Sec. 38a-480-5. Rules for coordination of benefits

(a) **Order of Benefits**.

(1) General.

(A) The Primary Plan must pay or provide its benefits as if the Secondary Plan or Plans did not exist.

(B) A Secondary Plan may take the benefits of another Plan into account only when, under these rules, it is Secondary to that other Plan.

(Reference: subsections 38a-480-4 (c) and 38a-480-4 (d) (2) (C) above.)

(2) Dependent Child/Parents Not Separated or Divorced.

(A) The word "birthday" in the wording shown in subsection 38a-480-4 (d) (3) (B) (ii) of this regulation refers only to month and day in a calendar year, not the year in which the person was born.

(Reference: subsections 38a-480-4 (d) (3) (B) (ii) above.)

(3) Longer/Shorter Length of Coverage.

(A) To determine the length of time a person has been covered under a Plan, two Plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended. Thus, the start of a new Plan does not include:

(i) a change in the amount or scope of a Plan's benefits;

(ii) a change in the entity which pays, provides or administers the Plan's benefits; or

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

(B) 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.

(Reference: subsection 38a-480-4 (d) (3) (B) (v) above.)

(b) **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.

(c) **Excess and Other Nonconforming Provisions**.

(1) Some Plans have order of benefit determination rules not consistent with this regulation which declare that the Plan's coverage is "excess" to all others, or "always secondary." This occurs because: (A) certain Plans may not be subject to insurance regulation; or (B) some group contracts have not yet been conformed with this regulation pursuant to Section 38a-480-7, Effective Date Existing Contract.

(2) A Plan with order of benefit determination rules which comply with this regulation (herein called a Complying Plan) may coordinate its benefits with a Plan which is "excess" or "always secondary" or which uses order of benefit determination rules which are inconsistent with those contained in this regulation (herein called a Noncomplying Plan) on the following basis:

(A) If the Complying Plan is the Primary Plan, it shall pay or provide its benefits on a primary basis.

(B) If the Complying Plan in the Secondary Plan, it shall, nevertheless, pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the Complying Plan were the Secondary Plan. In such a situation, such 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 Noncomlying Plan are identical to its own, and shall pay its benefits accordingly. However, the Complying Plan must adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the Noncomplying Plan.

(D) If:

(i) the Noncomplying Plan reduces its benefits so that the employee, subscriber, or member receives less in benefits that he or she would have received had the Complying Plan paid or provided its benefits as the Secondary Plan and the Noncomplying Plan paid or provided its benefits as the Primary Plan; and (ii) governing state law allows the right of subrogation set forth below; then the Complying Plan shall advance to or on behalf of the employee, subscriber, or member an amount equal to such difference. However, in no event shall the Complying Plan advance more than the Complying Plan would have paid had it been the Primary Plan less any amount it previously paid. In consideration of such advance, the Complying Plan shall be subrogated to all rights of the employee, subscriber, or member against the Noncomplying Plan. 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.

(Reference: subsections 38a-480-4 (d) (4), (5), (6) and (7) above.)

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

(Reference: subsection 38a-480-4 (d) (2) (D) above.)

(e) **Subrogation.** The COB concept clearly differs from that of subrogation. Provisions for one may be included in health care benefits contracts without compelling the inclusion or exclusion of the other.

(Reference: subsections 38a-480-4 (d) (4), (5), (6) and (7) above.)

(Effective September 25, 1992)