DEPARTMENT OF INSURANCE

Statutory Authority: 18 Delaware Code, Section 311 (18 **Del.C.** §311)
18 **DE Admin. Code** 1307

FINAL

ORDER

1307 Group Coordination Benefits [Formerly Regulation 61]

Proposed changes to Regulation 1307 relating to Group Coordination Benefits were published in the *Delaware Register of Regulations* on April 1, 2007. The comment period remained open until May 2, 2007. There was no public hearing on the proposed changes to Regulation 1307. Public notice of the proposed changes to Regulation 1307 in the *Register of Regulations* and two newspapers of general circulation were in conformity with Delaware law.

Summary of the Evidence and Information Submitted

Public comment was received as a result of the publication of the proposed changes for comment. That public comment expressed two area of concern: the first is that the coordination of benefits requirements could violate an insurance contract and current federal and state privacy laws. The second comment related to issuance of an insurance card, suggesting the providing of proof of insurance as an alternative. That public comment was considered and is reflected in the Regulation. With the reality of divorce and separation in marriages the need has long existed to provide insurance coverage for dependents in order to ensure that dependents have proof of coverage, no matter which parent is the ensured and which parents has custody.

Findings of Fact

Based on Delaware law and the record in this docket, I make the following findings of fact:

1. Either parent should be able to obtain from a carrier proof on insurance for a dependent without regard to which parent has custody or is the name insured.
2. Upon the request of either parent, the carrier needs to provide proof of insurance.
3. The providing of proof of insurance for the purposed of insurance for a dependent is not a violation of the privacy rights of the insured.

Decision and Effective Date

4. Based on the provisions of 18 **Del.C.** §§311(a) and 1307 and 29 **Del.C.** §§10113-10118 and the record in this docket, I hereby adopt Regulation 1307 as amended and as may more fully and at large appear in the version attached hereto to be effective on June 1, 2007.

Text and Citation

The text of the proposed amendments to Regulation 1307 last appeared in the *Register of Regulations* Vol. 10, Issue 10, pages 1539-1546.

IT IS SO ORDERED this 18th day of May 2007.

Matthew Denn
Insurance Commissioner

1307 Group Coordination Benefits [Formerly Regulation 61]

1.0 Authority

1.1 This regulation is adopted and promulgated by the Insurance Commissioner pursuant to 18 **Del.C.** §311 and promulgated under 29 **Del.C.** Ch. 101.

~~1.2 The purpose of the regulation is to:~~

~~1.2.1 permit, but not require, plans to include a coordination of benefits ("COB") provision;~~

~~1.2.2 establish an order in which plans pay their claims;~~

~~1.2.3 provide the authority for the orderly transfer of information needed to pay claims promptly;~~

~~1.2.4 reduce duplication of benefits by permitting a reduction of the benefits paid by a plan when the plan, pursuant to rules established by this regulation, does not have to pay its benefits first;~~

~~1.2.5 reduce claims payment delays; and~~

~~1.2.6 make all contracts that contain a COB provision consistent with this regulation.~~

~~1.3 The purpose of this Regulation is to encourage coordination of benefits, and is not intended to limit in any way the right to coordinate benefits which provide health coverage.~~

2.0 Purpose and Applicability

2.1 The purpose<u>s</u> of the~~is~~ <u>is</u> regulation ~~is~~ <u>are</u> to:

2.1.1 permit, but not require, plans to include a coordination of benefits ("COB") provision;

2.1.2 establish an order in which plans pay their claims;

2.1.3 provide the authority for the orderly transfer of information needed to pay claims promptly;

2.1.4 reduce duplication of benefits by permitting a reduction of the benefits paid by a plan when the plan, pursuant to rules established by this regulation, does not have to pay its benefits first;

2.1.5 reduce claims payment delays; and

2.1.6 make all contracts that contain a COB provision consistent with this regulation.

2.2 The purpose of this Regulation is to encourage coordination of benefits, and is not intended to limit in any way the right to coordinate benefits which provide health coverage.

3.0 Definitions

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

3.2 “Allowable Expense(s)” means the necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part under any of the plans involved, except where a statute requires a different definition.

3.2.1 Notwithstanding the above definition, items of expense under coverages such as dental care, vision care, prescription drug or hearing aid programs may be excluded from the definition of Allowable Expense. A plan which provides benefits only for any such items of expense may limit its definition of Allowable Expenses to like items of expense.

