

11:4-28.6 Rules for coordination of benefits

(a) The general order of benefit determination shall be as follows:

1. The primary plan shall pay or provide its benefits as if the secondary plan or plans did not exist.
2. A secondary plan shall take the benefits of another plan into account only when, under this subchapter, it is secondary to that other plan.
3. The benefits of the plan which covers the person as an employee, member, subscriber or retiree (that is, other than as a dependent) shall be determined before those of the plan which covers the person as a dependent.

(b) The rules for the order of benefits for a dependent child when the parents are not separated or divorced are as follows:

1. The benefits of the plan of the parent whose birthday falls earlier in a year shall be determined before those of the plan of the parent whose birthday falls later in that year.
2. If both parents have the same birthday, the benefits of the plan which covered the parent longer shall be determined before those of the plan which covered the other parent for a shorter period of time.
3. The word "birthday" refers only to month and day in a calendar year and not the year in which the person was born.
4. If the other plan does not follow the rules described in (b)1, 2 and 3 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 rule based upon the gender of the parent shall determine the order of benefits.

(c) If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child shall be determined according to the provisions of this subsection:

1. The plan of the parent with custody of the child shall have its benefits determined first;
2. The plan of the spouse of the parent with the custody of the child shall have its benefits determined next;
3. The plan of the parent not having custody of the child shall have its benefits determined last.
4. 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 if the plan of that parent is a secondary plan, and further, if the entity obligated to pay or provide the benefits of the plan of that parent has actual knowl-

edge of those terms, then the benefits of that plan shall be determined first. The plan of the other parent shall be considered the secondary plan. This paragraph shall not apply to any claim determination period or plan year during which any benefits are actually paid or provided before the entity that has actual knowledge.

(d) 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) shall be 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 particular provision, and if, as a result, the plans do not agree on the order of benefits, this subsection shall be ignored.

(e) When a person provided coverage under a right of continuation pursuant to Federal or State law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary and the continuation coverage is secondary unless the other plan does not contain a provision allowing it to apply this rule and as a result the plans do not agree on the order of benefits.

(f) If none of the provisions of (c) and (d) above determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer shall be determined before those of the plan which covered that person for the shorter term.

1. To determine the time a person has been covered under a plan, successive plans of a given group shall be treated as one if the claimant was eligible under the second plan within 24 hours after the first plan ended.
2. The start of a new plan shall 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; and
 - iii. A change from one plan to another (such as, from a single employer plan to that of a multiple employer plan).
3. The claimant's time covered under a plan shall be measured from the claimant's initial 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 time of the claimant's coverage under the present plan.

Amended by R.2002 d.106, effective April 1, 2002 (operative January 1, 2003).
See: 33 N.J.R. 2578(a), 34 N.J.R. 1440(a).

In (a)3, inserted "or retiree" following "subscriber"; added a new (e) and recodified former (c) as (f).

11:4-28.7 Procedure to be followed by other than primary plans to calculate benefits

(a) A plan determined to be a secondary plan pursuant to N.J.A.C. 11:4-28.6 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. Where a benefit is payable by both the primary and secondary plans on the basis of usual, customary and reasonable fees (UCR), the secondary plan shall pay the difference between billed charges for allowable expenses and the amount paid by the primary plan as long as such amount is no greater than the amount the secondary plan would have paid if primary. 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 claim is made. As each claim is submitted, the secondary plan shall determine its obligation to pay for allowable expenses based on all claims which were submitted up to that time during the claim determination period. This guideline is illustrated in examples W, X, Y, Z and AA of Appendix B.

(b) The benefits of the secondary plan shall be reduced when the sum of the benefits that would be payable for the allowable expenses under the secondary plan in the absence of this COB 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 COB provision, whether or not a claim is made, exceeds those allowable expenses in a claim determination period. In this case, the benefits of the secondary plan shall 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 (a) or (b) above, each benefit shall be reduced in proportion, and the amount paid shall then be charged against any applicable benefit limit of This Plan.

(d) The requirements of (c) above may be omitted if the plan provides only one benefit, or may be altered to suit the coverage provided.

(e) For purposes of this subsection, plans that pay network providers on the basis of contractual fee schedules shall include HMO plans, HMO POS plans as permitted by N.J.A.C. 8:38-14, indemnity plans using an SCA as permitted by N.J.A.C. 11:4-37 and those indemnity plans that have contracted with providers who have agreed to accept a negotiated payment.

