State of Utah
Administrative Rule Analysis
Revised November 2021

NOTICE OF PROPOSED RULE		
TYPE OF RULE: New ___; Amendment _x_; Repeal ___; Repeal and Reenact ___		
	Title No. - Rule No. - Section No.	
Utah Admin. Code Ref (R no.):	**R590-131**	**Filing ID (Office Use Only)**
Changed to Admin. Code Ref. (R no.):	**R**	

Agency Information

1. Department:	Insurance	
Agency:	Administration	
Room no.:	Suite 2300	
Building:	Taylorsville State Office Building	
Street address:	4315 S. 2700 W.	
City, state and zip:	Taylorsville, UT 84129	
Mailing address:	PO Box 146901	
City, state and zip:	Salt Lake City, UT 84114-6901	
Contact person(s):		
Name:	**Phone:**	**Email:**
Steve Gooch	801-957-9322	sgooch@utah.gov
Please address questions regarding information on this notice to the agency.		

General Information

2. Rule or section catchline:

R590-131. Accident and Health Coordination of Benefits Rule

3. Purpose of the new rule or reason for the change (Why is the agency submitting this filing?)**:**

The rule is being changed in compliance with Executive Order 2021-12. During the review of this rule, the department discovered a number of minor issues that needed to be amended.

4. Summary of the new rule or change (What does this filing do? If this is a repeal and reenact, explain the substantive differences between the repealed rule and the reenacted rule)**:**

The majority of the changes are being done to fix style issues to bring the rule text more in line with current rulewriting standards. Other changes make the language of the rule more clear, remove the Effective Date for Existing Contracts section, and remove the Penalties section. The changes do not add, remove, or change any regulations or requirements.

Fiscal Information

5. Provide an estimate and written explanation of the aggregate anticipated cost or savings to:

A) State budget:

There is no anticipated cost or savings to the state budget. The changes are largely clerical in nature, and will not change how the department functions.

B) Local governments:

There is no anticipated cost or savings to local governments. The changes are largely clerical in nature, and will not affect local governments.

C) Small businesses ("small business" means a business employing 1-49 persons)**:**

There is no anticipated cost or savings to small businesses. The changes are largely clerical in nature, and will not affect small businesses.

D) Non-small businesses ("non-small business" means a business employing 50 or more persons)**:**

There is no anticipated cost or savings to non-small businesses. The changes are largely clerical in nature, and will not affect non-small businesses.

E) Persons other than small businesses, non-small businesses, state, or local government entities ("person" means any individual, partnership, corporation, association, governmental entity, or public or private organization of any character other than an ***agency***)**:**

There is no anticipated cost or savings to any other persons. The changes are largely clerical in nature.

F) Compliance costs for affected persons (How much will it cost an impacted entity to adhere to this rule or its changes?)**:**

There are no compliance costs for any affected persons. The changes are largely clerical in nature.

G) Comments by the department head on the fiscal impact this rule may have on businesses (Include the name and title of the department head):

After conducting a thorough analysis, it was determined that this proposed rule amendment will not result in a fiscal impact to businesses. — Jonathan T. Pike, Insurance Commissioner

6. A) Regulatory Impact Summary Table (This table only includes fiscal impacts that could be measured. If there are inestimable fiscal impacts, they will not be included in this table. Inestimable impacts will be included in narratives above.)

Regulatory Impact Table

Fiscal Cost	**FY2022**	**FY2023**	**FY2024**
State Government	$0	$0	$0
Local Governments	$0	$0	$0
Small Businesses	$0	$0	$0
Non-Small Businesses	$0	$0	$0
Other Persons	$0	$0	$0
Total Fiscal Cost	**$0**	**$0**	**$0**
Fiscal Benefits			
State Government	$0	$0	$0
Local Governments	$0	$0	$0
Small Businesses	$0	$0	$0
Non-Small Businesses	$0	$0	$0
Other Persons	$0	$0	$0
Total Fiscal Benefits	**$0**	**$0**	**$0**
Net Fiscal Benefits	**$0**	**$0**	**$0**

B) Department head approval of regulatory impact analysis:

The Commissioner of Insurance, Jonathan T. Pike, has reviewed and approved this fiscal analysis.

Citation Information

7. Provide citations to the statutory authority for the rule. If there is also a federal requirement for the rule, provide a citation to that requirement:

Section 31A-2-201	Section 31A-22-619	

Incorporations by Reference Information

(If this rule incorporates more than two items by reference, please include additional tables.)

8. A) This rule adds, updates, or removes the following title of materials incorporated by references (a copy of materials incorporated by reference must be submitted to the Office of Administrative Rules; *if none, leave blank*)**:**

	First Incorporation
Official Title of Materials Incorporated (from title page)	
Publisher	
Date Issued	

Issue, or version	

B) This rule adds, updates, or removes the following title of materials incorporated by references (a copy of materials incorporated by reference must be submitted to the Office of Administrative Rules; *if none, leave blank*)**:**	
	Second Incorporation
Official Title of Materials Incorporated (from title page)	
Publisher	
Date Issued	
Issue, or version	

Public Notice Information

9. The public may submit written or oral comments to the agency identified in box 1. (The public may also request a hearing by submitting a written request to the agency. See Section 63G-3-302 and Rule R15-1 for more information.)		
A) Comments will be accepted until (mm/dd/yyyy)**:**		08/15/2022
B) A public hearing (optional) will be held:		
On (mm/dd/yyyy)**:**	**At** (hh:mm AM/PM)**:**	**At** (place)**:**

10. This rule change MAY become effective on (mm/dd/yyyy)**:**	08/22/2022
NOTE: The date above is the date the agency anticipates making the rule or its changes effective. It is NOT the effective date. To make this rule effective, the agency must submit a Notice of Effective Date to the Office of Administrative Rules on or before the date designated in Box 10.	

