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**COORDINATION OF BENEFITS PROCESS**  
**BlueCross BlueShield PPO**

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**COORDINATION OF BENEFITS**

This Plan includes the following Coordination of Benefits (COB) provision, which applies when a Member has coverage under more than one group contract or health care plan. Rules of this Section determine whether the benefits available under This Plan are determined before or after those of another plan. In no event, however, will benefits under This Plan be increased because of this provision.

If this COB provision applies, the order of benefits determination rules should be looked at first. Those rules determine whether This Plan's benefits are determined before or after those of another plan.

**Definitions**

As used in this Section, the following terms shall have the meanings indicated, unless the context clearly requires a different construction.

"Allowable Expense" means a necessary, reasonable and customary item of expense when the item of expense is covered at least in part by one or more plans covering the Member for whom the claim is made.

- When a plan provides benefits in the form of services, the reasonable cash value of a service is deemed to be both an Allowable Expense and a benefit paid.
- The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense under the above 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.
- We will determine only the benefits available under This Plan. You are responsible for supplying Us with information about Other Plans so We can act on this provision.

"Claim Determination Period" means a calendar year. However, it does not include any part of a year during which You have no coverage under This Plan or any part of a year prior to this date this COB provision or similar provision takes effect.

The term "plan" (shown in lower case) used in this Section, means form of medical or dental coverage with which coordination is allowed. "Plan" includes:

- Group, blanket or franchise insurance coverage;
- A group BlueCross BlueShield plan;
- Group or group-type coverage through HMOs or other prepayment, group practice and individual practice plans;
- Coverage under labor-management trust or employee benefit organization plans;
- Coverage under government programs to which an employer contributes or makes

payroll deductions;

- Coverage under a governmental plan or coverage required or provided by law;
- Medical benefits coverage in group, group-type and individual automobile “no-fault” and traditional automobile “fault” type coverages;
- Coverage under Medicare and other governmental benefits; and
- Any other arrangement of health coverage for individuals in this group.

“Plan” does not include individual or family:

- Insurance contracts;
- Subscriber Contracts;
- Coverage through Health Maintenance Organizations (HMOs);
- Coverage under other prepayment, group practice and individual practice plans;
- Public medical assistance programs (such as TennCare);
- Group or group-type hospital indemnity benefits of \$100 per day or less;
- School accident-type coverages.

Each contract or other arrangement for coverage is a separate plan. Also, if an arrangement has two parts and COB rules apply to only one of the two, each of the parts is a separate plan.

"Primary plan" and "Secondary Plan" – The Order of Benefit Determination Rules state whether This Plan is a Primary Plan or a Secondary Plan as to another plan covering You.

- When This Plan is a Primary Plan, its benefits are determined before those of the Other Plan. We do not consider the Other Plan's benefits.
- 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 same 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.

The term “Other Plan” applies to each arrangement for benefits or services, as well as any part of such an arrangement that considers the benefits and services of other contracts when benefits are determined.

"Secondary plan" means the plan which determines its benefit payments after the other plan or plans.

“This Plan” refers to this BCBS PPO medical plan under which benefits for health care expenses are provided.

### **Order of Benefit Determination Rules**

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

a. Non-Dependent/Dependent

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 and,
- If the rule established by the Social Security Act of 1965 (as amended) makes Medicare secondary to the plan covering the person as a Dependent of an active Employee, then the order of benefit determination shall be:
  - Benefits of the Plan of an active Employee covering the person as a Dependent;
  - Medicare;
  - Benefits of the Plan covering the person as an Employee, Member, or Subscriber.

b. Dependent Child – Parents Not Separated or Divorced

Except as stated in Paragraph (c) below, when This Plan and another Plan cover the same child as a Dependent of different persons, called “parents”:

- 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; but
- If both parents have the same birthday, the benefits of the plan that has covered one parent longer are determined before those of the plan that has covered the other parent for a shorter period of time.
- However, if the Other Plan does not have the rule described immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the Other Plan will determine the order of benefits.

c. 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:

- First, the plan of the parent with custody of the child;
- Then, the plan of the spouse of the parent with the 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. The plan of the other parent shall be the Secondary Plan. This paragraph 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.

- 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 plans covering the child shall follow the order of benefit determination rules outlined above in Paragraph (b), Dependent Child – Parents Not Separated or Divorced.
- If a court decree exists, the effective date of when This Plan is Primary or Secondary will be the date that This Plan is notified a court decree exists.

d. Active/Inactive Employee

The benefits of a Plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a Plan which covers that person as a laid off or retired Employee. 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.

e. Longer/Shorter Length of Coverage

If none of the above Rules determines the order of benefits, the benefits of the plan that has covered an Employee, Member, or Subscriber longer are determined before those of the Plan that has covered that person for the shorter term.

- 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.
- The start of the new plan does not include:
  - A change in the amount or scope of a plan's benefits;
  - A change in the entity that pays, provides, or administers the plan's benefits; or
  - A change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).
- 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.
- If the Other Plan does not contain provisions establishing the Order of Benefit Determination Rules, the benefits under the Other Plan will be determined first.

f. Plans with Excess and Other Non-conforming COB Provisions

Some Plans declare their coverage "in excess" to all Other Plans, "always Secondary," or otherwise not governed by COB rules. These plans are called "Non-complying Plans."

This Plan coordinates its benefits with a Non-complying Plan as follows:

- If This Plan is the Primary Plan, it will provide its benefits on a primary basis.

- If This Plan is the Secondary Plan, it will provide benefits first, but the amount of benefits and liability of This Plan will be limited to the benefits of a Secondary Plan.

This Plan is Secondary to individual automobile “no-fault” and traditional automobile “fault” type coverages.