3.2.2 When a plan provides benefits in the form of service, the reasonable cash value of each service will be considered as both an Allowable Expense and a benefit paid.

3.2.3 The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice.

3.2.4 When COB is restricted in its use to specific coverage in a contract (for example, major medical or dental), the definition of "Allowable Expense" must include the corresponding expenses or services to which COB applies.

3.3 “Claim” means a request that benefits of a plan be provided or paid is a claim. The benefits claimed may be in the form of:

3.3.1 services (including supplies);

3.3.2 payment for all or a portion of the expenses incurred;

3.3.3 a combination of sections 3.3.1 and 3.3.2 above; or

3.3.4 an indemnification.

3.4 “Claim Determination Period” is the period of time, which must not be less than twelve consecutive months, over which Allowable Expenses are compared with total benefits payable in the absence of COB, to determine whether overinsurance exists and how much each plan will pay or provide.

3.4.1 The Claim Determination Period is usually a calendar year, but a plan may use some other

period of time that fits the coverage of the group contract. A person may be covered by a plan during a portion of a Claim Determination Period if that person's coverage starts or ends during the Claim Determination Period.

3.4.2 As each claim is submitted, each plan is to determine its liability and pay or provide benefits based upon Allowable Expenses incurred to that point in the Claim Determination Period. But that determination is subject to adjustment as later Allowable Expenses are incurred in the same Claim Determination Period.

3.5 “Coordination of Benefits” is a provision establishing an order in which plans pay their claims.

3.6 “Hospital Indemnity Benefits” are 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.

3.7 “Plan” means a form of coverage with which coordination is allowed. The definition of Plan in the group contract must state the types of coverage which will be considered in applying the COB provision of that contract. The right to include a type of coverage is limited by the rest of this definition.

3.7.1 The definition shown in the Model COB Provision, attached to this rule as Appendix A, is an example of what may be used. Any definition that satisfies this subsection may be used.

3.7.2 ~~This subsection uses the term "plan." However, a group contract may, instead, use "program" or some other term~~ When describing a plan, an insurer may use the term “program” or other similar term to describe the coverage under a plan.

3.7.3 Plan may include:

3.7.3.1 Group insurance and group subscriber contracts;

3.7.3.2 Uninsured arrangements of group or group-type coverage;

3.7.3.3 Group or group-type coverage through HMOs and other prepayment, group practice and individual practice plans;

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

3.7.3.5 The amount by which group or group-type hospital indemnity benefits exceed $100 per day;

3.7.3.6 The medical benefits coverage in group, group-type and individual automobile "no fault" and traditional automobile "fault" type contracts; and

3.7.3.7 Medicare or other governmental benefits, except as provided in section 3.7.3.8.7 below. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program.

3.7.3.8 Plan shall not include:

3.7.3.8.1 Individual or family insurance contracts;

3.7.3.8.2 Individual or family subscriber contracts;

3.7.3.8.3 Individual or family coverage through Health Maintenance Organizations (HMOs);

3.7.3.8.4 Individual or family coverage under other prepayment, group practice and individual practice plans;

3.7.3.8.5 Group or group-type hospital indemnity benefits of $100.00 per day or less;

3.7.3.8.6 School accident-type coverages. These contracts cover grammar, high school and college students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis; and

3.7.3.8.7 A State plan under Medicaid, and shall not include a law or plan when, by law, its benefits are in excess of those of any private insurance plan or other non-governmental plan.

3.8 “Primary Plan” is a plan whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration. A plan is a Primary Plan if either of the following

conditions is true:

3.8.1 The plan either has no order of benefit determination rules, or it has rules which differ from those permitted by this subchapter. There may be more than one Primary Plan; or

3.8.2 All plans which cover the person use the order of benefit determination rules required by this regulation, and under those rules the plan determines its benefits first.

3.9 "Secondary Plan" is a plan which is not a Primary Plan. If a person is covered by more than one Secondary Plan, the order of benefit determination rules of this regulation decide the order in which their benefits are determined in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or plans and the benefits of any other plan which, under the rules of this regulation, has its benefits determined before those of that Secondary Plan.

