 16.5** *[this section and sections 13 through 15.5]* **of this rule.**

~~(c)~~ **(d)** The benefits of the plan ~~which~~ **that** covers the person as an employee, member, ~~or~~ subscriber, **policyholder, or retiree** (that is, other than as a dependent) are determined before those of the plan ~~which~~ **that** covers the person as a dependent. **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:**

(1) secondary to the plan covering the person as a dependent; and

(2) primary to the plan covering the person as other than a dependent, such as a retired employee; 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.

(Department of Insurance; 760 IAC 1-38.1-12; filed Feb 14, 1990, 3:30 p.m.: 13 IR 1172; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Sep 15, 2006, 2:02 p.m.: 20061011-IR-760050265FRA)

SECTION 16. 760 IAC 1-38.1-13 IS AMENDED TO READ AS FOLLOWS:

760 IAC 1-38.1-13 Order of benefits for dependent child/parents not separated or divorced

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 13. (a) **For a dependent child whose parents are:**

(1) married; or

(2) living together, whether or not they have ever married;

the benefits of the plan of the parent whose birthday falls earlier in a **calendar** year ~~are determined before those of~~ **is** *[sic., are]* the ~~plan of the parent whose birthday falls later in that year.~~ **primary.**

(b) If both parents have the same birthday, the ~~benefits of the~~ plan ~~which~~ **that has** covered the parent ~~longer are determined before those of~~ **longest is** the **primary** plan. ~~which covered the other parent for a shorter period of time.~~

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

~~(d) A group contract which includes coordination of benefits and which is issued or renewed, or which has an anniversary date on or after sixty (60) days after the effective date of this rule shall include the substance of the provision in subsections (a) through (c). Until that provision becomes effective, the group contract may instead contain wording such as: "Except as stated in 760 IAC 1-38.1-14, the benefits of a plan which covers a person as a dependent of a male are determined before those of a plan which covers the person as a dependent of a female.".~~

~~(e) If the other plan does not have the provisions described in subsections (a) through (c), but instead has a provision based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the provision based upon the gender of the parent will determine the order of benefits.~~

(Department of Insurance; 760 IAC 1-38.1-13; filed Feb 14, 1990, 3:30 p.m.: 13 IR 1172; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Sep 15, 2006, 2:02 p.m.: 20061011-IR-760050265FRA)

SECTION 17. 760 IAC 1-38.1-14 IS AMENDED TO READ AS FOLLOWS:

760 IAC 1-38.1-14 Order of benefits for dependent child/separated or divorced parents

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 14. (a) ~~If two (2) or more plans cover a person as~~ **For** a dependent child ~~of~~ **whose parents are** divorced or separated ~~parents,~~ **or do not live together, whether or not they have ever been married, this subsection applies:**

(1) 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 ~~determined in the following order:~~ **as follows:**

~~(1)~~ **(A)** The plan of the **custodial** parent. ~~with custody of the child.~~

~~(2)~~ **(B)** The plan of the spouse of the **custodial** parent. ~~with custody of the child.~~

~~(3)~~ **(C)** The plan of the **noncustodial** parent. ~~not having custody of the child.~~

(D) The plan of the spouse of the noncustodial parent.

~~(b)~~ **(2)** If the:

(A) specific terms of a court decree state that one (1) of the parents is responsible for the health care expenses of the child; and ~~the~~

(B) 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.~~ **is primary. If** the ~~plan of the other~~ parent ~~shall be~~ **with** the ~~secondary plan.~~ **responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan.** This 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 that actual knowledge.

~~(c)~~ **(3)** If the specific terms of a court decree state that ~~the parents shall share joint custody, without stating that one (1) of the~~ **both** parents ~~is~~ **are** responsible for the **dependent child's** health care expenses ~~of the child, the plans covering the child shall follow the order of benefit determination rules outline set forth in~~ **or health care coverage, the provisions of** section 13 of this rule **shall determine the order of benefits.**

(4) If a court decree states that the parents have joint custody without specifying that one (1) parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of section 13 of this rule shall determine the order of benefits.

(b) For a dependent child covered under more than one (1) plan of individuals who are not the parents of the child, the order of benefits shall be determined as applicable under section 13 of this rule as if those individuals were parents of the child.

