COORDINATION OF BENEFITS (COB)

The following is intended to provide a general understanding of COB and does not cover all possible COB scenarios. But, we do hope that you have a better understanding of the importance of the need for COB information after reading this.

What is COB?

Coordination of Benefits is a process of applying benefits when there is more than one health plan. If you are covered by more than one health plan (for example, when you are covered under your employer's group health plan as well as your spouse's group health plan) you have dual coverage. One plan is considered to be the primary carrier and the other is the secondary carrier. The primary carrier covers the major portion of the bill according to plan allowances and the secondary carrier covers any remaining allowable expenses. Benefits are not duplicated and therefore, will not exceed 100% of charges for covered services.

Who is the primary carrier?

The primary carrier is the plan that covers you as an employee (rather than your spouse's employer). If you have two jobs, the plan that has covered you longer is the primary carrier. For dependent child coverage, the primary carrier is generally the plan of the parent covering the child whose birthday occurs earlier in the calendar year (birthday rule). For example, if your birthday falls in July but your spouse's falls in September, your plan is primary. If both have the same birthday, the policy that has been in effect longer will be primary. The birthday rule is superseded when a court order or custody rule applies.

Examples of how dual coverage works:

Megan incurred medical expenses in the amount of $150. The primary plan considered the allowable expense of $100 to be payable at a benefit level of 80%. The remaining balance from the primary carrier will be picked up by the secondary carrier. The secondary carrier cannot make payment until the treating provider submits a claim with documentation of the primary carrier's payment.

Example of standard coordination:

Covered Service	Primary carrier pays (80% of allowable)	Secondary carrier pays	Patient pays
Office Visit $150 (billed charge) $100 (allowable)	$80	$20	$0

Please note that the above example may not apply to your plan or situation. Having coverage under more than one health plan does not always mean that you will not have any out of pocket expenses.

For more information about how benefits are coordinated please see your benefit summary and/or contact HMA Customer Service at (808) 951-4621 on Oahu or 1-866-331-5913 from the Neighbor Islands or mainland.

Coordination of Benefits Questionnaire

HMA
1440 Kapiolani Blvd., #1000, Honolulu, HI 96814
Phone: (808) 951-4621 Fax: (866) 298-9841

DO YOU OR ANY OF YOUR FAMILY MEMBERS HAVE OTHER MEDICAL INSURANCE?

Yes _____ Please complete and sign at the bottom of this form and return it to HMA
No _____ Please sign at the bottom of this form and return it to HMA

For questions or to provide your other insurance information over the phone to HMA, please call (808) 951-4621 on Oahu, or toll free (866) 331-5913 from the neighbor islands.

*****PLEASE NOTE THAT FAILURE TO COMPLETE & RETURN THIS FORM COULD RESULT IN DELAY OR TERMINATION OF BENEFITS*****

Full Name	Social Security Number	Relationship To Employee	Date of Birth Mo/Day/Yr
Employee			
Spouse			
Child(ren)			
Child(ren)			
Child(ren)			
Chid(ren)			

Please use reverse side if additional space is needed

Name of other Insurance Carrier:	Phone Number: ( ) -
Address:	
City, State, Zip Code:	
Full Name of policy holder:	Policy Holder Date of Birth: / /
Policy Number:	Group Name or Number:
Please check what is covered under this policy: __Medical ___Dental ___Vision ___Pharmacy	Please indicate the effective date:

If additional carriers are utilized, please explain on reverse side of this form

IF THIS COVERAGE IS FOR MEDICARE

Please check if it is coverage for Part A, Part B, or Both: ___Part A ___Part B ___Both
Do you carry Medicare due to a disability? (please check Yes or No below) ___Yes ___No
If you check Yes above please explain:
Do you carry Medicare due to end stage renal disease? (please check Yes or No below) ___Yes ___No
If you check Yes above please explain:

***The above information provided will only be used to coordinate benefits.**

Signature _____ Date _____