MEMORANDUM

To: County of Sonoma
Joint Labor Management Benefits Committee

From: Thomas M. Morrison, Jr.

Date: February 19, 2009

Re: Overview of Coordination of Benefits Rules

Attached are abstracts from the Plans’ Benefit Descriptions with respect to individual plan rules regarding coordination of benefits (COB). COB rules are governed for HMO plans in California by the Department of Managed Health Care (DMHC) and, for insured and self-insured PPO and other plans, by the National Association of Insurance Commissioners (NAIC).

HMO plans must comply with the DMHC guidelines to be licensed in California. Self-insured plans, such as all of the County Health Plans, may voluntarily abide by the NAIC guidelines; however, if they do not adhere to these guidelines, there are penalties. The penalty for not adhering to the NAIC guidelines is that the non-compliant plan will always be treated as primary, even though it may have otherwise been secondary in the order of payment.

CMS, which administers Medicare benefits, determines the order in which plans coordinate with Medicare for active employees and dependents and differently for retirees and their covered dependents covered by Medicare. New federal guidelines have been issued with respect to MediCal and Medicaid programs that always assume a secondary position, as does TRICARE with respect to Group Health Plans.

DMHC, NAIC, Medicare and TRICARE guidelines are the same in all areas except primary and secondary payment determination, except that in a secondary position, HMOs do not have to pay for any non-network services paid for when compared to the HMOs contracted network. Medicare, MediCal and TRICARE will never pay for any charges above a pre-contracted amount.
The COB rules cover:

- The order of determination for primary and secondary payer when more than one plan covers an employee, retiree or the spouse or dependent of an employee or retiree. For dependents, such things as "the birthday rule" is included in the payment order determination.

- The accepted types of COB, that is full supplement, carve out or non-duplication (benefits less benefits) and COB bank determinations. The CHP uses a full supplement method.

- Rules with respect to Court Ordered coverage for a former spouse and/or dependent

- How COBRA integrates with other coverage

- Rules when the primary and secondary determination is not possible

- Rules with respect to personal insurance (individually obtained health policies, such as AFLAC) and the medical payment component of automobile, travel accident and homeowners policies

- Treatment of liability settlements and the rights of subrogation of a plan, which are governed by individual state laws

It is important to note that coordination between HMO plans is limited to services provided within the closed panel, if the HMO is providing a closed panel type plan, such as Kaiser. In addition, HMOs are required by DMHC to do reserve accounting to pay for copayment and deductibles out of this reserve account if as the secondary plan, it pays less than it would otherwise have paid as primary. This can result in no copayments if duplicate HMO coverage exists.

We look forward to reviewing the individual rules of the Plans at this meeting.

/gg

Attachments

cc: Marcia Chadbourne  
    Jill Hager  
    Serena Chamberlain

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QUICK TIPS:

- When a person is covered by two or more plans, the primary plan must pay benefits as if the secondary plan(s) does not exist.
- Only a secondary plan may consider the benefits paid by another plan.
- A plan that covers an active employee (or dependent of an active employee) who is neither laid off nor retired is primary. However, this rule has no effect if the other plan does not have this rule and the two plans cannot come to an agreement as to the order of benefits.

Note: It is at the discretion of the individual states whether to adopt COB regulations based on the model guidelines drafted by the National Association of Insurance Commissioners (NAIC). As such, the proper procedure for the coordination of benefits among multiple plans is governed by the applicable statutory and contractual language, and to what extent those provisions incorporate these model rules.

In General:
The Model Coordination of Benefits (COB) rules apply to group insurance coverage, Medicare, and other governmental benefits, as permitted by law, except state plans under Medicaid. Other plans of coverage with which coordination is not allowed are individual plans, school accident-type coverage, long-term care indemnity policies, Medicare supplement.

Dependent Coverage:
If a person is the primary insured on a policy, for example as an employee, member, subscriber or retiree, and also is covered as a dependent under another plan, the plan that covers the person as an employee, retiree, etc., is primary and the plan that covers the person as a dependent is secondary. The exception to the rule is if the person is a Medicare recipient and as a result of Title XVII of the SSA, Medicare is secondary to the dependent coverage and primary to the plan covering the person as other than a dependent (e.g., employee, retiree, etc.). In that case, the plan covering the person as other than a dependent is secondary and the plan covering the person as a dependent is primary.