(Department of Insurance; 760 IAC 1-38.1-14; filed Feb 14, 1990, 3:30 p.m.: 13 IR 1173; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Sep 15, 2006, 2:02 p.m.: 20061011-IR-760050265FRA)

SECTION 18. 760 IAC 1-38.1-15 IS AMENDED TO READ AS FOLLOWS:

760 IAC 1-38.1-15 Order of benefits for active/inactive employee

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 15. The benefits of a plan ~~which~~ **that** covers a person as:
(1) an **active** employee, **meaning an employee** who is neither laid off nor retired; or ~~as~~
(2) that employee's dependent; ~~are determined before those of a~~
is the primary plan. ~~which covers~~ **The plan covering** that **same** person as a ~~laid off or~~ retired **or laid off** employee or as ~~that employee's~~ **a** dependent **of a retired or laid off employee is the secondary plan.** If the other plan does not have this provision, and if, as a result, the plans do not agree on the order of benefits, this section is ignored. **This section does not apply if section 12(d) of this rule can determine the order of benefits.**

(Department of Insurance; 760 IAC 1-38.1-15; filed Feb 14, 1990, 3:30 p.m.: 13 IR 1173; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Sep 15, 2006, 2:02 p.m.: 20061011-IR-760050265FRA)

SECTION 19. 760 IAC 1-38.1-15.5 IS ADDED TO READ AS FOLLOWS:

760 IAC 1-38.1-15.5 Order of benefits under COBRA or continuation coverage

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 15.5. If a person whose coverage is provided under COBRA or under a right of continuation under state or other federal law is covered under another plan, the plan covering the person as:
(1) an employee, member, subscriber, or retiree; or
(2) a dependent of an employee, member, subscriber, or retiree;
is the primary plan, and the plan covering that same person under COBRA or under a right of continuation under state or other federal law is the secondary plan. If the other plan does not have this rule and as a result the plans do not agree on the order of benefit, this rule is ignored. This section does not apply if the rule in section 12(d) of this rule can determine the order of benefits.

(Department of Insurance; 760 IAC 1-38.1-15.5; filed Sep 15, 2006, 2:02 p.m.: 20061011-IR-760050265FRA)

SECTION 20. 760 IAC 1-38.1-16 IS AMENDED TO READ AS FOLLOWS:

760 IAC 1-38.1-16 Order of benefits for longer/shorter length of coverage

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 16. (a) If the provisions of sections 12 through ~~15~~ **15.5** of this rule do not determine the order of benefits, the benefits of the plan ~~which~~ **that** covered ~~an employee, member, or subscriber~~ **the person for the:**
(1) longer ~~are determined before those of~~ **period of time is** the **primary** plan; ~~which covered that person for the~~ **and**
(2) shorter ~~term.~~ **period of time is the secondary plan.**

(b) To determine the length of time a person has been covered under a plan, two (2) plans shall be treated as one (1) **plan** if the claimant was eligible under the second **plan** within twenty-four (24) hours after the first **plan** ended.

(c) The start of a new plan does not include **a change:**
(1) ~~a change~~ in the amount or scope of a plan's benefits;
(2) ~~a change~~ in the entity ~~which~~ **that** pays, provides, or administers the plan's benefits; or
(3) ~~a change~~ from one (1) type of plan to another, such as from a single employer plan to that of a multiple employer plan.

(d) The claimant's length of time covered under a plan is measured from the claimant's first date of coverage under the 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.

(Department of Insurance; 760 IAC 1-38.1-16; filed Feb 14, 1990, 3:30 p.m.: 13 IR 1173; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Sep 15, 2006, 2:02 p.m.: 20061011-IR-760050265FRA)

SECTION 21. 760 IAC 1-38.1-17 IS AMENDED TO READ AS FOLLOWS:

760 IAC 1-38.1-17 Secondary plan procedures; total allowable expenses

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 17. ~~(a) When it is determined under sections 12 through 16 of this rule that this plan is a~~ **In determining the amount to be paid by the** secondary plan ~~it may reduce its~~ **on a claim, should the plan wish to coordinate benefits, the secondary plan shall calculate the** benefits ~~so that the total benefits~~ **it would have** paid ~~or provided by all plans during a~~ **on the** claim ~~determination period are not more than total~~ **in the absence of other health coverage and apply that calculated amount to any** allowable ~~expenses. The amount by which~~ **expense under its plan that is unpaid by the primary plan.** 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 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.~~

~~(b) 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 the coordination of benefits provision 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 this coordination of benefits provision, whether or not claim is made, exceeds those allowable expenses in a claim determination period. In that case, the benefits of 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.~~

~~(c) When the benefits of this plan are reduced as described in subsection (b), each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this plan.~~

~~(d) Subsection (c) may be omitted if the plan provides only one (1) benefit, or may be altered to suit the coverage provided.~~

(1) may reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed one hundred percent (100%) of the total allowable expense for that claim; and
(2) shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

