**Section 2009.40 Standards for Coordination of Benefits**

a) General

The general order of benefits is as follows:

1) The primary plan must pay or provide its benefits as if the secondary plan or plans do not exist. A plan that does not include a coordination of benefits provision may not take the benefits of another plan 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 is excess to any other parts of the plan provided by the contract holder.

2) A secondary plan may take the benefits of another plan into account only when, under these standards, it is secondary to that other plan.

3) The benefits of the plan that covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan that covers the person as a dependent; except that, if the person is also a Medicare beneficiary, Medicare is:

A) Secondary to the plan covering the person as a dependent; and

B) Primary to the plan covering the person as other than a dependent, for example a retired employee.

b) Dependent Child/Parents not Separated or Divorced

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

1) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year;

2) If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time;

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

4) A contract that includes COB and that is issued or renewed, or that has an anniversary date on or after January 7, 1989, shall include the substance of subsections (b)(1), (2) and (3).

5) If the other plan does not reflect the standards of subsections (b)(1), (2) and (3), but instead has a standard based upon the gender of the parent and, if, as a result, the plans do not agree on the order of benefits, the standard based upon the gender of the parent will determine the order of benefits.

c) Dependent Child/Separated or Divorced Parents

1) If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in the following order:

A) First, the plan of the parent with custody of the child;

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

C) Finally, the plan of the parent not having custody of the child.

2) 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 been informed of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the secondary plan. This subsection 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.

d) Dependent Child/Joint Custody

If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plan covering the child shall follow the order of benefit determination outlined in subsection (b).

e) Young Adult/Dependent

For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, subsection (h) applies. 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 shall be determined by applying the birthday rule of subsection (b) to the dependent child's parent or parents and the dependent's spouse.

f) Active/Inactive Employees

The benefits of a plan 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 that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other plan does not have this standard and if, as a result, the plans do not agree on the order of benefits, this subsection (f) shall not apply.

g) Continuation Coverage

1) If a person whose coverage is provided under a right of continuation, pursuant to federal or State law, also is covered under another plan, the following shall be the order of benefit determination:

A) First, the benefits of a plan covering the person as an employee, member or subscriber (or as that person's dependent);

B) Second, the benefits under the continuation coverage.

2) If the other plan does not contain the order of benefits determination described in subsection (g)(1) and, if, as a result, the plans do not agree on the order of benefits, this subsection (g) shall not apply.

h) Longer/Shorter Length of Coverage

If none of the other standards of this Section determines the order of benefits, the benefits of the plan that covered an employee, member or subscriber longer are determined before those of the plan that covered that person for the shorter term.

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 24 hours after the first ended.

2) The start of a new plan does not include:

A) A change in the amount of 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 that of a multiple employer plan).

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.

(Source: Amended at 39 Ill. Reg. 12548, effective September 1, 2015)