

Preferred Plans,
Selections® Plans,
HSA-Qualified Preferred Plans 80/80/60,
Traditional Plans, and
Traditional Dental Plans



The “Coordination of Benefits” provision is revised to read as follows:

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 Contract or contact your state insurance department.

Primary or Secondary? You will be asked to identify all the plans that cover members of your family. The Company needs this information to determine whether the Company is 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, the Company 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 calendar 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 the Company 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: The Company will be primary when any other provisions of state or federal law require the Company to be.

How The Company Pays Claims When The Company is Primary: When the Company is the primary plan, the Company 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 The Company Pays Claims When The Company is Secondary: When the Company is knowingly the secondary plan, the Company will make a reasonable estimate of the primary plan payment and base the Company's payment on that amount. After payment information is received from the primary plan, the Company may recover from the primary plan any excess amount paid under the "right of recovery" provision in the plan. The Company may not delay the Company's payments because of lack of information from the primary plan. The Company is required to pay claims within ninety days of receipt.

- If there is a difference between the amounts the plans allow, the Company will base the Company's payment on the higher amount. However, if the primary plan has a contract with the provider, the Company's combined payments will not be more than the amount called for in the Company's 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.
- The Company will determine the Company's payment by subtracting the amount the Company estimates that the primary plan will pay from the amount the Company would have paid if the Company had been primary. The Company 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 100% of the total allowable expense (the highest of the amounts allowed under each plan involved) for your claim. The Company is not required to pay an amount in excess of the Company's 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 the plan's deductible is fully credited, the Company 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 the Company does not cover, the Company may pay for those expenses.

- If you are covered by more than one health benefit plan, you or your provider should file all your claims with each plan at the same time. If Medicare is your primary plan, Medicare may submit your claims to your secondary carrier for you.

Questions About Coordination of Benefits? Contact Your State Insurance Department.

Please keep this insert with your brochure for an up-to-date record of your plan.