Subchapter V. Coordination of Benefits
28 TAC §§3.3502, 3.3503, and 3.3510

INTRODUCTION. The commissioner of insurance adopts amendments to 28 TAC §§3.3502, 3.3503, and 3.3510, concerning the applicability of coordination of benefits (COB) to vision and eye care plans. The amendments implement Senate Bill 861, 88th Legislature, 2023, and Senate Bill 1367, 83rd Legislature, 2013. The amendments are adopted without changes to the proposed text published in the February 9, 2024, issue of the *Texas Register* (49 TexReg 626). Figure: 28 TAC §3.3510(d) was republished for consistency and clarity in the March 1, 2024, issue of the *Texas Register* (49 TexReg 1315) without markup and with all proposed changes incorporated.

REASONED JUSTIFICATION. The amendments are necessary to enact changes in accordance with SB 1367, which abolished the Texas Health Insurance Pool, and SB 861, which specified COB requirements for vision benefit plans under Insurance Code Chapter 1203, Subchapter C. SB 861 set out provisions for the coordination of vision and eye care benefits. It also specified the responsibilities of the primary and secondary issuers of an applicable health or vision benefit plan for an enrollee who is covered by at least two different health or vision benefit plans that provide the enrollee coverage for the same vision or medical eye care services, procedures, or products.

The amendments to the sections are described in the following paragraphs.

Section 3.3502. To implement SB 861, an amendment to §3.3502 expands the applicability of the subchapter to include individual and group health benefit plans or

vision benefit plans, as described by Insurance Code Chapter 1203, Subchapter C, by adding new subsection (a)(6) listing such plans.

A nonsubstantive amendment relocates an exclusion addressing disability income protection coverage exclusion, removing it from subsection (a)(1) and addressing it with new text in (b)(1). Another amendment to subsection (a)(1) adds the title of Chapter 1251. And the acronym "(HMO)" is added to subsection (a)(2).

An amendment also removes a reference in subsection (b)(1) to the Texas Health Insurance Pool. The Texas Health Insurance Pool was dissolved by SB 1367, effective September 1, 2015.

Subsections (c) - (f) are also eliminated. The dates specified in these subsections have passed, and the transition period they establish is no longer needed. Existing subsection (g) is redesignated as new subsection (c).

Section 3.3503. To implement SB 861, the definition of "plan" under §3.3503(15) is expanded to include vision plans. An amendment to paragraph (15)(A)(iii) adds the terms "self-funded" and "self-insured" in parentheses to clarify the types of arrangements that are included in the definition. A nonsubstantive amendment to paragraph (15)(B) conforms to the changes made in §3.3502 by replacing the reference to the Texas Health Insurance Pool with a clarification of the exclusion of disability income protection coverage. An Insurance Code reference is also added to paragraph (15)(B)(v).

Section 3.3510. Amendments to Figure: 28 TAC §3.3510(d) update the definition of "plan" to add a reference to vision coverage and remove a reference to the Texas Health Insurance Pool, consistent with changes made in §3.3502 and §3.3503. These changes ensure the model COB contract provisions are consistent with the rules. Use of the model

COB contract provisions contained in Figure: 28 TAC §3.3510(d) is optional. Issuers may use the model COB provisions or make nonsubstantive changes to the provisions, as long as the contract provisions accurately reflect the COB rules. TDI also makes nonsubstantive amendments to Figure: 28 TAC §3.3510(e) to update the model COB notice to use more plain language and make the information easier for consumers to understand. The model COB notice is a resource for health benefit plan issuers. The notice provides a summary of the most common COB circumstances and does not replace or change the contract provisions.

SUMMARY OF COMMENTS. TDI provided an opportunity for public comment on the rule proposal for a period that ended on March 11, 2024. TDI did not receive any comments on the proposed amendments.

Subchapter V. Coordination of Benefits
28 TAC §§3.3502, 3.3503, and 3.3510

STATUTORY AUTHORITY. The commissioner adopts the amendments to §§3.3502, 3.3503, and 3.3510 under Insurance Code §1203.107 and §36.001.

