

COORDINATION OF BENEFITS

IMPORTANT NOTICE

This is a summary of only a few of the provisions of your health plan to help you understand coordination of benefits, which can be very complicated. This is not a complete description of all of the coordination rules and procedures, and does not change or replace the language contained in your insurance contract, which determines your benefits.

Double Coverage

It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.

When you are covered by more than one health plan, state law permits issuers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

Coordination of benefits (COB) is complicated, and covers a wide variety of circumstances. This is only an outline of some of the most common ones. If your situation is not described, read your evidence of coverage or contact your state insurance department.

Primary or Secondary?

You will be asked to identify all the plans that cover members of your family. To avoid delays in claim processing, if you are covered by more than one plan you should promptly report to your providers and plans any changes in your coverage. We need this information to determine whether we are the "primary" or "secondary" benefit payer. The primary plan always pays first when you have a claim.

Any plan that does not contain your state's COB rules will always be primary.

When This Plan is Primary

If you or a family member is covered under another plan in addition to this one, we will be primary when:

Your Own Expenses

- The claim is for your own health care expenses, unless you are covered by medicare and both you and your spouse are retired.

Your Spouse's Expenses

- The claim is for your spouse, who is covered by medicare, and you are not both retired.

- **Your child's expenses.** The claim is for the health care expenses of your child who is covered by this plan; and

- You are married and your birthday is earlier in the year than your spouse's or you are living with another individual, regardless of whether or not you have ever been married to that individual, and your birthday is earlier than that other individual's birthday. This is known as the "birthday rule"; or

- You are separated or divorced and you have informed us of a court decree that makes you responsible for the child's health care expenses; or

- There is no court decree, but you have custody of the child.

Other Situations

We will be primary when any other provisions of state or federal law require us to be.

How We Pay Claims When We Are Primary

When we are the primary plan, we will pay the benefits according to the terms of your contract, just as if you had no other health care coverage under any other plan.

How We Pay Claims When We Are Secondary

When we are knowingly the secondary plan, we will make payment promptly after receiving payment information from your primary plan. Your primary plan, and we as your secondary plan, may ask you and/or your provider for information in order to make payment. To expedite payment, be sure that you and/or your provider supply the information in a timely manner.

If the primary plan fails to pay within sixty calendar days of receiving all necessary information from you and your provider, you and/or your provider may submit your claim for us to make payment as if we were your primary plan. In such situations, we are required to pay claims within thirty calendar days of receiving your claim and the notice that your primary plan has not paid. This provision does not apply if medicare is the primary plan. We may recover from the primary plan any excess amount paid under the "right of recovery" provision in the plan.

- If there is a difference between the amounts the plans allow, we will base our payment on the higher amount. However, if the primary plan has a contract with the provider, our combined payments will not be more than the amount called for in our contract or the amount called for in the contract of the primary plan, whichever is higher. Health maintenance organizations (HMOs) and health care service contractors usually have contracts with their providers as do some other plans.

- We will determine our payment by subtracting the amount paid by the primary plan from the amount we would have paid if we had been primary. We must make payment in an 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 to one hundred percent of the total allowable expense (the highest of the amounts allowed under each plan involved) for your claim. We are not required to pay an amount in excess of our maximum benefit plus any accrued savings. If your provider negotiates reimbursement amounts with the plan(s) for the service provided, your provider may not bill you for any excess amounts once he/she has received payment for the highest of the negotiated amounts. When our deductible is fully credited, we will place any remaining amounts in a savings account to cover future claims which might not otherwise have been paid. For example, if the primary plan covers similar kinds of health care expenses, but allows expenses that we do not cover, we may pay for those expenses.

Questions About Coordination of Benefits? Contact Your State Insurance Department

[Statutory Authority: RCW 48.02.060, 48.21.200, 48.44.050, and 48.46.200. WSR 09-16-073 (Matter No. R 2008-20), § 284-51-260, filed

7/30/09, effective 9/1/09; WSR 07-13-008 (Matter No. R 2005-07), § 284-51-260, filed 6/8/07, effective 7/9/07.]