Dependent Child Coverage (“Birthday Rule”)
1. If a child is covered under more than one plan, the primary plan is the plan of the parent whose birthday is earlier in the year. This is the case if the parents are married or not separated (whether or not they were ever married), or if a court decree awarding joint custody does not stipulate that one parent is responsible for the child’s health care.

2. An actual court decree that stipulates that one parent is responsible for the child’s health care will have no effect on the order of benefit determination unless the plan of that parent has actual knowledge of those terms of the decree.

3. If there is no court decree allocating responsibility for the health care expenses of a child whose parents are not married or separated (whether or not they ever were married) or divorced, the order of benefit determination is as follows:

*This Material is provided for informational purposes only, and should not be construed as legal advice on any matter.*
QUICK TIPS:

- If the plans can not determine the order of benefits within 30 days, then each plan should pay its equal share of the claim and determine individual liability some time following the payment; however, no plan should be required in these circumstances to pay more than it would be required to if it were primary.

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1. Custodial parent’s plan
2. Plan of spouse of custodial parent
3. Non-custodial parent’s plan; and then
4. The plan of spouse of the non-custodial parent.

COBRA:
Continuation coverage pursuant to COBRA or comparable state law is secondary to the coverage under another plan covering the person as an employee, member, subscriber or retiree (or dependent thereof). However, this rule has no effect if the other plan does not have this rule and the two plans can not come to an agreement as to the order of benefits.

Length of Coverage:
If none of the above rules determine which plan is primary, benefits for the plan that covered the person for the longer period of time should be determined first, and that plan shall be primary.

What about secondary plans?
For the purpose of eliminating duplication of benefits, a secondary plan must reduce its benefits so that the total benefits paid during a claim determination period do not exceed 100% of allowable expenses. Examples of expenses that are not “allowable expenses” are private room charges and charges that exceed an applicable usual and customary (U&C) rate or negotiated fee. If one plan uses a U&C reimbursement methodology and the other plan calculates its benefits per a negotiated fee, the primary plan’s payment arrangement must be the “allowable expense” for all plans. If a provider has a contract with both plans, the provider may bill the higher of the two rates, if this is permitted in the contract.

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Offered by PacifiCare of California
Combined Evidence of Coverage and Disclosure Form (HMO)
Any payment assumes you have not exceeded your benefit limits. If you’ve reached or exceeded any applicable benefit limit, these bills will be your responsibility.

**How To Avoid Unnecessary Bills**

Always obtain your care under the direction of PacifiCare, your Participating Medical Group, or your Primary Care Physician. By doing this, you only will be responsible for paying any related Copayments and for charges in excess of your benefit limitations. Except for Emergency or Urgently Needed Services, if you receive services not authorized by PacifiCare or your Participating Medical Group, you may be responsible for payment. This is also true if you receive any services not covered by your plan. (Services not covered by your plan are included in Section 5. Your Medical Benefits.)

**Your Billing Protection**

All PacifiCare Members have rights that protect them from being charged for Covered Services in the event a Participating Medical Group does not pay a Provider, a Provider becomes insolvent or a Provider breaches its contract with PacifiCare. In none of these instances may the Participating Provider send you a bill, charge you, or have any other recourse against you for a Covered Service. However, this provision does not prohibit the collection of Copayment amounts as outlined in the *Schedule of Benefits.*

In the event of a Provider’s insolvency, PacifiCare will continue to arrange for your benefits. If for any reason PacifiCare is unable to pay for a Covered Service on your behalf (for instance, in the unlikely event of PacifiCare’s insolvency or a natural disaster), you are not responsible for paying any bills as long as you received proper authorization from your PacifiCare Participating Provider. You may, however, be responsible for any properly authorized Covered Services from a Non-Participating Provider or Emergency or Urgently Needed Services from a Non-Participating Provider.

**Note:** If you receive a bill because a Non-Participating Provider refused to accept payment from PacifiCare, you may submit a claim for reimbursement. See above: “Bills From Non-Participating Providers.”

**Coordination of Benefits**

Coordination of Benefits (COB) is a process, regulated by law, which determines the financial responsibility for payment when a person has group health care coverage under more than one plan. “Plan” is defined below. COB is designed to provide maximum coverage for medical and Hospital Services at the lowest cost by avoiding excessive or duplicate payments.

The objective of COB is to ensure that all group Health Plans that provide coverage to an individual will pay no more than 100 percent of the allowable expense for services that are received. This payment will not exceed total expenses incurred or the reasonable cash value of those services and supplies when the group Health Plan provides benefits in the form of services rather than cash payments.