Insurance Code §1203.107 provides that the commissioner may adopt rules necessary to implement Chapter 1203, Subchapter C.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§3.3502. Applicability.

(a) This subchapter applies to:

(1) group, blanket, or franchise accident and health insurance policies as described by Insurance Code Chapter 1251, concerning Group and Blanket Health Insurance;

(2) individual and group health maintenance organization (HMO) evidences of coverage as defined by Insurance Code §843.002, concerning Definitions;

(3) individual accident and health insurance policies as defined by Insurance Code §1201.001, concerning Definitions;

(4) individual and group preferred provider benefit plans and exclusive provider benefit plans as described by Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans;

(5) group insurance contracts, individual insurance contracts, and subscriber contracts that pay or reimburse for the cost of dental care;

(6) individual and group health benefit plans or vision benefit plans, as described by Insurance Code Chapter 1203, Subchapter C, concerning Vision and Eye Care Benefits; and

(7) the medical care components of individual and group long-term care contracts.

(b) This subchapter does not apply to:

(1) disability income protection coverage;

(2) workers' compensation insurance coverage;

(3) hospital indemnity coverage benefits or other fixed indemnity coverage;

(4) accident only coverage;

(5) specified disease or specified accident coverage;

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

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

(8) Medicare supplement policies;

(9) a state plan under Medicaid;

(10) a governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan; or

(11) an individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible.

(c) This subchapter does not apply to individual policies issued before March 25, 2014, that are noncancellable or guaranteed renewable.

§3.3503. Definitions.

The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise.

(1) Allowable expense--Except as otherwise provided in §3.3505 of this title (relating to Allowable Expenses), or where a statute requires a different definition, any health care expense, including coinsurance or copayments and without reduction for any

applicable deductible, that is covered in full or in part by any of the plans covering the person.

(2) Allowed amount--The amount of a billed charge that a carrier determines to be covered for services provided by a noncontracted health care provider or physician. The allowed amount includes the carrier's payment and any applicable deductible, copayment, or coinsurance amounts for which the insured is responsible.

(3) Birthday--Refers only to the month and day in a calendar year and does not include the year in which the individual is born.

(4) Carrier--An entity authorized under the Insurance Code to provide coverage subject to this subchapter, including an insurer, health maintenance organization, group hospital service corporation, or stipulated premium company.

(5) Certificate holder--An insured or enrollee who is covered other than as a dependent under a group plan or a group-type plan.

(6) Claim--A request that benefits be provided or paid. The benefits claimed may be in the form of:

(A) services, including supplies;

(B) payment for all or a portion of the expenses incurred;

(C) a combination of subparagraphs (A) and (B) of this paragraph; or

(D) an indemnification.

(7) Closed panel plan--A plan that provides health benefits to covered persons primarily in the form of services through a panel of health care providers and physicians that have contracted with or are employed by the plan, and that excludes benefits for services provided by other health care providers or physicians, except in cases of emergency or referral by a panel member.

(8) Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)--Coverage provided under a right of continuation under federal law.

(9) Contract--Refers to an insurance policy, insurance certificate, or health maintenance organization evidence of coverage.

(10) Coordination of benefits (COB)--A provision establishing an order in which plans pay their claims and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

(11) Custodial parent--

(A) the parent with the right to designate the primary residence of a child by a court order under the Family Code or other applicable law; or

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

(12) Group-type contract--A contract that is not available to the public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage.

(13) High-deductible health plan--A high-deductible health plan under §223 of the Internal Revenue Code of 1986, as amended by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and Insurance Code Chapter 1653, concerning High Deductible Health Plan.

(14) Hospital indemnity benefits--Benefits not related to expenses incurred. This 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.