Agency Authorization Information

To the agency: Information requested on this form is required by Sections 63G-3-301, 302, 303, and 402. Incomplete forms will be returned to the agency for completion, possibly delaying publication in the *Utah State Bulletin* and delaying the first possible effective date.			
Agency head or designee, and title:	Steve Gooch, Public Information Officer	**Date** (mm/dd/yyyy)**:**	06/21/2022

R590. Insurance, Administration.
R590-131. Accident and Health Coordination of Benefits Rule.
R590-131-1. Authority.

This rule is [~~adopted and~~]promulgated by the commissioner pursuant to [~~Subsection 31A-2-201(3)(a) and Section~~]Sections 31A-2-201 and 31A-22-619.

R590-131-2. Purpose and [~~Applicability~~|Scope.

(1) The purpose of this rule is to:

(a) establish [~~a uniform~~]an order [~~of benefit determination under which a plan pays~~]for an insurer to pay a coordination of benefits claim;

(b) [~~reduce duplication of benefits by permitting a reduction of the benefits to be paid by a plan when the plan, pursuant to this rule, does not have to pay its benefits first~~]establish when benefits may be reduced under a secondary plan; and

(c) provide [~~greater~~]efficiency in [~~the~~]processing [~~of~~]a claim when [~~a person~~]an enrollee is covered under more than one plan.

(2) This rule applies to [~~any~~]an insurer offering accident and health insurance[~~, plan issued on or after the effective date of this rule~~].

R590-131-3. Definitions.

[~~For the purposes of this rule, the commissioner adopts the definitions in Section 31A-1-301, and the following~~]Terms used in this rule are defined in Section 31A-1-301. Additional terms are defined as follows:

(1) "Allowable [~~E~~]expense" means a[~~ny~~] health care expense, including coinsurance or a copayment[~~s and~~] without reduction for any applicable deductible, that is covered in full or in part by any [~~of the plans~~]plan covering [~~the person~~]an enrollee.

(a) If an enrollee advises an insurer [~~is advised by a covered person~~]that each plan covering the [~~person~~]enrollee is a high-deductible health plan and the [~~person~~]enrollee intends to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986, then the primary high-deductible health plan's deductible is not an allowable expense, except for a[~~ny~~] health care expense incurred that [~~may not be~~]is not subject to the deductible as described in Section 223(c)(2)(C) of the Internal Revenue Code of 1986.

(b) An expense or a portion of an expense that is not covered by any [~~of the plans~~]plan is not an allowable expense.

(c) Any expense that a provider, by law or in accordance with a contractual agreement, is prohibited from charging [~~a covered person~~]an enrollee is not an allowable expense.

(d) The [~~following are~~]examples [~~of expenses that~~]in this subsection (1)(d) are not an allowable expense[~~s~~].

(i) If [~~a person~~]an enrollee is confined in a private hospital room, the difference between the cost of a semi-private room [~~in the hospital~~]and the private room is not an allowable expense, unless one of the plans provides coverage for a private hospital room expense[~~s~~].

(ii) If [~~a person~~]an enrollee is covered by two or more plans that compute their benefit [~~payments~~]on the basis of a usual and customary fee[~~s or~~], a relative value schedule[~~reimbursement~~], or 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.

(iii) If [~~a person~~]an enrollee is covered by two or more plans that provide [~~benefits or services~~]a benefit or service on the basis of a negotiated fee[~~s~~], any amount in excess of the highest [~~of the~~]negotiated fee[~~s~~] is not an allowable expense.

(iv) If [~~a person~~]an enrollee is covered by one plan that calculates its [~~benefits or services~~]benefit or service on the basis of a usual and customary fee[~~s~~], a relative value schedule[~~reimbursement~~], or other similar reimbursement methodology and another plan that provides its [~~benefits or services~~]benefit or service on the basis of a negotiated fee[~~s~~], then the primary plan's payment arrangement shall be the allowable expense for each [~~of the plans. However, if the~~]plan.

(v) If a provider has [~~contracted~~]a contract 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.

(e) The definition of "allowable expense" may exclude certain types of coverage or benefits such as dental care, vision care, prescription drugs, or hearing aids.

(i) A plan that limits the application of COB to certain coverages or benefits may limit the definition of "allowable expense" in its contract to expenses that are similar to the expenses that it provides.

(ii) When COB is restricted to specific coverages or benefits in a contract, the definition of "allowable expense" shall include similar expenses to which COB applies.

(f) When a plan provides benefits in the form of [~~services~~]a service, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.

(g) The amount of [~~the~~]a reduction may be excluded from allowable expense when [~~a covered person's~~]an enrollee's benefits are reduced under a primary plan because the [~~covered person~~]enrollee does not comply with the plan provisions concerning a second surgical opinion or pre-certification of [~~admissions or services~~]an admission or a service.

(2)(a) "Birthday" [~~refers only to~~]means the month and day [~~in a calendar year and does not include the year in which the person~~]the enrollee was born.