(Department of Insurance; 760 IAC 1-38.1-17; filed Feb 14, 1990, 3:30 p.m.: 13 IR 1173; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Sep 15, 2006, 2:02 p.m.: 20061011-IR-760050265FRA)

SECTION 22. 760 IAC 1-38.1-19 IS AMENDED TO READ AS FOLLOWS:

760 IAC 1-38.1-19 Excess and other nonconforming provisions

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 19. ~~(a) Some plans have order of benefit determination provisions not consistent with this rule, which declare that the plan's coverage is "excess" to all others, or "always secondary". This occurs because certain plans may not be subject to insurance regulation, or because some group contracts have not yet conformed with this rule.~~

~~(b)~~ **(a)** A plan with order of benefit determination provisions ~~which~~ **that** comply with this rule (complying plan) may coordinate its benefits with a plan ~~which~~ **that** is "excess" or "always secondary", or ~~which~~ **that** uses order of benefit determination provisions ~~which~~ **that** are inconsistent with those contained in this rule (noncomplying plan) on the following basis:

(1) If the complying plan is the:

(A) primary plan, it shall pay or provide its benefits on a primary basis; **or**

~~(2) If the complying plan is the~~ **(B)** secondary plan, it shall, nevertheless, pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the complying plan were the secondary plan. In such a situation, ~~such~~ **the** payment shall be the limit of the complying plan's liability.

~~(3)~~ **(2)** 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 **do the following:**

(A) Assume that the benefits of the noncomplying plan are identical to its own. ~~and shall~~

(B) 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 plan, **it shall adjust payment accordingly.**

~~(c)~~ **(b)** If the noncomplying plan:

(1) reduces its benefits so that the ~~employee, subscriber, or member~~ **covered person** 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~~

(2) paid or provided its benefits as the primary plan;

and governing state law allows the right of subrogation under section 21 of this rule, then the complying plan shall advance to or on behalf of the ~~employee, subscriber, or member~~ **covered person** an amount equal to ~~such~~ **the** difference.

~~(d)~~ **(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 such advance, the complying plan shall be subrogated to all rights of the employee, 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~~ **the** subrogation.

(Department of Insurance; 760 IAC 1-38.1-19; filed Feb 14, 1990, 3:30 p.m.: 13 IR 1174; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Sep 15, 2006, 2:02 p.m.: 20061011-IR-760050265FRA)

SECTION 23. 760 IAC 1-38.1-20 IS AMENDED TO READ AS FOLLOWS:

760 IAC 1-38.1-20 Allowable expense

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 20. ~~A term~~ **Terms** such as:

(1) "usual, ~~and~~ customary, **and reasonable",** "usual and prevailing", or "reasonable and customary" may be substituted for the term ~~"necessary~~ **"usual,** reasonable, and customary"; ~~Terms such as~~ **and**

(2) "medical care" or "dental care" may be substituted for "health care";

to describe the coverages to which the coordination of benefits provisions apply.

(Department of Insurance; 760 IAC 1-38.1-20; filed Feb 14, 1990, 3:30 p.m.: 13 IR 1174; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Sep 15, 2006, 2:02 p.m.: 20061011-IR-760050265FRA)

SECTION 24. 760 IAC 1-38.1-21.2 IS ADDED TO READ AS FOLLOWS:

760 IAC 1-38.1-21.2 Notice to covered persons

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 21.2. A plan shall, in its explanation of benefits provided to covered persons, include the language, "If you are covered by more than one health benefit plan, you should file all your claims with each plan.".

(Department of Insurance; 760 IAC 1-38.1-21.2; filed Sep 15, 2006, 2:02 p.m.: 20061011-IR-760050265FRA)

SECTION 25. 760 IAC 1-38.1-21.6 IS ADDED TO READ AS FOLLOWS:

760 IAC 1-38.1-21.6 Failure to agree

Authority: IC 27-1-3-7
Affected: IC 27-8-5-19

Sec. 21.6. 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:
(1) immediately pay the claim in equal shares; and
(2) 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.

(Department of Insurance; 760 IAC 1-38.1-21.6; filed Sep 15, 2006, 2:02 p.m.: 20061011-IR-760050265FRA)

SECTION 26. THE FOLLOWING ARE REPEALED: 760 IAC 1-38.1-4; 760 IAC 1-38.1-10.

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Documents Incorporated by Reference: Appendix A to the Group Coordination of Benefits Model Regulation, amended April 2005 by the National Association of Insurance Commissioners (NAIC) (2005 Proc. I), appearing in the NAIC Model Insurance Laws, Regulations and Guidelines, Vol. I, pages 120-14 through 120-19.
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