COORDINATION OF BENEFITS (COB)

BENEFITS SUBJECT TO THIS PROVISION

All benefits under medical coverage in the Plan are subject to this provision.

There is no Coordination of Benefits between the Prescription Drug Plan and any other medical or prescription drug plan, previously or currently in place with a Plan Member.

End-stage renal disease pharmaceuticals prescribed for Medicare recipients (not including age 65+ retirees) will be coordinated with the South Dakota State Employee Health Plan. Claims for these pharmaceuticals should be submitted to DAKOTACARE using the Plan Claim Form.

If other valid and collectible insurance is available to an "insured" for a loss, covered by this Plan, it shall be primary, and the coverage under the South Dakota State Employee Health Plan shall be excess over any other insurance.

DEFINITIONS

As used in this provision:

(a) **"Allowable Expense"** - Limited to those expenses that would be incurred by the Member through same or similar treatment at a provider or facility where the State has a direct contract for specific treatment.

(b) **"Claim Period"** - A Plan Year. If a person is not covered under the South Dakota State Employee Health Plan for a full Plan year, the Claim Period for that year will be the part of the year during which the person was covered under the Plan.

(c) **"Medical Coverage"** - Any coverage in the Plan providing benefits for any type of charge for which Medicare provides benefits.

(d) **"Plan"** - A plan, insured or not, which provides benefits or services for medical, dental, or vision care through:

1) Group, individual or blanket coverage;

2) Group practice or other group prepayment coverage, including Hospital or medical services coverage;

3) Labor-management trusted plans;

4) Union welfare plans;

5) Plan Administrator organization Plans;

6) Employee benefit organization Plans; or

7) Coverage required or provided by law or government programs, except Medicaid. However, this coverage will not be considered a Plan, if covered expenses under the coverage are excluded from benefits under the South Dakota State Employee Health Plan.

The parts of a Plan, which coordinate benefits or services with other Plans, and the parts that do not coordinate benefits are considered separate Plans. For purposes of this Section, the term "Plan" refers only to those parts of a Plan, which provide benefits that are subject to this provision.

(e) **"Primary to Medicare"** - Medicare is not considered for the purpose of the Coordination of Benefits provision. When a medical coverage is primary to Medicare, the benefits under that coverage are not coordinated with the ones that Medicare provides.

(f) **"Senior Dependent"** - The spouse of an active Employee while:

1) The spouse is age 65 or over and qualifies as a Dependent of the Employee; and

2) The Employee's Dependents are eligible under the Plan.

(g) **"Senior Employee"** - Any active Employee age 65 or over who belongs to a class of employees eligible for medical coverage.

EFFECT ON BENEFITS

(a) Coordination of Benefits apply to Allowable Expenses Incurred during any Claim Period by a covered Employee, Spouse or Dependent, if the sum of the benefits payable for those Expenses under the two items below would exceed the Allowable Expense:

1) This Plan in the absence of this provision; and

2) All other Plans in the absence of similar provisions.

(b) If Coordination of Benefits applies to a Claim Period, this Plan will reduce the benefits it would have otherwise paid for Allowable Expenses Incurred by the claimant during the Claim Period.

The reduction will be made to the extent needed. The sum of the reduced benefits and the benefits payable for Expenses under all other Plans coordinating benefits does not exceed the Allowable Expenses.

Benefits payable under another Plan include:

1) Those which would have been payable had a claim been duly made; and

2) In the case of Medicare coverage, all benefits, including Optional Benefits, whether or not the claimant is enrolled in these.

(c) To determine benefits, this Plan will ignore another Plan if:

1) The other Plan which is coordinating its benefits with those of this Plan has a rule stating that it will determine its benefits after the benefits of this Plan have been determined; and

2) The rules set forth in (d) below would require this Plan to determine its benefits before such other Plan.

(d) For the purpose of (c) above, here is the order in which this Plan determines benefits.

1) The benefits of the Plan which covers the person as an Employee, Member, subscriber or COBRA subscriber (that is, other than as a Spouse or Dependent) are determined before those of the Plan which covers the person as a Spouse or Dependent.