(b) "Birthday" does not include the year the enrollee was born.

(3) "Child" means a:

(a) child as defined in Section 78B-12-102; or

(b) dependent child [~~that~~]who is provided coverage pursuant to Sections 31A-22-610, 31A-22-610.5, and 31A-22-611.

(4)(a) "Claim" means a request that a plan's benefits [~~of a plan~~]be provided or paid.[~~The benefits claimed~~]

(b) A benefit claimed may be in the form of:

[~~(a)~~](i) a service[~~s~~], including [~~supplies~~]a supply;

[~~(b)~~](ii) payment for all or a portion of the expenses incurred;

[~~(c)~~](iii) a combination of Subsections [~~R590-131-3(4)(a) and R590-131-3(4)(b)~~](4)(b)(i) and (4)(b)(ii); or

[~~(d)~~](iv) an indemnification.

(5) "Closed [~~Panel Plan~~]panel plan" means a plan that:

(a) provides [~~health~~]benefits to [~~covered persons~~]an enrollee primarily in the form of services through a panel of providers that have contracted with or are employed by [~~a plan, and that~~]an insurer; and

(b) excludes [~~benefits for services~~]a benefit for a service provided by [~~other~~]a non-panel provider[~~s~~], except in the case[~~s~~] of:

(i) an emergency; or

(ii) a referral by a panel [~~member~~]provider.

(6)(a) "Conforming [~~P~~]plan" or "Plan" means a plan [~~that is subject to this rule~~]that allows COB.

(b) "Conforming plan" or "Plan" includes:

(i) an individual, group, or group-type accident and health insurance contract, including a closed panel plan;

(ii) a group or group-type uninsured arrangement;

(iii) a medical care benefit in a long-term care contract that provides reimbursement for an incurred expense, rather than an indemnity benefit; and

(iv) a Medicare or other governmental benefit, as permitted by law.

(7) [~~"Continuation Coverage" means coverage provided under right of continuation pursuant to the federal (COBRA) law, Utah mini-COBRA, or a state extension law. For the purposes of this rule, a person's eligibility status will maintain the same classification under continuation coverage~~]"Continuation coverage" or "COBRA" means coverage provided under the Consolidated Omnibus Budget Reconciliation Act of 195, Section 31A-22-722, or another state extension required by law.

(8) "Coordinated package" means multiple plans or separate parts of a plan that are intended to be part of a coordinated plan of benefits.

(9) "Coordination of [~~B~~]benefits" or "COB" means a plan provision [~~establishing~~]that establishes an order in which a plan[~~s pay their~~] pays a coordination of benefit claim[~~s~~], and [~~permitting secondary plans~~]a plan, other than a primary plan, to reduce [~~their~~]the plan benefits so that the combined benefit[~~s~~] of [~~each plan does~~]all plans do not exceed the total allowable expense[~~s~~].

[~~(9)~~](10) "Custodial [~~P~~]parent" means:

(a) the [~~legal custodial parent or physical custodial parent as~~]parent awarded custody of a child by a court [~~decree~~]order; or

(b) in the absence of a court [~~decree~~]order, the parent with whom the child resides more than one[-]-half of the calendar year without regard to any temporary visitation.

[~~(10)~~](11)(a) "Group-type contract" means a contract that:

(i) is not available to the general public; and

(ii) is obtained and maintained only because of membership in, or a connection with, a particular organization or group, including blanket coverage.

(b) "Group-type contract" does not [~~include~~]mean an individually underwritten [~~and issued~~]guaranteed renewable policy even if the policy is purchased through payroll deduction at a premium savings [~~to the insured since the insured would have~~]and the enrollee has the right to maintain or renew the policy independently of continued employment with the employer.

[~~(11) "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~~](12) "High-deductible health plan" means a high-deductible plan as defined in Section 223, Internal Revenue Code.

[~~(12) "Hospital Indemnity Benefits" means benefits not related to expenses incurred. The term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim~~](13)(a) "Hospital indemnity benefit" or "fixed indemnity benefit" means a benefit that is not related to actual incurred expenses.

(b) "Hospital indemnity benefit" or "fixed indemnity benefit" does not include a reimbursement-type benefit designed or administered to give the enrollee the right to elect an indemnity-type benefit at the time of a claim.

[~~(13)~~](14)(a) "Non-conforming [~~P~~]plan" means a plan [~~that is not subject to this rule~~]that may not coordinate benefits.

(b) "Non-conforming plan" includes:

(i) hospital indemnity benefits or fixed indemnity benefits;

(ii) accident-only coverage;

(iii) specified disease or specified accident coverage;

(iv) limited benefit health coverage described in Section R590-126-7;

(v) school accident coverage that covers a student for accidents only, including athletic injuries, either on a 24-hour basis or on a to-and-from-school basis;

(vi) benefits provided in a long-term care contract for a non-medical service, including:

(A) personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care; and

(B) a contract that pays a fixed daily benefit without regard to an expense incurred or the receipt of a service;

(vii) a Medicare supplement contract;

(viii) a state plan under Medicaid; and

(ix) a governmental plan that, by law, provides benefits that are in excess to any private insurance plan or other non-governmental plan.