PacifiCare’s COB activities will not interfere with your medical care.

The order of benefit determination rules below determine which Health Plan will pay as the Primary Plan. The Primary Plan that pays first pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the benefits it pays so that payment from all group plans do not exceed 100 percent of the total allowable expense. “Allowable Expense” is defined below.

**Definitions**

The following definitions only apply to coverage provided under this explanation of Coordination of Benefits.

A. **A Plan** is any of the following that provides benefits or services for medical or dental care or treatment.

1. **Plan** includes: group insurance, closed panel (HMO, POS, PPO or EPO) coverage or other forms of group or group-type coverage (whether insured or uninsured); Hospital indemnity benefits in excess of $200 per day; medical care components of group long-term care contracts, such as Skilled Nursing Care;
or other governmental benefits, as permitted by law (Medicare is not included as a “Plan” as defined here; however, PacifiCare does coordinate benefits with Medicare. Please refer to Section 6, "Important Rules for Medicare and Medicare Eligible Members."

2. **Plan** does not include: non-group coverage of any type, including, but not limited to, individual or family insurance; amounts of Hospital indemnity insurance of $200 or less per day; school accident-type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies, a state plan under Medicaid; and coverage under other governmental plans, unless permitted by law.

Each contract for coverage under (1) or above is a separate Plan. However, if the same carrier provides coverage to Members of a group under more than one group contract each of which provide for different types of coverage (for example, one covering dental services and one covering medical services), the separate contracts are considered parts of the same plan and there is no COB among those separate contracts. However, 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. **Primary Plan or Secondary Plan** – The order of benefit determination rules determine whether this Plan is a “Primary Plan” or “Secondary Plan” when compared to another Plan covering the person.

When this Plan is primary, its benefits are determined before those of any other Plan and without considering any other Plan’s benefits. When this Plan is secondary, its benefits are determined after those of another Plan and may be reduced because of the Primary Plan’s benefits.

C. **Allowable Expense** means a health care service or expense, including deductibles and Copayments, that is covered at least in part by any of the Plans covering the person. When a plan provides benefits in the form of services, (for example, an HMO) the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the plans is not an Allowable Expense. The following are examples of expenses or services that are not Allowable Expenses:

1. If a covered person is confined in a private Hospital room, the difference between the cost of a semi-private room in the Hospital and the private room; (unless the patient’s stay in a private Hospital room is Medically Necessary) is not an Allowable Expense.

2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees 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 calculates its benefits or services on the basis of usual and customary fees and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan’s payment arrangements shall be the allowable expense for all plans.

5. The amount a benefit is reduced by the Primary Plan because a covered person does not comply with the Plan provisions. Examples of these provisions are precertification of admissions and preferred Provider arrangements.

D. **Claim Determination Period** means a calendar year or that part of the calendar year during which a person is covered by this Plan.

E. **Closed Panel Plan** is a plan that provides health benefits to covered persons primarily in the form of services through a panel of Providers that have contracted with, or are employed by, the Plan, and that limits or excludes benefits for services provided by other Providers, except in cases of emergency or referral by a panel Member.
F. **Custodial Parent** means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

**Order of Benefit Determination Rules**

If the Member is covered by another group Health Plan, responsibility for payment of benefits is determined by the following rules. These rules indicate the order of payment responsibility among PacifiCare and other applicable group Health Plans be establishing which plan is primary, secondary and so on:

A. The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.

B. A Plan that does not contain a coordination of benefits provision is always primary. There is one exception: Coverage that is obtained by virtue of membership in a group 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. 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.

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. The first of the following rules that describes which Plan pays its benefits before another Plan is the rule that will apply.

1. **Subscriber (Non-Dependent) or Dependent.** The Plan that covers the person other than as a Dependent; for example as an employee, Member, Subscriber or retiree, is primary, and the plan that covers the person as a Dependent is secondary.