2) Except as stated in (3) below, when this Plan and another Plan both cover a Dependent child whose parents are separated or divorced:

(A) 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 the year; however

(B) If both parents have the same birthday, the benefits of the Plan, which covered the parent longer, are determined before those of the Plan, which covered the other parent for a shorter period of time.

If the other Plan has a rule based upon the gender of the parent instead of the rules described in (A) or (B) and if, as a result, the Plans do not agree on the order of benefits, the rules in the other Plan will determine the order of benefits.

3) 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:

(A) First, the Plan of the parent with custody of the child;

(B) Second, if the parent with custody has remarried, the Plan of the spouse of the parent with custody of the child; and

(C) 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 healthcare 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. This paragraph does not apply with respect to any Claim Period or Plan Year during which any benefits are actually paid or provided before the entity has actual knowledge.

4) The benefits of the Plan which cover a person as an Employee who is actively at work (or a Spouse or Dependent of such person) are determined before those of a Plan which cover the person as a laid off or Retired Employee (or a Spouse or Dependent of such person). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, the rules in the other Plan will determine the order of benefits.

5) If none of the above rules determines the order of benefits, the benefits of the Plan, which covered an Employee, Member, or subscriber longer, are determined before those of the Plan, which covered the person for the shorter time.

(e) When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefits limit of this Plan.

MEDICAL COVERAGE FOR SENIOR EMPLOYEES

A person is deemed to be age 65 or over from the first day of the month in which the person attains age 65.

NOTE: Employees are not allowed to Opt-Out of the South Dakota State Employee Health Plan solely on the basis of Medicare and Medicaid eligibility. These programs are not considered valid group coverage for purposes of this provision.

A Senior Employee is eligible for the same medical coverage as younger Employees in the class to which the Senior Employee belongs.

Whether hired before or after age 65, Employees who enroll in the South Dakota State Employee Health Plan within 30 days of date of hire are covered for medical coverage one month and one day from date of hire.

While the Senior Employee remains covered for medical coverage, the Senior Employee's benefits under the coverage will be primary to Medicare. However, the Senior Employee will not remain covered for any medical coverage after the earlier of the date the Senior Employee's benefits under that coverage would end if the Senior Employee was under age 65; or if the Employee terminates employment, the end of the period covered by the Senior Employee's last contribution for the coverage.

The ending date of Health Coverage will be based on the pay period for which the Employee received his or her final paycheck. Employees should contact their Human Resource Office for specific information.

MEDICAL COVERAGE FOR A SENIOR DEPENDENT

An Employee's Senior Dependent is eligible for the same medical coverage as younger Dependent spouses of Employees in the class to which the Employee belongs.

While the Employee's spouse (Senior Dependent) remains covered for medical coverage, the Employee spouse's (Senior Dependent) benefits under the coverage will be primary to Medicare.

Medical coverage for the Employee's spouse will end as indicated below:

(a) As the spouse of an Active Employee, medical coverage will end on the date the Employee terminates employment or benefits under that coverage would otherwise end.

(b) As the spouse of a retiree, medical coverage under this Plan will end the first of the month in which the spouse turns age 65.

MEDICAL COVERAGE FOR RETIRED EMPLOYEES

Medicare is primary to the South Dakota State Employee Health Plan for Members and spouses who are retired. Medical coverage under the South Dakota State Employee Health Plan will end the first of the month in which the Member turns age 65. At that time, coverage may be converted to the State-sponsored Medicare Supplement Plan.

MEDICAL COVERAGE FOR CERTAIN EMPLOYEES, SPOUSES, AND DEPENDENTS

Whether this Plan is the primary payer of medical and pharmaceutical claims for an Employee or covered Spouse or Dependent with end-stage renal disease depends on which occurs first: End-stage renal disease or attainment of age 65.

This Plan has secondary responsibility for the claims of a covered Member:

(a) Who is eligible for Medicare benefits because of end-stage renal disease; but

(b) Who first became eligible for Medicare Part A because of age or another disability.

This Plan has primary responsibility for the claims of a Member who is eligible for Medicare benefits solely because of end-stage renal disease, and then later also becomes eligible for Medicare benefits because of age or another disability.