[~~(14) "Plan" means a form of coverage with which coordination is allowed.~~

~~(a) Separate parts of a plan that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one plan and there is no COB among the separate parts of the plan.~~

~~(b) If a plan coordinates benefits, its contract shall state the types of coverage that will be considered in applying the COB provision of that contract.~~

~~(c) Whether a plan's contract uses the term "plan" or some other term such as "program," the contractual definition may be no broader than the definition of "plan."~~

~~(d) Plan shall include:~~

~~(i) individual and group accident and health insurance contracts and subscriber contracts except as provided by Subsection R590-131-3(14)(e);~~

~~(ii) uninsured arrangements of group or group-type coverage;~~

~~(iii) coverage through closed panel plans;~~

~~(iv) group-type contracts;~~

~~(v) medical care components of long-term care contracts, such as skilled nursing care; and~~

~~(vi) Medicare or other governmental benefits, as permitted by law.~~

~~(e) Plan may not include:~~

~~(i) hospital indemnity coverage benefits or other fixed indemnity coverage;~~

~~(ii) accident only coverage;~~

~~(iii) specified disease or specified accident coverage;~~

~~(iv) limited benefit health coverage, as defined in Rule R590-126;~~

~~(v) school accident-type coverages that cover students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis;~~

~~(vi) benefits provided in long-term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;~~

~~(vii) Medicare supplement policies;~~

~~(viii) a state plan under Medicaid; or~~

~~(ix) a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.~~

~~(15) "Policyholder" means the primary insured named in a non-group insurance policy.~~]

[~~(16)~~](15)(a) "Primary [~~P~~]plan" means a plan whose benefits for [~~a person's~~]an enrollee's health care coverage must be determined without [~~taking the existence of~~]considering any other plan[~~, into consideration~~].

(b) A plan is a primary plan if:

[~~(a) the plan~~](i) a plan either:

(A) has no order of benefit determination; or

[~~(b) its rules~~](B) has a benefit determination provision that differs from [~~those permitted by~~]the provisions in this rule; or

[~~(c) each plan that covers the person use the~~](ii) a plan uses this rule's order of benefit determination [~~provisions in Section R590-131-6~~]and under [~~those requirements~~]Section R590-131-6 the plan determines its benefits first.

[~~(17)~~](16) "Retiree employee benefit plan" means an employee benefit plan as defined in the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1002(3).

[~~(18)~~](17) "Secondary [~~P~~]plan" means a[~~ny~~] plan that is not a primary plan[~~.~~

~~(19) "Separated" means married persons who are legally separated~~].

R590-131-4. [~~COB~~]Coordination of Benefits Contract Provisions.

(1) A COB provision may not be used that permits a plan to reduce [~~its~~]the plan benefits on the basis that an enrollee is eligible to enroll in another plan and the enrollee did not enroll in that plan[~~:~~

~~(a) another plan exists and the covered person did not enroll in that plan;~~

~~(b) a person is or could have been covered under another plan, except with respect to a retiree employee benefit plan; or~~

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

(2)(a) Under the terms of a closed panel plan, benefits are not payable if the [~~covered person~~]enrollee does not use the services of a closed panel plan's providers[~~ for either plan~~].

[~~(a)(i)~~](b) In most instances, COB does not occur if [~~a covered person~~]an enrollee is enrolled in two or more closed panel plans and obtains services from a provider in only one of the closed panel plans because the other closed panel plan, the one whose providers were not used, has no liability[~~.~~

~~(ii) The closed panel plan whose providers were not used has no liability~~].

[~~(b)(i) COB~~](c)(i) COB may occur [~~during the plan year when the covered person~~]when an enrollee receives [~~services from a provider who is on each closed panel, or~~]emergency services that [~~would have been~~]are covered by both plans.

(ii) The secondary plan shall use [~~the provisions of~~]Section R590-131-7 to determine the amount it [~~should~~]shall pay for the benefit.

(3) [~~No plan may~~]A plan may not use a COB [~~provision or any~~]or 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 a plan under Section R590-131-3~~]reduces the plan's benefits for non-conforming benefits.

(4) A coordinated package is one plan and there is no COB among the multiple plans or separate parts of a plan.

(5) If a plan coordinates benefits, the plan shall state the type of coverage that will be considered in applying the COB provision.

(6) Whether a plan uses the term "plan" or some other term such as "program," the definition may not be broader than the definition of "plan."

R590-131-5. Rules for Coordination of Benefits.

When [~~a person~~]an enrollee is covered by [~~two or more plans~~]more than one plan, the rules for determining the order of benefit payments are as follows:

(1) The primary plan shall pay or provide [~~its~~]benefits as if [~~the~~]a secondary plan[~~s or plan did~~] does not exist.

(2) If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall pay or provide benefits as [~~if it were~~]the primary plan[~~ when a covered person uses a non-panel provider~~], except for an emergency service[~~s~~] or an authorized referral[~~s that are paid or provided~~] that is paid by the primary plan.

(3) [~~When multiple contracts providing coordinated coverage are treated as a single plan under this rule, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts.~~

~~(4) If more than one insurer pays or provides benefits under the plan, the insurer designated as primary within the plan shall be responsible for the plan's compliance with this rule.~~

~~(5) If a person~~]If an enrollee is covered by more than one secondary plan, the order of benefits [~~are~~]is determined using [~~the rules in~~]Section R590-131-6[~~, and each secondary plan shall take into consideration the benefits of the primary plan or plans and the benefits of any other plan, which, under the rules of this rule, has its benefits determined before those of the secondary plan~~].