3.10 "This Plan" in a COB provision, refers to the part of the group 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 group contract providing health care benefits is separate from This Plan. A group contract may apply one COB provision to certain of its benefits (such as dental benefits), coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.

4.0 Model Cob Contract Provision

4.1 Appendix A contains a model COB provision for use in group contracts. That use is subject to the provisions of sections 4.2, ~~and~~ 4.3 and ~~to the provisions of section~~ 5.0.

4.2 A group contract's COB provision does not have to use the words and format shown at Appendix A. Changes may be made to fit the language and style of the rest of the group contract or to reflect the difference among plans which provide services, which pay benefits for expenses incurred, and which indemnify. No other substantive changes are allowed.

4.3 A group contract may not reduce benefits on the basis that:

4.3.1 another plan exists;

4.3.2 a person is or could have been covered under another plan, except with respect to Part B of Medicare; or

4.3.3 a person has elected an option under another plan providing a lower level of benefits than another option which could have been elected.

4.4 No contract may contain a provision that its benefits are "excess" or "always secondary" to any plan as defined in this regulation, except in accord with the rules permitted by this regulation.

5.0 Rules for Coordination of Benefits

5.1 The general order of benefits is as follows:

5.1.1 The Primary Plan must pay or provide its benefits as if the Secondary Plan or Plans did not exist. A Plan that does not include a coordination of benefits provision may not take the benefits of another Plan as defined in section 3.0~~, definitions~~ into account when it determines its benefits. There is one exception: a contract holder's coverage that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder.

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

5.1.3 The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than a dependent) are determined before those of the plan which covers the person as a dependent.

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

5.2.1 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;

5.2.2 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;

5.2.3 The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born;

5.2.4 A group contract which includes COB and which is issued or renewed, or which has an anniversary date on or after sixty days after the effective date of this subchapter shall include the substance of the provision in sections 5.2.1, 5.2.2, and 5.2.3 above. Until that provision becomes effective, the group contract may

instead contain wording such as: "Except as stated in section 5.1.3, the benefits of a plan which covers the person as a dependent of a female."

5.2.5 If the other plan does not have the rule described in sections 5.2.1, 5.2.2, and 5.2.3 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 will determine the order of benefits.

5.3 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:

5.3.1 First, the plan of the parent with custody of the child;

5.3.2 Then, the plan of the spouse of the parent with the custody of the child; and

5.3.3 Finally, the plan of the parent not having custody of the child.

5.3.4 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 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.

5.3.5 Upon request by either parent of a dependent child, a carrier subject to this Section 5.3 shall immediately issue an insurance card **[~~showing~~ or, if it does not issue such cards to its policy holders, equivalent]** proof of applicable insurance for the dependent child to the parent making such request.

5.3.6 If benefits are not assigned and would be paid to an individual other than the provider, the carrier shall issue the benefits to the parent who sought the treatment for the dependent child.

5.4 The benefits of a plan ~~which~~ that 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 is ignored.

5.5 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.

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

5.5.2 The start of a new plan does not include:

5.5.2.1 a change in the amount of scope of a plan's benefits;

5.5.2.2 a change in the entity which pays, provides or administers the plan's benefits; or

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

5.5.3 The claimant's length of time covered under a plan is measured from the claimant's first date of coverage under that plan. If that date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time the claimant's coverage under the present plan has been in force.

6.0 Procedure to be Followed by Secondary Plan

6.1 Total Allowable Expenses

6.1.1 When it is determined, pursuant to section 5.0, that this Plan is a Secondary Plan, it may reduce its benefits so that the total benefits paid or provided by all plans during a Claim Determination Period are not more than total Allowable Expenses. 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 determines its obligation to pay for Allowable Expenses based on all claims which were submitted up to that point in time during the Claim Determination Period.

6.1.2 The benefits of the Secondary Plan will be reduced when the sum of the benefits that would be payable for the Allowable Expenses under the Secondary Plan in the absence of the 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 claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of the Secondary Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

6.1.2.1 When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

6.1.2.2 Section 6.1.2.1 above may be omitted if the plan provides only one benefit, or may be altered to suit the coverage provided.