(15) Plan--A form of coverage with which coordination is allowed. For purposes of this subchapter:

(A) plan includes:

(i) any contract to which this subchapter applies;

(ii) limited benefit policies under §3.3079 of this title (relating to Minimum Standards for Limited Benefit Coverage), excluding Disability Income Protection Coverage under §3.3075 of this title (relating to Minimum Standards for Disability Income Protection Coverage);

(iii) uninsured (i.e., self-funded or self-insured) arrangements of group or group-type coverage;

(iv) the medical benefits coverage in automobile insurance contracts;

(v) Medicare or other governmental benefits, as permitted by law;

(vi) group insurance contracts, individual insurance contracts, and subscriber contracts that pay or reimburse for the cost of dental care; and

(vii) individual and group health benefit plans or vision benefit plans, as described by Insurance Code Chapter 1203, Subchapter C, concerning Vision and Eye Care Benefits;

(B) plan does not include:

(i) disability income protection coverage;

(ii) workers' compensation insurance coverage;

(iii) hospital confinement indemnity coverage or other fixed indemnity;

(iv) specified disease coverage;

(v) supplemental benefit coverage under §3.3080 of this title (relating to Supplemental Coverage) and as described in Insurance Code Chapter 1203, concerning Coordination of Benefits Provisions;

(vi) accident-only coverage;

(vii) specified accident coverage;

(viii) 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;

(ix) benefits provided in long-term care insurance contracts for nonmedical 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;

(x) Medicare supplement policies;

(xi) a state plan under Medicaid;

(xii) a governmental plan which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan; or

(xiii) an individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible.

(16) Policyholder--The primary insured named in an individual health insurance policy or evidence of coverage.

(17) Primary plan--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:

(A) the plan either has no order of benefit determination rules, or its rules differ from those permitted by this subchapter; or

(B) all plans that cover the person use the order of benefit determination rules required by this subchapter, and under those rules, the plan determines its benefits first.

(18) Secondary plan--A plan that is not a primary plan.

§3.3510. Model COB Contract Provisions.

(a) Subsection (d) of this section contains an optional model COB provision form for use in contracts. The use of this model form is subject to the provisions of §3.3509 of this title (relating to Miscellaneous Provisions) and the provisions of §3.3507 of this title (relating to Rules for COB and Order of Benefits).

(b) Subsection (e) of this section contains an optional model plain language description of the COB process that explains to the covered person how health plans will implement COB. It is not intended to replace or change the provisions that are set forth in the contract. Its purpose is to explain the process by which two or more plans will pay for or provide benefits.

(c) A COB provision or a plain language description does not have to use the words and format shown in the model forms. Changes may be made to fit the language and style of the rest of the contract or to reflect the difference among plans that provide services, pay benefits for expenses incurred, and indemnify. No substantive changes are allowed.

(d) The model COB contract provisions are as follows:

Figure: 28 TAC §3.3510(d)

Form COB TX

Coordination of This Contract's Benefits with Other Benefits

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one plan. Plan is defined below.

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accord with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans equal 100 percent of the total allowable expense.

Definitions

(a) A "plan" is any of the following that provides benefits or services for medical, dental, or vision care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) Plan includes: group, blanket, or franchise accident and health insurance policies; individual and group health maintenance organization evidences of coverage; individual accident and health insurance policies; individual and group preferred provider benefit plans and exclusive provider benefit plans; group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care; a vision benefit plan that provides coverage for vision or eye care expenses; medical care components of individual and group long-term care contracts; limited benefit coverage that is not issued to supplement individual or group in-force policies; uninsured (i.e., self-funded or self-insured) arrangements of group or group-type coverage; the medical benefits coverage in automobile insurance contracts; and Medicare or other governmental benefits, as permitted by law.

(2) Plan does not include: disability income protection coverage; workers' compensation insurance coverage; hospital confinement indemnity coverage or

other fixed indemnity coverage; specified disease coverage; supplemental benefit coverage; accident only coverage; specified accident coverage; school accident-type coverages that cover students for accidents only, including athletic injuries, either on a "24-hour" or a "to and from school" basis; benefits provided in long-term care insurance contracts 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; Medicare supplement policies; a state plan under Medicaid; a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan; or an individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible.

Each contract for coverage under (a)(1) or (a)(2) is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

(b) "This plan" means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.