[~~(6)(a)~~](4)(a) Except as provided in Subsection [~~R590-131-5(6)(b)~~](4)(b), a plan that does not contain [~~order of benefit determination provisions that are~~]a COB provision consistent with this [~~regulation is always~~]rule is the primary plan unless [~~the provisions of~~]both plans[~~, regardless of the provisions of this subsection,~~] state that the [~~complying~~]conforming plan is primary.

(b) [~~Coverage~~]Supplemental coverage that is obtained [~~by virtue of~~]through membership in a group [~~and designed to supplement a part of~~]may be excess to a plan with 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. Examples of these types of situations are~~].

(i) Supplemental coverage includes:

(A) major medical coverage[~~s that are~~] that is superimposed over a base plan providing hospital and surgical expense benefits[~~,~~]; and

(B) insurance type coverage[~~s that are~~] that is written in connection with a closed panel plan to provide out-of-network benefits.

(ii) Supplemental coverage does not include a non-conforming plan.

[~~(7) A plan may take into consideration the~~](5) Consideration of benefits paid or provided by another plan [~~only when, under this rule, it~~]may only occur when the plan is secondary to [~~that~~]the other plan.

R590-131-6. Determining Order of Benefits.

[~~Each plan shall determine its~~]The order of benefits for each plan is determined using the first [~~of the following rules that apply:~~]rule that applies in this section.

(1) Non-dependent or Dependent Rule.

The plan [~~that covers the person other than as a~~]covering an enrollee as a non-dependent, such as an employee, member, policyholder, or retiree[~~ or subscriber~~], is the primary plan and the plan [~~that covers the person~~]covering the enrollee as a dependent is the secondary plan.

(2) Child Covered Under More Than One Plan Rule.

[~~Unless there is a court decree stating otherwise, a plan covering a child shall determine the order of benefits as follows:~~]A plan covering a child shall determine the order of benefits as follows, unless there is a court order stating otherwise.

(a) For a child whose parents are married or whose parents are living together if they have never been married:

(i) [~~The~~]the plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

(ii) [~~If~~]if both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

(b) For a child whose parents are divorced[~~ or~~], legally separated, or are not living together if they have never been married:

(i)(A) [~~If a court decree~~]if a court order states that one of the parents is responsible for the child's health care expenses or health care coverage, the responsible parent's plan is the primary[~~,~~] plan; or

(B) [~~If the parent with responsibility has no~~]if the parent responsible for the child's health care expenses or health care coverage does not have health care coverage for the child[~~'s health care expenses~~], but the responsible parent's spouse [~~of the responsible parent does have~~]has health care coverage for the child[~~'s health care expenses~~], the responsible parent's spouse's plan is the primary plan[~~.~~];

(ii) [~~If a court decree~~]if a court order states that both parents are responsible for the child's health care expenses or health care coverage, [~~the provisions of Subsection R590-131-6(2)(a) shall determine the order of benefits.~~]Subsection (2)(a) applies;

(iii) [~~If a court decree~~]if a court order states that the parents have joint custody without stating that one parent has responsibility for the health care expenses or health care coverage of the child, [~~the provisions of Subsection R590-131-6(2)(a) shall determine the order of benefits.~~]Subsection (2)(a) applies; and

(iv) [~~If there is no court decree allocating~~]if no court order allocates responsibility for the child's health care expenses or health care coverage, the order of benefits for the child [~~are as follows~~]is:

(A) the plan covering the custodial parent;

(B) the plan covering the custodial parent's spouse;

(C) the plan covering the non-custodial parent; and then

(D) the plan covering the non-custodial parent's spouse.

[~~(v) For a child covered under more than one plan, and one or more of the plans~~](c) If a plan provides coverage for a child through an individual[~~s who are not the parents~~] who is not a parent of the child, [~~such as a guardian,~~]the order of benefits [~~shall be~~]is determined under [~~Subsection R590-131-6(2)(a) or R590-131-6(2)(b) as if those individuals were parents of the child~~]Subsections (2)(a) and (2)(b) as if the individual is the child's parent.

(3) Active, Retired, or Laid-Off Employee Rule.

(a)(i) [~~The plan that covers a person as~~]A plan covering an active employee who is [~~neither laid-off, nor retired, nor a~~]not laid-off, retired, or a dependent of an active employee, is the primary plan[~~, and the~~].

(ii) A plan covering [~~that same person as~~]a retired employee or a laid-off employee, or [~~as~~]a dependent of a retired employee or laid-off employee, is the secondary plan.

[~~(b) If the other plan does not have this rule, and the plans do not agree on the order of benefits, this rule is ignored.~~

~~(c) Subsection R590-131-6(3) does not apply if Subsection R590-131-6(1) can determine the order of benefits.~~]

(b) Subsection (3) does not apply if:

(i) the other plan does not have an active, retired, or laid-off rule and the plans do not agree on the order of benefits; or

(ii) Subsection (1) determines the order of benefits.

(4) [~~COBRA or State~~]Continuation of Coverage Rule.

(a) [~~If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan~~]If an enrollee is covered under a continuation of coverage law and another plan, the plan under a continuation of coverage law is the secondary plan.