1. Where both the primary and secondary plans pay network providers on the basis of contractual fee schedules, and the provider who provides or arranges for the services or supplies is a network provider of the primary and secondary plans, the allowable expense shall be considered to be the contractual fee of the primary plan. The primary plan shall pay the benefit it would have paid without regard to the existence of other coverage, and the secondary plan shall pay any deductible, coinsurance or copayment for which the covered person is liable up to the amount the secondary plan would have been required to pay if primary and provided that the total amount received by the provider from the primary plan, the secondary plan and the covered person does not exceed the contractual fee of the primary plan. In no event shall the covered person be responsible for any payment in excess of the copayment, coinsurance or deductible for the secondary plan. This guideline is illustrated in examples A, B, C, D, E, F and G of Appendix B.

2. Where the primary plan pays a benefit on the basis of UCR, and the secondary plan pays on the basis of a contractual fee schedule, and the provider who provides or arranges for the services or supplies is a network provider of the secondary plan, the primary plan shall pay the benefit it would have paid without regard to the existence of other coverage. The secondary plan shall pay the difference between the provider's billed charges and the benefit paid by the primary plan up to the amount the secondary plan would have paid if primary. The payment of the secondary plan shall be applied first toward satisfaction of the covered person's liability for any copayment, coinsurance or deductible of the primary plan. The covered person shall only be liable for the copayment, deductible and coinsurance under the secondary plan if the covered person has no liability for a copayment, coinsurance or deductible under the primary plan and the total payments by both the primary and secondary plans are less than the provider's billed charges. The covered person shall not be liable for any billed charges in excess of the sum of the benefits paid by the primary plan, the benefits paid by the secondary plan, and the copayment, deductible or coinsurance paid by the covered person under either the primary or the secondary plans. In no event shall the covered person be responsible for any payment in excess of the copayment, coinsurance or deductible of the secondary plan. This guideline is illustrated in examples H, I, J, K, L and M of Appendix B.

3. Where the primary plan pays providers on the basis of a contractual fee schedule, and the secondary plan pays for the particular benefit on the basis of UCR, and a service or supply is provided by a network provider of the primary plan, the allowable expense considered by the secondary plan shall be the contractual fee of the primary plan. The secondary plan shall pay any copayment, coinsurance or deductible for which the covered person is liable under the terms of the primary plan up to the amount that the secondary plan would have been required to pay if primary. This guideline is illustrated in examples N and O of Appendix B.

4. Where an HMO plan, other than an HMO POS plan, is primary, and the provider is not a network provider of the HMO, and the services and supplies are not covered by the HMO as urgent care, emergency care or a referral to an out-of-network provider, and an HMO POS, SCA or indemnity plan is secondary, the secondary plan shall pay as if it were primary. This guideline is illustrated in example P of Appendix B.

5. Where the primary plan pays providers on the basis of capitation, and the secondary plan is either an HMO plan that pays network providers on the basis of a contractual fee schedule or an SCA, and a service or supply is provided by a network provider of both the primary and secondary plans, the secondary plan shall pay any copayment, coinsurance or deductible for which the covered person is liable under the terms of the primary plan up to the amount the secondary plan would have been required to pay if primary. This guideline is illustrated in examples Q and R of Appendix B.

6. Where the primary plan pays network providers on a basis of capitation or a contractual fee schedule or pays a benefit on the basis of UCR, and the secondary plan pays network providers on the basis of capitation, and a service or supply is provided by a network provider of the secondary plan, the secondary plan shall not be obligated to pay to such network provider any amount other than the capitation payment required under the contract between the secondary plan and the network provider, and shall not be liable for any deductible, coinsurance or copayment imposed by the primary plan. The covered person shall not be responsible for the payment of any amount for eligible services. This guideline is illustrated in examples S, T, U and V of Appendix B.

7. Where both the primary and secondary plans are HMO plans, and the covered person obtains services or supplies from a provider who is in the secondary HMO plan's network but is not in the primary HMO plan's network, the primary HMO plan shall have no liability and the secondary HMO plan shall pay or provide benefits as if it were primary except for emergency services or referrals authorized by the primary plan.

(f) The secondary plan shall not reduce allowable expenses on the basis that precertification, notification or second surgical opinions were not given where the services or supplies in question were determined to have been medically necessary.

Amended by R.2002 d.106, effective April 1, 2002 (operative January 1, 2003).

See: 33 N.J.R. 2578(a), 34 N.J.R. 1440(a).

Rewrote (a); added (e) and (f).

11:4-28.8 Notice to covered persons

An explanation of benefits provided to covered persons under a plan shall include the following language: "If you are covered by more than one health benefit plan, you

should file all your claims with each plan and provide each plan with information regarding the other plans under which you are covered."

Repeal and New Rule, by R.2002 d.106, effective April 1, 2002 (operative January 1, 2003).
See: 33 N.J.R. 2578(a), 34 N.J.R. 1440(a).