The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan. When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits equal 100 percent of the total allowable expense.

(c) "Allowable expense" is a health care expense, including deductibles, coinsurance, and copayments, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any

expense that a health care provider or physician by law or in accord with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

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

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

(2) If a person is covered by two or more plans that do not have negotiated fees and compute their benefit payments based on the usual and customary fees, allowed amounts, or relative value schedule reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

(3) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

(4) If a person is covered by one plan that does not have negotiated fees and that calculates its benefits or services based on usual and customary fees, allowed amounts, relative value schedule reimbursement methodology, or other similar reimbursement methodology, and another plan that provides its benefits or services based on negotiated fees, the primary plan's payment arrangement must be the allowable expense for all plans. However, if the health care provider or physician 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 health care provider's or physician's contract permits, the negotiated fee or payment must be the allowable expense used by the secondary plan to determine its benefits.

(5) The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, prior authorization of admissions, and preferred health care provider and physician arrangements.

(d) "Allowed amount" is the amount of a billed charge that a carrier determines to be covered for services provided by a nonpreferred health care provider or physician. The

allowed amount includes both the carrier's payment and any applicable deductible, copayment, or coinsurance amounts for which the insured is responsible.

(e) "Closed panel plan" is a plan that provides health care benefits to covered persons primarily in the form of services through a panel of health care providers and physicians that have contracted with or are employed by the plan, and that excludes coverage for services provided by other health care providers and physicians, except in cases of emergency or referral by a panel member.

(f) "Custodial parent" is the parent with the right to designate the primary residence of a child by a court order under the Texas Family Code or other applicable law, or in the absence of a court order, is the parent with whom the child resides more than one-half of the calendar year, excluding any temporary visitation.

Order of Benefit Determination Rules

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

(a) The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.

(b) Except as provided in (c), a plan that does not contain a COB provision that is consistent with this policy is always primary unless the provisions of both plans state that the complying plan is primary.

(c) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage must be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

(d) A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.

(e) If the primary plan is a closed panel plan and the secondary plan is not, the secondary plan must pay or provide benefits as if it were the primary plan when a covered person

uses a noncontracted health care provider or physician, except for emergency services or authorized referrals that are paid or provided by the primary plan.

(f) When multiple contracts providing coordinated coverage are treated as a single plan for the purposes of COB, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan must be responsible for the plan's compliance with this subchapter.

(g) If a person is covered by more than one secondary plan, the order of benefit determination rules of this subchapter decide the order in which secondary plans' benefits are determined in relation to each other. Each secondary plan must take into consideration the benefits of the primary plan or plans and the benefits of any other plan that, under the rules of this contract, has its benefits determined before those of that secondary plan.

(h) Each plan determines its order of benefits using the first of the following rules that apply.

(1) Nondependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber, or retiree, is the primary plan, and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent, then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policyholder, subscriber, or retiree is the secondary plan and the other plan is the primary plan. An example includes a retired employee.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court order stating otherwise, plans covering a dependent child must determine the order of benefits using the following rules that apply.

(A) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

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

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

(B) For a dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married:

(i) if a court order states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.

(ii) if a court order states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of (h)(2)(A) must determine the order of benefits.

(iii) if a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of (h)(2)(A) must determine the order of benefits.

(iv) if there is no court order allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child is as follows:

(I) the plan covering the custodial parent;

(II) the plan covering the spouse of the custodial parent;

(III) the plan covering the noncustodial parent; then

(IV) the plan covering the spouse of the noncustodial parent.

(C) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of (h)(2)(A) or (h)(2)(B) must determine the order of benefits as if those individuals were the parents of the child.

(D) For a dependent child who has coverage under either or both parents' plans and has their own coverage as a dependent under a spouse's plan, (h)(5) applies.

(E) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits must be determined by applying the birthday rule in (h)(2)(A) to the dependent child's parent(s) and the dependent's spouse.