[~~(b) If the other plan does not have this rule, and the plans do not agree on the order of benefits, this rule is ignored.~~

~~(c) Subsection R590-131-6(3) does not apply if Subsection R590-131-6(1) can determine the order of benefits.~~]

(b) Subsection (4)(a) does not apply if:

(i) the other plan does not have a continuation of coverage rule and the plans do not agree on the order of benefits; or

(ii) Subsection (1) determines the order of benefits.

(5) Longer or Shorter Length of Coverage Rule.

(a) [~~If the preceding rules~~]If Subsections (1) through (4) do not determine the order of benefits[~~,~~];

(i) the plan [~~that covered the person for the longer period of time~~]covering an enrollee for the longest time period is the primary plan; and

(ii) the plan [~~that covered the person for the shorter period of time~~]covering an enrollee for the shortest time period is the secondary plan.

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

(ii) The start of a new plan does not include:

(A) a change in the amount or scope of a plan's benefits;

(B) a change in the entity that pays, provides, or administers the plan's benefits; or

(C) a change from one type of plan to another, such as[~~,~~] from a single employer plan to a multiple employer plan.

[~~(iii) The person's length of time~~](iii)(A) The time an enrollee is covered under a plan is measured from the [~~person's~~]enrollee's first date of coverage under that plan.[~~If that date~~]

(B) If the date in Subsection (5)(b)(iii)(A) is not readily available, the date the [~~person~~]enrollee first became a member of the group [~~shall be used as the date to~~]will determine the length of time [~~the person's coverage under the present plan has been in force~~]the enrollee is covered under a plan.

(6) [~~If Section R590-131-6~~]If Subsections (1) through (5) cannot determine the primary plan, the plans shall equally share the allowable expense[~~s shall be shared equally between the plans~~].

(7)(a) If the plans cannot agree on the order of benefits within 30 calendar days after the plans have received the information needed to pay the claim, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment[~~, except that no plan shall be~~].

(b) A plan is not required to pay more than it would have paid [~~had it been the~~]as a primary plan.

R590-131-7. Procedure to be Followed by Secondary Plan to Calculate Benefits and Pay a Claim.

(1) If a secondary plan [~~wishes to~~]coordinates benefits, the secondary plan shall:

(a) calculate the plan benefits it would have paid [~~on the claim in the absence of~~]absent any other health care coverage; and

(b) apply [~~that~~]the amount calculated [~~amount~~]in Subsection (1)(a) to any allowable expense [~~under its plan that is~~]unpaid by the primary plan.

(2) The secondary plan may reduce its payment amount so that when combined with the [~~amount paid by the~~]primary plan's payment, the total benefits paid or provided by all plans for the claim do not exceed 100% of the total allowable expense for that claim.

(3) The secondary plan shall credit to [~~its~~]the plan deductible any amounts it would have credited to [~~its~~]the plan deductible in the absence of other health care coverage.

R590-131-8. Miscellaneous Provisions.

(1) Reasonable Cash Value of Services.

(a) A secondary plan that provides [~~benefits~~]a benefit in the form of [~~services~~]a service may recover the reasonable cash value of providing the service[~~s~~] from the primary plan, [~~to the extent that benefits for~~]if the service[~~s are~~] is covered by the primary plan and [~~have not already~~]has not been paid or provided by the primary plan.

(b) Nothing in this [~~provision~~]Subsection may be interpreted to require a plan to reimburse [~~a covered person in cash for the~~]an enrollee the cash value of [~~services~~]a service provided by a plan[~~, which~~] that provides [~~benefits~~]a benefit in the form of [~~services~~]a service.

(2) Excess and Other Provisions.

(a) Except as provided in Subsection [~~R590-131-8(2)(b), no policy or plan subject to this rule may~~](2)(b), a conforming plan may not contain a provision that [~~its~~]the plan benefits are [~~"excess" or "always secondary"~~]excess or always secondary to any other plan or policy.

(b) [~~An~~]A blanket accident-only [~~blanket policy~~]plan may contain a provision that its benefits are [~~"excess" or "always secondary"~~]excess or always secondary to any other plan[~~ or policy~~].

(3) Non-conforming Plan.

[~~(c) A plan with COB rules that comply with these rules, which is called a conforming plan,~~](a) A conforming plan may coordinate benefits with a non-conforming plan[~~ that is "excess" or "always secondary" or that uses COB rules inconsistent with this rule, which is called a non-conforming plan, on the following basis:~~].

(i) [~~if~~]If the conforming plan is the primary plan, it shall pay or provide its benefits [~~on a primary basis~~]as the primary plan;

(ii) [~~if~~]If the conforming 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 conforming plan were the secondary plan. In such a situation,~~]as the secondary plan, and the payment shall be the limit of the conforming plan's liability[~~;~~].

(iii) [~~if~~]If the non-conforming plan does not provide the information needed by the conforming plan to determine its benefits within a reasonable time after it is requested to do so, the conforming plan shall assume that the benefits of the non-conforming plan are identical to its own and shall pay its benefits accordingly[~~;~~].

(iv) [~~if~~]If the conforming plan receives information as to the actual benefits of the non-conforming plan, it may adjust any payments in compliance with Subsection 31A-26-301.6(14)(a)(ii)[~~; and~~].

[~~(v)(A) if the~~](b)(i) If a non-conforming plan reduces its benefits so that the [~~covered person~~]enrollee receives less in benefits than the [~~covered person~~]enrollee would have received had the conforming plan paid or provided its benefits as the secondary plan, and the non-conforming plan paid or provided its benefits as the primary plan, then the conforming plan shall advance to the [~~covered person~~]enrollee, or on behalf of the [~~covered person~~]enrollee, an amount equal to [~~such~~]the difference.