11:4-28.9 Excess and other nonconforming provisions

(a) A plan with order of benefit determination rules which comply with this subchapter (complying plan) shall coordinate its benefits with a plan that declares itself "excess" or "always secondary" or which uses order of benefit determination rules which are inconsistent with those contained in this subchapter (noncomplying plan) on the following basis:

1. If the complying plan is the primary plan, it shall pay or provide its benefits on a primary basis;
2. If the complying plan is the secondary plan, it shall:
 - i. Attempt to secure the necessary information from the noncomplying plan to make the determination of the complying plan's liability as the secondary plan; or
 - ii. Assume the primary position and pay its benefits as the primary plan, if the noncomplying plan is unwilling to act as the primary plan or does not supply the information necessary for the complying plan to determine its benefits as a secondary plan.

Amended by R.2002 d.106, effective April 1, 2002 (operative January 1, 2003).

See: 33 N.J.R. 2578(a), 34 N.J.R. 1440(a).

Rewrote the section.

11:4-28.10 Substitute terminology in contracts

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

11:4-28.11 Compliance

(a) Administration of coordination of benefits provisions for all plans shall be in compliance with this subchapter by January 1, 2003.

(b) All plans shall include the notice required pursuant to N.J.A.C. 11:4-28.8 in their explanation of benefits forms by January 1, 2003.

(c) Explanations of coordinations of benefits provisions using the model language set forth in Appendix A to this subchapter issued to contractholders, certificateholders and covered persons on or after January 1, 2003 shall comply with the language of Appendix A as amended effective April 1, 2002.

Amended by R.2002 d.106, effective April 1, 2002 (operative January 1, 2003).

See: 33 N.J.R. 2578(a), 34 N.J.R. 1440(a).

Rewrote the section.

11:4-28.12 Severability

If any provision of this subchapter or the application thereof to any person or circumstance is held invalid, the remainder of the subchapter and the application of such provision to other persons or circumstances shall not be affected thereby.

APPENDIX A

MODEL COB PROVISIONS

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 should be looked at first. Those 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 benefits determination rules, another plan determines its benefits first. The above reduction is described in Section (IV) Effect on the Benefits of This Plan.

(C) If this COB provision applies, but the other plan assumes an always secondary position or refuses to follow the order of benefit determination rules, the benefits of This Plan shall not be reduced.

(II) DEFINITIONS.

(A) "Plan" is any of these which provides benefits or services for, or because of, medical or dental care or treatment;

i. Group insurance or group or group-type 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 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 when, by law, its benefits are excess to those of any private insurance program or other nongovernmental program.

Each contract or other arrangement for coverage under ii. is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

(B) "This Plan" is the part of the group contract that provides benefits for health care expenses.

(C) "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 Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

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 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.

(D) "Allowable Expense" means the charge for any health care service, supply or other item of expense for which the covered person is liable when the health care service, supply or item of expense is covered at least in part under any of the plans involved, except where a statute requires a different definition or as specified in this subchapter.

The following are examples of expenses or services that are not allowable expenses:

i. The difference between the cost of a private hospital room and the cost of a semi-private hospital room 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.

ii. An amount in excess of the negotiated fee of whichever plan is primary when a person is covered by plans all of which provide benefits or services on the basis of negotiated fees.

iii. An expense or service that none of the plans cover.

(E) “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.

(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, in subparagraph (B) below, 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. Nondependent/Dependent. The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent.

ii. Dependent Child/Parents not Separated or Divorced. Except as stated in subparagraph (B)iii below, 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.

However, if the other plan does not have the rule described in a. immediately 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 rule in the other plan will 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.

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 if the plan of that parent is a secondary plan, and further, if 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. The plan of the other parent shall be the Secondary Plan. 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.

v. Continuation coverage. If a person whose coverage is provided under a right of continuation pursuant to Federal or State law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person’s dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and the plans do not agree on the order of benefits as a result, this rule 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 term.

(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) immediately below.

(B) Reduction in This Plan’s Benefits. The benefits of This Plan will be reduced when the sum of:

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; exceeds those Allowable Expenses in a Claim Determination Period. In that case, 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.

(C) When the benefits of This Plan are reduced as described in (B) above, each benefit is reduced in proportion. The amount paid is then charged against any applicable benefit limit of This Plan.

(V) RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

Certain facts are needed to apply these COB rules. (Insurer) has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. (Insurer) need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give (Insurer) 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, (Insurer) 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. (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 monetary value of the benefits provided in the form of services.

(VII) RIGHT OF RECOVERY.

If the amount of the payments made by (Insurer) 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 monetary value of any benefits provided in the form of services.

Amended by R.2002 d.106, effective April 1, 2002 (operative January 1, 2003).

See: 33 N.J.R. 2578(a), 34 N.J.R. 1440(a).

Rewrote the section.

APPENDIX B