VIII. COORDINATION OF BENEFITS (COB)

Certain terms used in this Section are defined throughout and/or in the **Glossary of Terms.**

Coordination of Benefits Provision

This Coordination of Benefits (COB) section applies when a Member has coverage through more than one health plan (such as a group-type or government plan) or out-of-network pharmacy policy, as described below. Please note that We coordinate benefits following all applicable federal and state laws.

Definitions: For the purpose of this COB section, the following terms are defined:

Plan for the purposes of this Coordination of Benefits Section means any of the following that provides benefits or services for, or because of, medical or dental care:

- Individual or 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.
- 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 (42 USC 301 et seq.), as amended from time to time).
- Each contract or other arrangement for coverage described above is a separate plan. Also, if an arrangement has two parts and Coordination of Benefits rules apply only to one of the two, each of the parts is a separate plan.

Plan does not include:

- Hospital indemnity coverage benefits or other fixed indemnity coverage;
- Accident only coverage;
- Specified disease or specified accident coverage;
- Limited benefit health coverage;
- 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;
- 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 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,
- Disability income protection coverage.

This Plan means the group health plan offered by Us and described in this Certificate.

Primary Plan means the Plan that pays for health care expenses first. When this Plan is Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

Secondary Plan means the Plan that pays for health care expenses after the Primary Plan pays. 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.

Allowable Expense means a necessary, usual 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 semiprivate hospital room is not considered an Allowable Expense under this 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 cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

Claim Determination Period means the Benefit 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 Coordination of Benefits provision or a similar provision takes effect.

Effect on the Benefits of this Plan

We will apply these provisions when you incur Allowable Expenses, during a Benefit Year, for which benefits are payable under any other Plan. The provisions will apply only when the sum of the Allowable Expenses under This Plan and any other Plan would, in the absence of this COB provision or any similar provision in the other Plan, exceed the Allowable Expenses.

Benefits provided under This Plan during a Benefit Year for Allowable Expenses incurred will be determined as follows:

1. If benefits under this Plan are to be paid after any other Plan, the benefits under This Plan will be reduced so total benefits payable by all Plans will not exceed the total of the Allowable Expenses; or,
2. If benefits under This Plan are to be paid before benefits are paid under any other Plan, benefits under This Plan will be paid without regard to the other Plan.

Allowable Expenses under any other Plan include the benefits that would have been payable had a Claim been duly made.

Reimbursement will not exceed 100 percent of the total Allowable Expenses incurred under This Plan and any other Plan included under this provision.

Order of Benefit Determination Rules

This Plan determines the order of benefits using the first of the following rules that applies:

1. Non-Dependent before Dependent

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

However, if the person is also a Medicare beneficiary, 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, for example a retired employee.

2. Dependent Child – Parents Not Separated or Divorced

- When this Plan and another Plan cover the same child as a dependent of different subscribers:
  - The Plan benefits of the parent whose birthday (month and day) falls earlier in a calendar year are determined before those of the Plan of the parent whose birthday falls later in the year.
  - If both parents have the same birthday, whichever parent's plan has been in effect longer is primary.

"Birthday" means the month and day (e.g., January 20) the parent was born. The year of birth is not considered when determining which parent's birthday comes first. Determining the order of plans by looking to whose birthday falls earlier in the year is referred to as the "Birthday Rule."

3. Dependent Child – Separated or Divorced Parents

If two or more Plans cover a person as a Dependent Child of divorced or separated parents, benefits for the Child are determined in this order:

- When parents are separated or divorced and the parent with custody of the Child has not remarried, the benefits of a Plan that covers the Child as a Dependent of the parent with custody of the Child will be determined before the benefits of a Plan that covers the Child as a Dependent of the parent without custody.
- If two or more Plans cover a person as a Dependent Child of divorced or separated parents and the parent with custody of the Child has remarried, benefits for the Child are determined in the following order:
  - First, the Plan of the parent with custody of the Child;
  - Then, the Plan of the spouse of the parent with custody of the Child; and,
  - Finally, the Plan of the parent not having custody of the Child.
- However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the Child, and 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. This paragraph does not apply with respect to any Benefit Year during which any benefits are actually paid or provided before the entity has that actual knowledge. It is the obligation of the person claiming benefits to notify Us and, upon Our request, to provide a copy of the court decree.

4. Dependent Child – if Parents Share Joint Custody

If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the Birthday Rule described in #2.

5. Young Adult Dependent

   For an adult 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, the Longer/Shorter rule described in #8 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 will be determined by applying the Birthday Rule described in #2 to the dependent child's parent or parents and the dependent's spouse.

6. Active Employee before Inactive Employee

   The benefits of a Plan that covers a person as a laid-off or retired Employee or as the Dependent of laid-off or retired Employee are determined after the benefits of a Plan that covers such person through present employment.

7. Continuation Coverage is Secondary

   If a person has continuation coverage under Federal or State law and is also covered under another Plan, the Plan covering the person as an Employee, Member or Subscriber or as a Dependent of an Employee, Member or Subscriber is the Primary Plan and the continuation coverage is the Secondary Plan.

8. Longer Length of Coverage before Shorter Length of Coverage

   The benefits of a Plan that has covered the member for the longer length of time are determined before the benefits of a Plan that has covered such person for the shorter length of time. This rule is referred to as the "Longer/Shorter Rule."

   Whenever one plan does not contain a COB provision, that plan must pay its benefits before any other plan pays.

   When these provisions reduce the total amount of benefits otherwise payable to you under this Plan during any Benefit Year, each benefit that would be payable in the absence of this provision is reduced proportionately and such reduced amounts are charged against any applicable benefit limit under this Plan.

Coordination of Benefits with Medicare

This section explains how the benefits under this plan work with benefits available under Medicare.

When we say Medicare, we mean the health insurance provided by Title XVIII of the Social Security Act, as amended. It also includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of Medicare.

You are eligible for Medicare when you meet the criteria for coverage because of:

- Your age;

- A disability;
- End stage renal disease (ESRD).

You are also eligible for Medicare even if you are not enrolled because you:
- Refused it;
- Dropped it;
- Did not make a proper request for it.

When a member is enrolled in both Medicare and an Individual Health Plan, Medicare is the primary payer.

Facility of Payment
A payment made under another plan may include an amount that should have been paid under this plan. If this occurs, We may pay that amount to the organization that made that payment. That amount will then be treated as if it were a benefit paid under this plan. We will be fully discharged from liability under this plan to the extent of any payment so made. The term "payment made" means cash value of the benefits provided in the form of services.

Right to Recovery
We reserve the right to recover any payment made for an Allowable Expense under this Plan in the amount by which the payment exceeds the maximum amount We are required to pay under these provisions.

This right of recovery applies to Us against the following:
- Any person(s) to, for or with respect to whom, such payments were made; or,
- Any other insurance company or organization which, according to these provisions, owes benefits due for the same Allowable Expense under any other Plan.

We shall determine against whom this right of recovery will be exercised.

End of Section VIII