[~~(B)~~](ii) In no event shall the conforming plan advance more than the conforming plan would have paid had it been the primary plan, less any amount it had previously paid.

[~~(C)~~](iii) In consideration of [~~such~~]an advance, the conforming plan shall be subrogated to all rights of the covered person against the non-conforming plan in the absence of subrogation.

(iv) An advance by the conforming plan shall be without prejudice to any claim it may have against a non-conforming plan in the absence of subrogation.

[~~(3) If the plans cannot agree on the order of benefits within 30 calendar days after the plans have received the information needed to pay the claim, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan shall be required to pay more than it would have paid had it been the primary plan.~~]

(4) Subrogation.

[~~COB clearly~~]COB differs from subrogation. [~~-~~]Provisions for [~~one~~]either COB or subrogation may be included in [~~health care benefit contracts~~]a contract without compelling the inclusion or exclusion of the other.

(5) Right To Receive and Release Needed Information.

(a) [~~Certain facts are needed to apply these COB rules and an insurer has the right to decide the facts it needs.~~

~~(b)~~]An insurer may obtain or give needed [~~facts from or give them to any other organization or personand it need not tell or obtain consent from any person to do this~~]information to another person without obtaining consent from an enrollee.

[~~(c)~~](b) To facilitate cooperation with insurers, guidelines for medical privacy issues are provided under Rule R590-206, Privacy of Consumer Financial and Health Information Rule, and [~~Title V of~~]Gramm-Leach-Bliley Act of 1999, 15 U.S.C. 6801 et. seq.

[~~(d) Each person~~](c) Each enrollee claiming benefits under a plan shall give the insurer any [~~facts it needs~~]information necessary to pay the claim.

(6) Right of Recovery.

(a) If [~~the amount of the payments made by~~]an insurer is paid more than [~~it should have paid~~]required under [~~the provisions of~~]this rule, subject to Section 31A-26-301.6, [~~it~~]the insurer may recover the [~~excess paid~~]overpayment from one or more of the following[~~, if they were paid by the insurer~~]:

(i) [~~an insured~~]the enrollee;

(ii) [~~a non-contracted~~]the provider;

(iii) [~~a contracted provider;~~

~~(iv) other insurance companies~~]an insurer; or

[~~(v) other organizations~~](iv) another organization.

(b) [~~Reversals of payments made due to issues related to this rule are limited to the time period stated in Section 31A-26-301.6, except as provided in Section 31A-21-313.~~

~~(c) It is the insurer's responsibility to see that the proper~~]The insurer is responsible for adjustments between insurers and providers[~~ are made~~].

(7) Notice to [~~Covered Persons. A plan shall, in its~~]Enrollee. The explanation of benefits provided to [~~covered persons, include the following language: ~~]an enrollee shall include, "If you are covered by more than one health benefit plan, you should file all your claims with each plan."

(8) If [~~otherwise~~]covered benefits are due to a loss [~~subject to~~]under Section 31A-22-306, [~~then~~]an accident and health insurer may exclude benefits covered by personal injury protection described in Subsection 31A-22-307(1)(a), up to[~~ the~~]:

(a) the personal injury protection benefit provided by motor vehicle insurance; or

(b) if motor vehicle insurance is not in effect, the minimum amount [~~required by Section~~]provided in Subsection 31A-22-307(1)(a)[~~, if motor vehicle insurance is not in effect~~].

(9) Facility of Payment.

(a) [~~A payment made under another plan may include~~]If a plan pays an amount that should have been paid under [~~the~~]an insurer's plan[~~, and if it does~~], the insurer may pay that amount to the [~~organization that made that payment~~]other plan.

(b) The amount [~~paid will then be~~]the insurer pays to the other plan is treated as [~~though it were~~]a benefit paid under the plan and the insurer will not have to pay that amount again[~~.~~

~~(c) 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~~].

R590-131-9. COB Scenarios.

The [~~following~~]scenarios identified in this section are provided to [~~assist in demonstrating the~~]demonstrate the possible use of the COB rules.[~~:~~]

(1) Parents Not Married, Living Together, No Court [~~Decree~~]Order. The order of benefits [~~pursuant to~~]under Subsection R590-131-6(2)(a) [~~shall be~~]is:

(a)(i) the parent whose birthday falls earlier in the calendar year; then

[~~(b)~~](ii) the parent whose birthday falls later in the calendar year; or

[~~(c)~~](b)(i) if the parents have the same birthday, the plan that has covered the parent the longest; then

[~~(d)~~](ii) the plan that has covered the parent the shortest.

(2) Parents Divorced, Separated, [~~Or~~]or Not Living Together.

(a) [~~The court decree gives~~]A court order awards joint custody [~~with~~]to the parents, the father is responsible for the child's health care expenses or health care coverage, and the father has health care coverage. The order of benefits [~~pursuant to~~]under Subsection R590-131-6(2)(b)(i) [~~shall be the~~]is:

(i) natural father;

(ii) step[-]mother;

(iii) natural mother;[~~, then~~]

(iv) step[-]father.