7.0 Miscellaneous Provisions

7.1 Reasonable Cash Values of Services

7.1.1 A Secondary Plan which provides benefits in the form of services may recover the reasonable cash value of providing the services from the Primary Plan, to the extent that benefits for the services are covered by the Primary Plan. Nothing in this provision shall be interpreted to require a plan to reimburse a covered person in cash for the value of services provided by a plan which provides benefits in the form of services.

7.2 Excess and Other Nonconforming Provisions

7.2.1 Some plans have order of benefit determination rules not consistent with this regulation which declare that the plan's coverage is "excess" to all others, or "always secondary." This occurs because certain plans may not be subject to insurance regulation, or because some group contracts have not yet been conformed ~~with~~ to this regulation pursuant to section 2.0.

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

7.2.2.1 If the Complying Plan is the Primary Plan, it shall pay or provide its benefits on a primary basis;

7.2.2.2 If the Complying Plan is the Secondary Plan, it shall, never the less, pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the Complying Plan were the Secondary Plan. In such a situation, such payment shall be the limit of the Complying Plan's liability; and

7.2.2.3 If the Noncomplying Plan does not provide the information needed by the Complying Plan to determine its benefits within a reasonable time after it is requested to do so, the Complying Plan shall assume that the benefits of the Noncomplying Plan are identical to its own, and shall pay its benefits accordingly. However, the Complying Plan must adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the Noncomplying Plan.

7.2.3 If the Noncomplying Plan reduces its benefits so that the employee, subscriber, or member receives less in benefits than he or she would have received had the Complying Plan paid or provided its benefits as the Secondary Plan and the Noncomplying Plan paid or provided its benefits as the Primary Plan, and governing State law allows the right of subrogation set forth below, then the Complying Plan shall advance to or on behalf of the employee, subscriber or member an amount equal to such difference. However, in no event shall the Complying Plan advance more than the Complying Plan would have paid had it been the Primary Plan less any amount it previously paid. In consideration of such advance, the Complying Plan shall be subrogated to all rights of the employee, subscriber or member against the Noncomplying Plan. Such advance by the Complying Plan shall also be without prejudice to any claim it may have against the Noncomplying Plan in the absence of such subrogation.

7.3 Allowable Expense

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

7.4 Subrogation

7.4.1 The COB concept clearly differs from that of subrogation. Provisions for one may be included in health care benefits contracts without compelling the inclusion of the other.

8.0 Effective Date; Compliance Dates of Existing Contracts

8.1 ~~This subchapter is applicable to every group contract which provides health care benefits and which is issued on or after the effective date of this regulation, which is 30 days after signature of the Commissioner.~~ This regulation first became effective on October 6, 1988. The amendments hereto shall become effective on June 11, 2007.

8.2 A group contract which provides health care benefits and was issued before the effective date of

this regulation shall be brought into compliance with this regulation by the later of:

8.2.1 the next anniversary date or renewal date of the group contract; or

8.2.2 the expiration of any applicable collectively bargained contract pursuant to which it was written.

Appendix A. Model Cob Provisions
Coordination Of The Group Contracts 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:

(1) Shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another plan; but

(2) 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."

II. Definitions

A. "Plan" is any of these which provides benefits or services for, or because of, medical or dental care or treatment:

(1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

(2) 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).

Each contract or other arrangement for coverage under (1) or (2) 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 a necessary, reasonable and customary item of expense for health care; when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition 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. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

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:

(1) The other plan has rules coordinating its benefits with those of This Plan; and

(2) Both those rules and This Plan's rules, in Subsection 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:

(1) Non-Dependent/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.

(2) Dependent Child/Parents not Separated or Divorced. Except as stated in Paragraph (B)(3) 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 one 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.

(3) Dependent Child/Separated or Divorced. If two or more plans cover a person as a dependent child of divorces 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 expense of the child, and 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 the actual knowledge.

(d) Upon request by either parent of a dependent child, a carrier subject to this Section 5.3 shall immediately issue an insurance card showing proof of applicable insurance for the dependent child to the parent making such request.

(e) If benefits are not assigned and would be paid to an individual other than the provider, the carrier shall issue the benefits to the parent who sought the treatment for the dependent child.

(4) 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 (4) is ignored.

(5) 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:

(1) The benefits that would be payable for the Allowable Expense under This Plan in the absence of the COB provision; and

(2) 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. When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

V. Right To Receive And Release Needed Information

Certain facts are needs 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.