2. **Child Covered Under More Than One Plan.** The order of benefits when a child is covered by more than one plan is:
   a. **Birthday Rule.** The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:
      - The parents are married;
      - The parents are not separated (whether or not they ever have been married); or
      - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

      If both parents have the same birthday, the plan that covered either of the parents longer is primary.
   b. If the specific terms of a court decree state that one of the parents is responsible for the child’s health care expenses or health care coverage, that Plan is primary if the parent has enrolled the child in the Plan and provided the Plan with a copy of the court order as required in the Eligibility section of this Combined Evidence of Coverage and Disclosure Form. This rule applies to Claim Determination Periods or plan years, commencing after the Plan is given notice of the court decree.
   c. If the parents are not married and/or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
      - The Plan of the Custodial Parent;
      - The Plan of the Spouse or Domestic Partner of the Custodial Parent;
      - The Plan of the non-Custodial Parent; and then
      - The Plan of the Spouse of the non-Custodial Parent.
3. **Active or Inactive Employee.** The Plan that covers a person as an employee who is neither laid off nor retired (or his or her Dependent) is primary in relation to a Plan that covers the person as a laid off or retired employee (or his or her 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. Coverage provided an individual by one Plan as a retired worker and by another Plan as a Dependent of an actively working Spouse or Domestic Partner will be determined under the rule labeled D(1).

4. **COBRA Continuation Coverage.** If a person whose coverage is provided under a right of continuation provided by federal (COBRA) or state law (similar to COBRA) also is covered under another Plan, the Plan covering the person as an employee, Member, Subscriber or retiree (or as that person's Dependent) is primary, and the continuation coverage is secondary. 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. **Longer or Shorter Length of Coverage.** If the preceding rules do not determine the order or payment, the Plan that covered the person as an employee, Member, Subscriber or retiree for the longer period is primary.

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 during a Claim Determination Period are not more than 100 percent of total Allowable Expenses.

B. If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the person's having received services from a non-panel Provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed 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.

PacifiCare may obtain the facts it needs from, or give them to, other organizations or persons 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 PacifiCare any facts it needs to apply those rules and determine benefits payable. PacifiCare may use and disclose a Member's protected health information for the purposes of carrying out treatment, payment or health care operations, including, but not limited to, diagnoses payment of health care services rendered, billing, claims management or other administrative functions of PacifiCare, without obtaining the Member's consent, in accordance with state and federal law.

PacifiCare's Right to Pay Others

A "payment made" under another Plan may include an amount that should have been paid under this Plan. If this happens, PacifiCare 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. PacifiCare 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" includes the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the "amount of the payments made" by PacifiCare is more than it should have paid under this COB provision, PacifiCare may recover the excess from one or more of the persons it has paid or for whom it has paid or for any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services.
KAISER PERMANENTE
Kaiser Foundation Health Plan, Inc.
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A nonprofit corporation

Kaiser Permanente Traditional Plan
Evidence of Coverage for
COUNTY OF SONOMA

Purchaser ID: 602484  Contract: 2  Version: 5  EOC Number: 4

July 9, 2008, through July 7, 2009

Member Service Call Center
Weekdays 7 a.m.–7 p.m.; weekends 7 a.m.–3 p.m.
(except holidays)
1-800-464-4000 toll free
1-800-777-1370 (toll free TTY for the hearing/speech impaired)
kp.org
• Services covered under "Services Associated with Clinical Trials" in the "Benefits and Cost Sharing" section

Please refer to the "Dispute Resolution" section for information about Independent Medical Review related to denied requests for experimental or investigational Services.

Services related to a noncovered Service

When a Service is not covered, all Services related to the noncovered Service are excluded, except for Services we would otherwise cover to treat complications of the noncovered Service.

Speech therapy

Speech therapy Services to treat social, behavioral, or cognitive delays in speech or language development unless Medically Necessary.

Surrogacy

Services for anyone in connection with a surrogacy arrangement, except for otherwise-covered Services provided to a Member who is a surrogate. A surrogacy arrangement is one in which a woman (the surrogate) agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child. Please refer to "Surrogacy arrangements" under "Reductions" in this "Exclusions, Limitations, Coordination of Benefits, and Reductions" section for information about your obligations to us in connection with a surrogacy arrangement, including your obligation to reimburse us for any Services we cover.

Transgender surgery

Travel and lodging expenses

Travel and lodging expenses, except that in some situations if the Medical Group refers you to a Non-Plan Provider as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section, we may pay certain expenses that we preauthorize in accord with our travel and lodging guidelines. Our travel and lodging guidelines are available from our Member Service Call Center.