(b) [~~The court decree gives~~]A court order awards joint custody [~~with~~]to the parents, the order specifies the father is responsible for the child's health care expenses or health care coverage, the father does not have health care coverage, [~~but his wife does~~]and the father's wife has health care coverage. The order of benefits [~~pursuant to~~]under Subsection R590-131-6(2)(b)(i) [~~shall be the~~]is:

(i) step[-]mother;

(ii) natural mother;[~~, then~~]

(iii) step[-]father.

(c) [~~The court decree gives~~]A court order awards custody to the father and requires both parents to [~~be responsible~~]share responsibility for the child's health care expenses or health care coverage. The father's [~~date of birth (DOB) 12/01~~]birthday is December 1, the step[-]mother's [~~DOB 02/17~~]birthday is February 17, the mother's [~~DOB 08/23~~]birthday is August 23, and the step[-]father's [~~DOB 01/10~~]birthday is January 1. The order of benefits [~~pursuant to~~]under Subsection R590-131-6(2)(b)(ii) [~~shall be the~~]is:

(i) step[-]father;

(ii) step[-]mother;

(iii) natural mother;[~~, then~~]

(iv) natural father.

(d) A court [~~decree~~]order awards joint custody[~~, and~~], the father physical custody[~~. The court decree does not address~~], and does not specify responsibility for the child's health care expenses or health care coverage. The father's [~~DOB is 12/01~~]birthday is December 1, the step[-]mother's [~~DOB is 02/17~~]birthday is February 17, the mother's [~~DOB is 08/23~~]birthday is August 23, and the step[-]father's [~~DOB is 01/10~~]birthday is January 10. The order of benefits [~~pursuant to~~]under Subsection R590-131-6(2)(b)(iii) [~~shall be the~~]is:

(i) step[-]father;

(ii) step[-]mother;

(iii) natural mother;[~~, then~~]

(iv) natural[-] father.

(e) A court [~~decree~~]order awards joint custody and requires both parents to [~~be responsible~~]share responsibility for health care expenses or health care coverage. The child lives with the mother 51% of the year. The father's [~~DOB is 12/01~~]birthday is December 1, the step[-]mother's [~~DOB is 02/17~~]birthday is February 17, the mother's [~~DOB is 08/23~~]birthday is August 23, and the step[-]father's [~~DOB is 01/10~~]birthday is January 10. The order of benefits [~~pursuant to~~]under Subsection R590-131-6(2)(b)(ii) [~~shall be the~~]is:

(i) step[-]father;

(ii) step[-]mother;

(iii) natural mother;[~~, then~~]

(iv) natural father.

(3) Parents Never Married, Not Living Together.

(a) [~~The parents are not living together and no~~]No court [~~decree~~]order exists. The order of benefits [~~pursuant to~~]under Subsection R590-131-6(2)(b)(iv) [~~shall be the~~]is;

(i) custodial parent;

(ii) custodial parent's spouse;

(iii) non-custodial parent;[~~, and then~~]

(iv) non-custodial parent's spouse.

(b) [~~The parents are not living together and the~~]A court [~~decree~~]order awards custody to the mother, [~~but the decree~~]and does not address the child's health care expenses or health care coverage. The order of benefits [~~pursuant to~~]under Subsection R590-131-6(2)(b)(iv) [~~shall be the~~]is:

(i) natural mother;

(ii) step[-]father;

(iii) natural father;[~~, then~~]

(iv) step[-]mother.

(4) [~~Children~~]Child No Longer [~~Minors~~]a Minor.

(a) A court [~~decree orders that~~]orders the natural father [~~is~~]to provide [~~insurance for the minor children~~]health care coverage for a child up to age 18 or while attending high school, whichever is later, and custody is awarded to the natural mother. [~~The dependents are age 18 and older~~]The child is now age 18, or older, no longer attends high school, and resides with the natural mother. The order of benefits [~~pursuant to~~]under Subsection R590-131-6(2)(b)(iv) [~~shall be the~~]is:

[~~(a)~~](i) natural mother;

[~~(b)~~](ii) step[~~-~~]father;

[~~(c)~~](iii) natural father;[~~ then~~]

[~~(d)~~](iv) step[~~-~~]mother.

(b) A court [~~decree orders that~~]orders the natural father [~~is~~]to provide [~~insurance for the minor child~~]health care coverage for a child up to age 18 or while attending high school, whichever is later, and custody is awarded to the natural mother. [~~The dependent is age 20 and does not reside at either parent's home~~]The child is now age 18, or older, no longer attends high school, and does not reside with either parent. The order of benefits [~~shall be based on~~]under Subsection R590-131-6(5)[~~, Longer or Shorter Length of Coverage.~~] is:

(i) the plan covering an enrollee for the longest period;

(ii) the plan covering an enrollee for the shortest period.

R590-131-10. [~~Effective Date for Existing Contracts.~~

~~A contract that provides health care benefits issued before the effective date of this rule shall be brought into compliance with this rule no later than the first renewal date on or after January 1, 2021.~~

~~R590-131-11. Penalties.~~

~~Any insurer that fails to comply with the provisions of this rule shall be subject to the forfeiture and penalty provisions of Section 31A-2-308.~~

~~R590-131-12.~~]Severability.

If any provision of this rule, R590-131, or its application to any person or situation is held invalid, such invalidity does not affect any other provision or application of this rule [~~which~~]that can be given effect without the invalid provision or application. The remainder of this rule shall be given effect without the invalid provision or application.

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