- If the Non-complying Plan does not provide information needed to determine This Plan's benefits within a reasonable time after it is requested, This Plan will assume that the benefits of the Non-complying Plan are the same as the benefits of This Plan and provide benefits accordingly. However, This Plan must adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the Non-complying Plan.

- If:

- The Non-complying Plan reduces its benefits so that the Member receives less in benefits than he or she would have received had the Complying Plan paid, or provided its benefits as the Secondary Plan, and the Non-complying Plan paid or provided its benefits as the Primary Plan; and

- Governing state law allows the right of subrogation set forth below;

then the Complying Plan shall advance to You or on Your behalf an amount equal to such difference. However, in no event shall the Complying Plan advance more than the Complying Plan would have paid, had it been the Primary Plan, less any amount it previously paid. In consideration of such advance, the Complying Plan shall be subrogated to all Your rights against the Non-complying Plan. Such advance by the Complying Plan shall also be without prejudice it may have against the Non-complying Plan in the absence of such subrogation.

### **Effect on Benefits of This Plan**

This Coordination of Benefits provision applies where there is a basis for a claim under This Plan and the Other Plan and when benefits of This Plan are determined as a Secondary Plan.

Benefits of This Plan will be reduced when the sum of:

- The benefits that would be payable for the Allowable Expenses under This Plan, in the absence of this COB provision, and
- The benefits that would be payable for the Allowable Expenses under the Other Plan(s), in the absence of provisions with a similar purpose to this COB provision, whether or not a claim for benefits is made;

exceeds Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the Other Plan(s) do not total more than Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced proportionately and is then charged against any applicable benefit limit of This Plan.

The Administrator will not, however, consider the benefits of the Other Plan(s) in determining

benefits under This Plan when:

- The Other Plan has a rule coordinating its benefits with those of This Plan and such rule states that benefits of the Other Plan will be determined after those of This Plan; and
- The order of benefit determination rules requires Us to determine benefits before those of the Other Plan.

Upon attaining age sixty-five (65) or otherwise becoming entitled to Medicare benefits, benefits for active Employees shall continue under this Plan and Medicare shall be considered the Secondary Plan for: (a) active Employees; and (b) Dependents of active Employees.

Upon attaining age sixty-five (65) or otherwise becoming entitled to Medicare benefits, benefits for Pensioners and the Dependents of Pensioners from This Plan shall be Secondary and Medicare shall be considered the Primary Plan, this being in accordance with federal regulations.

#### **RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION**

For the purpose of determining the applicability of, and implementing the terms of this Coordination of Benefit provision of this Plan, or any provision of similar purpose of any other plan, the Administrator may, without the consent of or notice to any person, release to or obtain from any other insurance company or other organization or person, only such information that the Administrator is entitled to receive under HIPAA and which the Administrator reasonably deems necessary and appropriate for such purposes. Any person claiming benefits under this Plan shall furnish to the Administrator such information as may be necessary to implement this provision.

#### **FACILITY OF PAYMENT**

Whenever payments which should have been made under This Plan in accordance with this Coordination of Benefits provision, have been made under any Other Plans, the Administrator shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments, any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under This Plan and, to the extent of such payments, the Administrator shall be fully discharged from liability under This Plan.

#### **RIGHT TO RECOVERY**

Whenever payments have been made by the Administrator with respect to Allowable Expenses, in a total amount which is, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Coordination of Benefit provision, the Administrator shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Administrator shall determine: any persons to or for or with respect to whom such payments were made, any other insurance companies, any other organizations. The amount of payments made includes the reasonable cash value of any benefits provided in the

form of services.

### **DEPENDENTS PREVIOUSLY COVERED AS EMPLOYEES AND EMPLOYEES PREVIOUSLY COVERED AS DEPENDENTS**

Benefits payable on behalf of a Dependent previously covered under the Plan as a Subscriber, for Hospital, surgical and medical expenses incurred during a period which began while the Dependent was insured as a Subscriber shall not exceed the maximum limitation of benefits that would have been payable during such period the Dependent remained insured as a Subscriber. The provisions of this Section also apply for Subscribers previously covered by the Plan as Dependents.

### **COORDINATION WITH MEDICARE**

This provision applies when benefits are available under this Plan and Medicare, and if Medicare is the primary plan. Benefits will be reduced under this Plan so that the sum of the benefits payable under both this Plan and Medicare will not be more than the total amount covered under this Plan. Payments by this Plan will be based on Medicare allowance. This provision applies for Members who retired from Metro after October 1, 1993. If a Pensioner who is eligible for Medicare does not elect both Parts A and B of Medicare, benefits will be reduced by this Plan and benefits will be provided for Part B at 20% of billed charges.

### **COORDINATION OF BENEFITS – END STAGE RENAL DISEASE**

This provision applies when benefits are available under this Plan and benefits are also available under Medicare because a participant has End Stage Renal Disease (“ESRD”). Medicare has special Coordination of Benefits rules for individuals covered by virtue of ESRD who are also covered by an employer group health plan. Under the terms of the Medicare rules and this Plan, during the 30 months after a Member is eligible for Medicare, the Plan is the Primary plan and Medicare is the Secondary plan. After the 30 month period, Medicare becomes the Primary plan for individuals and the Plan becomes the Secondary Plan. Under the Plan, benefits are determined and paid as if the Member with ESRD has enrolled in Medicare even if the Member has not enrolled in Medicare. A Member who enrolls in Medicare can enroll after becoming eligible for Medicare but must enroll before the 30-month period that commences upon Medicare eligibility to avoid paying higher premiums to Medicare. The Member must pay the Part B premium.

Once Medicare becomes the Primary plan, the employee contribution may be changed to reflect the fact that Medicare is the Primary payer. Please see Medicare’s rules to determine when You are eligible for Medicare by virtue of ESRD.