Limitations

We will do our best to provide or arrange for our Members' health care needs in the event of unusual circumstances that delay or render impractical the provision of Services under this EOC, such as major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a Plan Facility, complete or partial destruction of facilities, and labor disputes. Under these extreme circumstances, if you have an Emergency Medical Condition, go to the nearest hospital as described under "Emergency Care" in the "Emergency, Post-Stabilization, and Out-of-Area Urgent Care from Non-Plan Providers" section, and we will provide coverage and reimbursement as described in that section.

Additional limitations that apply only to a particular benefit are listed in the description of that benefit in the "Benefits and Cost Sharing" section.

Coordination of Benefits (COB)

The Services covered under this EOC are subject to coordination of benefits (COB) rules. If you have medical or dental coverage with another health plan or insurance company, we will coordinate benefits with the other coverage under the COB rules of the California Department of Managed Health Care. Those rules are incorporated into this EOC.

If both the other coverage and we cover the same Service, the other coverage and we will see that up to 100 percent of your covered medical expenses are paid for that Service. The COB rules determine which coverage pays first, or is "primary," and which coverage pays second, or is "secondary." The secondary coverage may reduce its payment to take into account payment by the primary coverage. You must give us any information we request to help us coordinate benefits.

If your coverage under this EOC is secondary, we may be able to establish a Benefit Reserve Account for you. You may draw on the Benefit Reserve Account during a calendar year to pay for your out-of-pocket expenses for Services that are partially covered by either your other coverage or us during that calendar year. If you are entitled to a Benefit Reserve Account, we will provide you with detailed information about this account.

If you have any questions about COB, please call our Member Service Call Center.

Reductions

Employer responsibility

For any Services that the law requires an employer to provide, we will not pay the employer, and when we cover any such Services we may recover the value of the Services from the employer.
COUNTY HEALTH PLAN - SUMMARY PLAN DESCRIPTION

1. We will automatically have a lien, to the extent of benefits provided, upon any recovery, whether by settlement, judgment or otherwise, that you receive from the third party, the third party's insurer, or the third party's guarantor. The lien will be in the amount of benefits we paid under this plan for the treatment of the illness, disease, injury or condition for which the third party is liable.
   - Our lien will not be more than the amount we paid for those services.
   - If you hired an attorney to gain your recovery from the third party, our lien will not be for more than one-third of the money due you under any final judgment, compromise, or settlement agreement.
   - If you did not hire an attorney, our lien will not be for more than one-half of the money due you under any final judgment, compromise or settlement agreement.
   - If a final judgment includes a special finding by a judge, jury, or arbitrator that you were partially at fault, our lien will be reduced by the same comparative fault percentage by which your recovery was reduced.
   - Our lien is subject to a pro rata reduction equal to your reasonable attorney's fees and costs in line with the common fund doctrine.

2. You must advise us in writing, within 60 days of filing a claim against the third party and take necessary action, furnish such information and assistance, and execute such papers as we may require to facilitate enforcement of our rights. You must not take action, which may prejudice our rights or interests under your plan. Failure to give us such notice or to cooperate with us, or actions that prejudice our rights or interests will be a material breach of this plan and will result in your being personally responsible for reimbursing us.

3. We will be entitled to collect on our lien even if the amount you or anyone recovered for you (or your estate, parent or legal guardian) from or for the account of such third party as compensation for the injury, illness or condition is less than the actual loss you suffered.

COORDINATION OF BENEFITS

If you are covered by more than one group medical plan, your benefits under this Plan will be coordinated with the benefits of those Other Plans, as shown below. These coordination provisions apply separately to each beneficiary, per benefit year. Any coverage you have for medical benefits will be coordinated as shown below.

Definitions for Coordination of Benefits Section

The meanings of key terms used in this section are shown below. Whenever any of the key terms shown below appear in these provisions, the first letter of each word will be capitalized. When you see these capitalized words, you should refer to this "Definitions" provision.

Allowable Expense is any necessary, reasonable and customary item of expense, which is at least partially covered by at least one Other Plan. For the purposes of determining our payment, the total value of Allowable Expense as provided under this plan and all other plans will not exceed the amount, which this plan would pay, if you were covered under this plan only.

Other Plan is any of the following:

1. Group, blanket or franchise insurance coverage;
2. Group service plan contract, group practice, group individual practice and other group prepayment coverages;
3. Group coverage under labor-management trusteed plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.
COUNTY HEALTH PLAN - SUMMARY PLAN DESCRIPTION

The term "Other Plan" refers separately to each agreement, policy, contract, or other arrangement for services and benefits, and only to that portion of such agreement, policy, contract, or arrangement which reserves the right to take the services or benefits of other plans into consideration in determining benefits.

