



SPECIAL RIDER
TO SMALL AND LARGE GROUP MEDICAL AND DENTAL PLANS

Effective January 1, 2008, the Contracts described above are modified as follows:

The "COORDINATION OF BENEFITS UNDER THIS CONTRACT WITH OTHER BENEFITS AVAILABLE TO THE MEMBER" provision is revised to read as follows:

"COORDINATION OF THIS CONTRACT'S BENEFITS WITH OTHER BENEFITS. The Coordination of Benefits (COB) provision applies when a Member has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100 percent of the total Allowable Expense.

DEFINITIONS. For the purpose of this Section, the following definitions shall apply:

- a. A "Plan" is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate plan.
 - (1) Plan includes: group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), Closed Panel Plans or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.
 - (2) Plan does not include: hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for nonmedical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. 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. “This Plan” means, in a COB provision, the part of the Contract providing the health care Benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the Contract providing health care Benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
- c. The order of benefit determination rules determine whether This Plan is a “Primary Plan” or “Secondary Plan” when the Member has health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its Benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its Benefits after those of another Plan and 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 100 percent of the total Allowable Expense for that claim. This means that when This Plan is secondary, it must pay the amount which, when combined with what the Primary Plan paid, totals 100 percent of the highest Allowable Expense. In addition, if This Plan is secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the Primary Plan) and record these savings as a benefit reserve for the Member. This reserve must be used to pay any expenses during that Year, whether or not they are an Allowable Expense under This Plan. If This Plan is secondary, it will not be required to pay an amount in excess of its maximum Benefit plus any accrued savings.

- d. “Allowable Expense” is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the Member. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the Member is not an Allowable Expense.

The following are examples of expenses that are not Allowable Expenses:

- (1) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room expenses.
- (2) If a Member is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
- (3) If a Member 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.

- e. “Closed Panel Plan” is a Plan that provides health care benefits to Members in the form of services through a panel of providers who are primarily employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.
- f. “Custodial Parent” is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the Year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES. When a Member is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

- a. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.
- b. A Plan that does not contain a coordination of benefits provision that is consistent with chapter 284-51 of the Washington Administrative Code is always primary unless the provisions of both Plans state that the complying plan is primary, except coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage is excess to any other parts of the Plan provided by the contract holder. Examples include major medical coverages that are superimposed over 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 calculating payment of its benefits only when it is secondary to that other Plan.
- d. Each Plan determines its order of benefits using the first of the following rules that apply:
 - (1) Non-Dependent or Dependent. The Plan that covers the Member other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the Member as a dependent is the Secondary Plan. However, if the Member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the Member as a dependent, and primary to the Plan covering the Member as other than a dependent (e.g., a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering the Member as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.
 - (2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
 - (a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - (i) The Plan of the parent whose birthday falls earlier in the Year is the Primary Plan; or

- (ii) If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
 - (b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - (i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to claim determination periods commencing after the Plan is given notice of the court decree;
 - (ii) If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;
 - (iii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of rule d(2)(a) above determine the order of benefits;
 - (iv) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of rule d(2)(a) above determine the order of benefits; or
 - (v) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 1. The Plan covering the Custodial Parent, first;
 2. The Plan covering the spouse of the Custodial Parent, second;
 3. The Plan covering the noncustodial parent, third; and then
 4. The Plan covering the spouse of the noncustodial parent, last.
 - (c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of rules d(2)(a) or (b) above determine the order of benefits as if those individuals were the parents of the child.
- (3) Active Employee or Retired or Laid-off Employee. The Plan that covers a Member as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering that same Member as a retired or laid-off employee is the Secondary Plan. The same would hold true if a Member is a dependent of an active employee and that same Member is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under d(1) can determine the order of benefits.
- (4) COBRA or State Continuation Coverage. If a Member whose coverage is provided under COBRA or under a right of continuation provided by

state or other federal law is covered under another Plan, the Plan covering the Member as an employee, member, subscriber or retiree or covering the Member as a dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under d(1) can determine the order of benefits.

- (5) Longer or Shorter Length of Coverage. The Plan that covered the Member as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the Member the shorter period of time is the Secondary Plan.
- (6) If the preceding rules do not determine the order of benefits, the Allowable Expenses must be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

EFFECT ON THE BENEFITS OF THIS PLAN. 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 the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan 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 one hundred percent of the total Allowable Expense for that claim. Total Allowable Expense is the highest Allowable Expense of the Primary Plan or the Secondary Plan. In addition, the Secondary Plan must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

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. The Company may get 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 Member claiming Benefits. The Company need not tell, or get the consent of, any person to do this. Each Member claiming Benefits under This Plan must give the Company any facts it needs to apply those rules and determine Benefits payable.

FACILITY OF PAYMENT. If payments that should have been made under This Plan are made by another Plan, the Company has the right, at its discretion, to remit to the other Plan the amount it determines appropriate to satisfy the intent of this provision. The amounts paid to the other Plan are considered Benefits paid under This Plan. To the extent of such payments, the Company is fully discharged from liability under This Plan.

RIGHT OF RECOVERY. The Company has the right to recover excess payment whenever it has paid allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. The Company may recover excess payment from any person to whom or for whom payment was made or any other issuers or plans.

If the Group or Member has questions about this Coordination of Benefits provision, please contact the Washington State Insurance Department.”

Except as modified by this Rider, the Contracts described above and all other Riders thereto shall continue unchanged.

Asuris Northwest Health

By 

Mary O. McWilliams, President