(3) Active, Retired, or Laid-off Employee. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan that covers that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the plan that covers the same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if (h)(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by 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 COBRA, state, or other federal continuation coverage 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 benefits, this rule does not apply. This rule does not apply if (h)(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The plan that has covered the person as an employee, member, policyholder, subscriber, or retiree longer is the primary plan, and the plan that has covered the person the shorter period is the secondary plan.

(6) If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

Effect on the Benefits of This Plan

(a) When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then 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 equal 100 percent of the total allowable expense for that claim. In addition, the secondary plan must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

(b) If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a nonpanel provider, benefits are not payable by one closed panel plan, COB must not apply between that plan and other closed panel plans.

Compliance with Federal and State Laws Concerning Confidential Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. [Organization responsible for COB administration] will comply with federal and state law concerning confidential information for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. Each person claiming benefits under this plan must give [Organization responsible for COB administration] any facts it needs to apply those rules and determine benefits.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, [Organization responsible for COB administration] may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. [Organization responsible for COB administration] 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 the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by [Organization responsible for COB administration] is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

(e) The model COB notice publication is as follows:

Figure: 28 TAC §3.3510(e)

FORM COB NOTICE TX

What to know about coordination of benefits (COB)

Notice: This document is only a summary and does not cover every circumstance. Your benefits will be based on the official terms in your insurance contract. If you have questions, call your health plan at [company phone #] or the Texas Department of Insurance (TDI) Help Line at 800-252-3439.

It's common for families to have more than one health care plan. For example, this can happen if two parents both work and have family coverage through both employers.

When you have more than one health plan, state law allows your plan to follow a rule—called "coordination of benefits"—to decide how much each plan will pay when you have a claim. The goal is to make sure the two plans don't pay more than the total cost of the health care.

How do I know which plan will pay?

We will ask you what other health plans you and your family have. This will help us know if we are the "primary" or "secondary" payer. The primary plan always pays first when you

have a claim. Any plan that doesn't have Texas COB rules will be primary, unless both plans say that the plan with Texas COB rules is primary.

This health plan will be the primary plan if:

- The claim is for your own health care expenses. There is an exception if you have Medicare and you and your spouse are retired.
- The claim is for your spouse who has Medicare and you aren't both retired.
- The claim is for your child who is covered by this plan and any of these are true:
    - You're married and your birthday is earlier in the year than your spouse's.
    - You're living with another person (whether or not you've ever been married to that person) and your birthday is earlier than that other person's birthday. This is called the "birthday rule."
    - You're separated or divorced and you told us about a court order that makes you responsible for your child's health care expenses.
    - You don't have a court order, but you have custody of your child.

We will also be primary when state or federal law require us to be. We will be secondary when the rules don't require us to be primary.

How do we pay if we're the primary plan?

When we're the primary plan, we'll pay your health care, just as if you didn't have another plan.

How do we pay if we're the secondary plan?

When we're the secondary plan, we don't pay until the primary plan has paid. We will then pay some or all of the allowable expenses that are left. An "allowable expense" is a health care expense that's covered by your health plan.

Cost differences

If there's a cost difference between what the plans can pay, we will usually base our payment on the higher amount. If one plan has a contract with the doctor or facility and the other doesn't, our combined payments won't be more than the contracted amount. HMOs and PPOs usually have contracts with the providers in their networks.

We might lower our payment to be sure that the amount both plans pay toward your claim combine to equal the total cost. We will credit you any amount we would have paid if you didn't have another plan toward our plan's deductible.

We won't pay any health care expenses that your primary plan didn't cover because you didn't follow its rules and procedures. For example, say your plan paid a lower amount because you didn't get a prior authorization for your health care like the plan requires. We won't pay the amount of the reduction because it isn't an allowable expense.

CERTIFICATION. This agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on April 29, 2024.

DocuSigned by:
Jessica Barta
5DAC5618BBC74D4...

Jessica Barta, General Counsel
Texas Department of Insurance

The amendments to 28 TAC §§3.3502, 3.3503, and 3.3510 are adopted.

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Cbrown
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Cassie Brown
Commissioner of Insurance

Commissioner's Order No. 2024-8635