Primary Plan is the plan which will have its benefits determined first.

This Plan is that portion of this plan that provides benefits subject to this provision.

Effect On Benefits

1. If This Plan is the Primary Plan, then its benefits will be determined first without taking into account the benefits or services of any Other Plan.

2. If This Plan is not the Primary Plan, then its benefits may be reduced so that the benefits and services of all the plans do not exceed Allowable Expense.

3. The benefits of This Plan will never be greater than the sum of the benefits that would have been paid if you were covered under This Plan only.

Order Of Benefits Determination

The following rules determine the order in which benefits are payable:

1. A plan that has no Coordination of Benefits provision pays before a plan, which has a Coordination of Benefits provision.

2. A plan that covers you as an employee pays before a plan, which covers you as a dependent. But, if you are retired and entitled to Medicare, Medicare pays (a) after the plan, which covers you as a dependent of an active employee, but (b) before the plan, which covers you as a retired employee.

For example: You are covered as a retired employee under this plan and entitled to Medicare (Medicare would normally pay first). You are also covered as a dependent of an active employee under another plan (in which case Medicare would pay second). In this situation, the plan which covers you as a dependent will pay first and the plan which covers you as a retired employee would pay last.

3. For a dependent child covered under plans of two parents, the plan of the parent whose birthday falls earlier in the benefit year pays before the plan of the parent whose birthday falls later in the benefit year. But if one plan does not have a birthday rule provision, the provisions of that plan determine the order of benefits.

Exception to rule 3: For a dependent child of parents who are divorced or separated, the following rules will be used in place of Rule 3:

a. If the parent with custody of that child for whom a claim has been made has not remarried, then the plan of the parent with custody that covers that child as a dependent pays first.

b. If the parent with custody of that child for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:

i. The plan that covers that child as a dependent of the parent with custody.

ii. The plan that covers that child as a dependent of the stepparent (married to the parent with custody).

iii. The plan that covers that child as a dependent of the parent without custody.

iv. The plan that covers that child as a dependent of the stepparent (married to the parent without custody).

c. Regardless of a and b above, if there is a court decree which establishes a parent's financial responsibility for that child's health care coverage, a plan which covers that child as a dependent of that parent pays first.
COUNTY HEALTH PLAN - SUMMARY PLAN DESCRIPTION

4. The plan covering you as a laid-off or retired employee or as a dependent of a laid-off or retired employee pays after a plan covering you as other than a laid-off or retired employee or the dependent of such a person. But if either plan does not have a provision regarding laid-off or retired employees, provision 6 applies.

5. The plan covering you under a continuation of coverage provision in accordance with state or federal law pays after a plan covering you as an employee, a dependent or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the Other Plan does not agree under these circumstances with the Order of Benefit Determination provisions of This Plan, this rule will not apply.

6. When the above rules do not establish the order of payment, the plan on which you have been enrolled the longest pays first unless coverage under two of the plans became effective on the same date. In this case, Allowable Expense is split equally between the two plans.

Our Rights Under This Provision

Responsibility For Timely Notice. We are not responsible for coordination of benefits unless timely information has been provided by the requesting party regarding the application of this provision.

Reasonable Cash Value. If any Other Plan provides benefits in the form of services rather than cash payment, the reasonable cash value of services provided will be considered Allowable Expense. The reasonable cash value of such service will be considered a benefit paid, and our liability reduced accordingly.

Facility of Payment. If payments which should have been made under This Plan have been made under any Other Plan, we have the right to pay that Other Plan any amount we determine to be warranted to satisfy the intent of this provision. Any such amount will be considered a benefit paid under This Plan, and such payment will fully satisfy our liability under this provision.

Right of Recovery. If payments made under This Plan exceed the maximum payment necessary to satisfy the intent of this provision, we have the right to recover that excess amount from any persons or organizations to or for whom those payments were made, or from any insurance company or service plan.

BENEFITS FOR MEDICARE ELIGIBLE BENEFICIARIES

For Active Employees and Dependents. Any beneficiary who is a full-time employee or a dependent of a full-time employee, and eligible for Medicare, will receive the full benefits of this plan, except for the following:

1. Beneficiaries who are receiving treatment for end-stage renal disease following the first 30 months such beneficiaries are entitled to end-stage renal disease benefits under Medicare; and

2. Beneficiaries who are entitled to Medicare benefits as disabled persons; unless the beneficiaries have a current employment status, as determined by Medicare rules, through a group of 100 or more employees (according to OBRA legislation).

