COORDINATION OF BENEFITS

You may be entitled to receive benefits under the Fox Valley Laborers Health and Welfare Fund and *another group health insurance plan,* for example, if your spouse works and also has group health insurance.

For purposes of this coordination of benefits provision, another group health plan is:

- another group, blanket, or franchise plan;
- service plan contracts, group practice, individual practice, and other prepayment coverage;
- labor-management trustee plans, union welfare plans, or employee benefit organization plans; and,
- any coverage under governmental programs and any coverage required or provided by any statute that provides benefits or services for hospital, medical, prescription drug, dental, and vision care or treatment.

In these situations, the two plans will coordinate their benefit payments so that the combined payments of both plans will not be more than your actual covered expenses. One plan (the primary plan) will pay its full benefits. Then, the second plan will consider any covered expenses that are not completely covered by the first plan's benefits. No plan pays more than it would without the coordination of benefits provision.

If the other plan seeks to limit benefits payments in the presence of secondary coverage to a nominal amount, this plan will pay benefits only up to an amount not to exceed 20% of the allowable expenses incurred.

The order of payment between the plans is as follows:

- the health care plan without a coordination provision similar to this one will always pay first;
- if the patient is both covered as an active employee or as a dependent of an active employee and coverage under another health care plan as either a laid-off employee, a retired employee, or a dependent, then the active employee's health care plan will have primary responsibility;
- the health care plan listing the patient as the employee (rather than a dependent) will pay first;
- a dependent child whose parents are not separated or divorced and who is covered under both parents' health care plans will receive coverage as follows:
    - the plan of the parent having his or her birthday earlier in the calendar year, (i.e., month and day) will have primary responsibility;

- the health care plan covering the parent longer will have primary responsibility, if the parents have the same birthday; or,

- if the other health care plan does not have a “birthday” provision and uses another rule to determine primary responsibility, that rule will determine which plan is primary;

- a dependent child covered either by divorced or separated parents that have no court decree of financial responsibility for the child’s health care expenses, will receive primary coverage under the custodial parent’s health care plan.

  If the parent with custody remarries, we use the following order to determine primary responsibility:

  - the plan of the parent with legal custody;

  - the plan of the stepparent with legal custody; then,

  - the plan of the parent without legal custody.

A dependent child covered by either divorced or separated parents that has a court decree specifying which parent has financial responsibility for the child’s health care expenses will have primary coverage under that parent’s plan if that parent’s plan has actual knowledge of that decree.

This plan will pay first for a dependent child enrolled in Medicaid or a state CHIP.

- If none of the above apply, or if there is a conflict, the plan that has covered the person for the longer time will pay first.
- If the other plan that covers the patient is Medicare, the benefits of this Plan will be determined before the benefits of Medicare are determined, unless federal law specifies otherwise.

Coordination Of Benefits With Medicare

You don’t have to be retired to be eligible for Medicare. Once you or your spouse reach age 65, you are eligible for Medicare benefits even if you are still working. Some people become eligible for Medicare before age 65, such as people who are disabled as defined by the Social Security Administration or people with end stage renal disease (ESRD). However, you must enroll in Medicare to receive Medicare benefits. To avoid any delay in receiving Medicare benefits, you should apply to your local Social Security office at least three months before you reach age 65.

Medicare consists of four parts: Part A, which provides hospital benefits, Part B which provides medical benefits, and Part C, Medicare Advantage, which is the managed care portion of Medicare and Part D which is prescription drug coverage. Part A is generally provided at no cost to you. There is, however, a

premium for Part B and Part D. The Fund does not reimburse the cost of the Medicare Part B or Part D premium. The Fund will pay its benefits as if you have enrolled in Medicare Part B, whether you do or not. If you have enrolled in Medicare Part D you will lose eligibility for all Plan benefits.

The Fund will be primary over Medicare for expenses if you are age 65 or over and covered as an active participant. In all other instances, the Fund will have secondary responsibility for you and your dependents. The Fund will also have secondary responsibility for expenses if you or your dependent is eligible for Medicare benefits solely because of end stage renal disease where Medicare has primary responsibility.

The Fund will have primary responsibility for expenses for the first 30 months if you or your dependent is eligible for Medicare benefits solely because of end stage renal disease where Medicare has secondary responsibility. In addition, the Fund will have primary responsibility for expenses if you are an active participant and have received Social Security benefits for 24 consecutive months. However, if you or your dependent is covered under a Medicare private contract arrangement (Part C), services covered under that plan will not be considered a covered expense by the Fund.