For cases where exceptions 1 or 2 apply, payment will be determined under the plan and the amount of benefits available from Medicare will be subtracted from such payment. The plan will pay the amount that remains after subtracting Medicare's payment.

For Retired Employees and Their Spouses. If you are a retired employee or the spouse, domestic partner, or dependent of a retired employee and you are eligible for Medicare, your benefits under this plan will be coordinated.

Medicare is the Primary Plan and this plan is the Secondary plan. When you incur covered expenses under this plan, Medicare will make its payment first. Then, the plan will pay an amount, based on the type of covered expense (see examples below). Please note, the plan will not pay any benefit when Medicare's payment is equal to or more than the amount, which the plan would have paid in the absence of Medicare.

Example of Medicare & CHP Coordination of a Co-Insurance benefit (Applicable to CHPO members only). For an in-network covered expense of $100, and in the absence of Medicare, the plan would have paid $90. If Medicare pays $80, the plan would subtract that amount from the $90 and pay $10. The combined amount of benefits from
COUNTY HEALTH PLAN - SUMMARY PLAN DESCRIPTION

Medicare and this plan will equal, but not exceed, what your benefit would have been from this plan alone if you were not eligible for Medicare. For an out-of-network covered expense of $100, and in the absence of Medicare, the plan would have paid $70. If Medicare pays $80, the plan would subtract that amount from the $70 and pay $0, because Medicare already paid more than the normal plan benefit.

Example of Medicare & CHP Coordination of a Co-Payment benefit (Applicable to CHVPP and CHVP members only). If you have a co-payment for an office visit, the chart below describes how your benefits will coordinate with Medicare.

<table>
<thead>
<tr>
<th>Example #1 - Medical Provider Bill is more than $200</th>
</tr>
</thead>
<tbody>
<tr>
<td>$260 Charges submitted to Medicare as Primary payor</td>
</tr>
<tr>
<td>$228 $20 Member Co-pay + Medicare Payment of $208</td>
</tr>
<tr>
<td>$32 Balance Due - submitted to Blue Cross to pay as secondary payor</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Example #2 - Medical Provider Bill is equal to $200</th>
</tr>
</thead>
<tbody>
<tr>
<td>$200 Charges submitted to Medicare as Primary payor</td>
</tr>
<tr>
<td>$180 $20 Member Co-pay + Medicare Payment of $160</td>
</tr>
<tr>
<td>$20 Balance Due - submitted to Blue Cross to pay as secondary payor</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Example #3 - Medical Provider Bill is less than $200</th>
</tr>
</thead>
<tbody>
<tr>
<td>$60 Charges submitted to Medicare as Primary payor</td>
</tr>
<tr>
<td>$68 $20 Member Co-pay + Medicare Payment of $48</td>
</tr>
<tr>
<td>-$8 Overpayment - provider owes retiree $8</td>
</tr>
</tbody>
</table>

MEDICAL MANAGEMENT PROGRAMS

Benefits are provided only for medically necessary and appropriate services. Medical management programs including Utilization Review, Authorization, and Case Management are designed to work together with you and your provider to ensure you receive appropriate medical care and avoid unexpected out of pocket expense. The utilization review program applies to hospital admissions. The authorization program applies to certain specialized services or treatments. The personal case management program helps you coordinate and manage long-term intensive medical care.

No benefits are payable, however, unless your coverage is in force at the time services are rendered, and the payment of benefits is subject to all the terms and requirements of this plan.

Important: Medical management requirements described in this section do not apply when coverage under this plan is secondary to another plan providing benefits for you or your dependents.

UTILIZATION REVIEW PROGRAM

The utilization review program evaluates the medical necessity and appropriateness of care and the setting in which care is provided. You and your physician are advised if it has been determined that services can be safely provided in an outpatient setting, or if an inpatient stay is recommended. Services that are medically necessary and appropriate are certified by the claims administrator and monitored so that you know when it is no longer medically necessary and appropriate to continue those services.

It is your responsibility to see that your physician starts the utilization review process before scheduling you for any service subject to the utilization review program. If you receive any such service, and do not follow the procedures set forth in this section, your benefits will be reduced as shown in the "Effect on Benefits" portion of UTILIZATION REVIEW PROGRAM.