n05736
Coordination of Benefits

Values

Accountability ● Integrity ● Service Excellence ● Innovation ● Collaboration

Abstract Purpose:

This reimbursement policy outlines Network Health's process, for all lines of business, when a member has medical insurance coverage with more than one plan.

Policy Detail:

Coordination of Benefits (COB) is a provision which establishes the order in which insurance plans reimburse claims when an individual has coverage under more than one plan.

The insurance industry has developed a consistent and orderly way to determine which plan pays its full benefits and which plan pays a reduced amount, if any, which when added together equal a single plan's benefit, but not more than the total amount of the allowable expenses incurred. It is intended that individuals do not profit when having coverage under more than one plan, and that members and/or providers receive the appropriate amount of reimbursement for medical services.

I. COB Applies When:

A. Both spouses cover their family through their employers
B. Both spouses are covered by the same insurance carrier but work for different employers
C. The member is Federal Medicare eligible
D. The member is retired from one job and actively employed elsewhere
E. The primary subscriber has more than one employer

Network Health ensures the accuracy of COB information by establishing who the primary payer for the family **or** member is when more than one carrier exists. It is imperative that the most current COB information is on file in order to accurately process claims.

II. COB Order of Determination:

A. The rules below determine which group health plan is primary and which group health plan is secondary:

1. No COB Provision**:** If the member's other group health plan does not have a COB provision, that plan will be primary.
2. Non-dependent/Dependent**:** A subscriber's plan will be primary over a plan that covers that subscriber as a dependent.

3. Dependent Children**:** The "Birthday Rule" will determine which plan is primary for a dependent child with coverage under both parents' plans.
    a. Birthday Rule: The plan of the parent whose birth date occurs first in a calendar year is primary. If both parents have the same birth date, the plan that has covered the parent for a longer period of time is primary.

III. Dependent Children with Unmarried, Separated or Divorced Parents:

A. The rules below determine which group health plan is primary for a child for whom a court order awards custody to one parent.

B. If the specific terms of the court decree state that the parents have joint custody and do not specify which parent is responsible for health care expenses, the *Birthday Rule* will apply. If a court decree orders that one parent is responsible for health care expenses, the plan of that parent will be primary.

1. The plan of the parent with custody of the child.
2. The plan of the spouse of the parent with custody of the child.
3. The plan of the parent without custody of the child.
4. The plan of the spouse without custody of the child.
    a. The rules for dependent children of divorced or separated parents only apply after Network Health has been informed of the court ordered terms.

IV. Active/Inactive Employee:

A. If a spouse is laid off or retired, a plan that covers an actively at work spouse is primary for the inactive spouse and their dependents.

1. Continuation of Coverage: The plan that covers a member as an actively at work employee or dependent is primary over any continuation of coverage plan.
2. Longer/Shorter Length of Coverage: If none of the above rules determines the order of benefits, the plan that has covered the person for a longer period of time will be primary.
3. COB with Medicare: COB with Medicare will conform to Federal Statutes and Regulations. If a Network Health member is eligible for Medicare benefits, but not enrolled, Network Health will coordinate benefits as if they were covered by Medicare.
    a. Except as required by Federal Statutes and Regulations, Network Health is secondary to Medicare.

V. Effect on Benefits When Network Health is Secondary:

A. Network Health will apply these provisions to allowable expenses payable under both Network Health and any other plan.

B. To be eligible, members must incur the allowable expenses while they are a Network Health member and claims must be submitted to Network Health within ninety days (90) of receipt of the primary group health plan's explanation of benefits.

C. Network Health will cover allowable expenses for active members as follows:

1. If Network Health is primary, benefits will be considered for reimbursement without regard to any other plan.
2. If another plan is primary, Network Health will reduce benefits so that the total benefits payable by all plans does not exceed the total allowable expenses.
3. If the charge(s) were denied because the provider did not follow the policies and procedures outlined by the primary plan, Network Health will not reimburse for those services.

D. If it is determined that Network Health is both the primary and secondary carrier, the charges are first processed under the member's primary policy. Charges are then processed under the secondary policy according to COB guidelines.

E. Network Health's prior authorization, coverage, and criteria requirements apply regardless of whether Network Health is the primary or secondary health plan.

F. Because Network Health cannot predict how the primary plan will process the claim, obtaining prior authorization for services will help ensure that the member's services will be covered in the event the primary health plan denies coverage.

VI. Effect on Benefits with Workers Compensation:

A. Network Health does not coordinate benefits with workers compensation. If workers compensation denies the services Network Health will review services for benefits.

B. To be eligible, members must incur the allowable expenses while they are a Network Health member. Claims denied by workers compensation must be submitted to Network Health and must include the workers compensation denial letter. This information must be received within ninety days (90) of the date listed on the workers compensation denial letter.

C. Please refer to Workers' Compensation Submission policy for additional information.

VII. Right to Necessary Information:

A. Network Health may require additional information to determine proper payment. Network Health may obtain that information from any organization or person without the member's consent, but will do so only as needed to apply the COB rules. Network Health may also provide necessary information to another organization or person in order to coordinate benefits. Network Health uses and discloses confidential medical and patient information only as State and Federal law allows.

VIII. Facility of Payment:

A. Network Health may directly pay another plan that pays an amount Network Health should have paid.

IX. Right to Recovery:

A. Network Health may recover payments made that are in excess of the amount owed.

X. Timely Filing - Commercial:

A. When Network Health is the secondary payer, claims must be submitted within ninety days (90) of the payment date listed on the primary payer's remittance advice, or as specified in your provider contract.

XI. Timely Filing – Medicare:

A. When Network Health is the secondary payer, claims must be submitted within the following timeframes:
    a. Participating Provider – Within ninety days (90) of the payment date listed on the primary payer's remittance advice, or as specified in your provider contract.
    b. Non-Participating Provider – Within three hundred sixty five days (365) of the payment date listed on the primary payer's remittance advice.

XII. All claims are subject to the provisions outlined in the coverage document(s), including the Exclusions and Limitations and any applicable Rider(s).

XIII. Network Health will not reimburse above the provider's contracted rate, or above the submitted billed charges.

Definitions:

Allowable Expense: An allowable expense is a Medically Necessary health care service or product for which a Member is eligible, as determined by Network, to receive benefits pursuant to the terms of the Member's Health Plan.

Coverage Document: A coverage document is a written document that describes the benefits, services, exclusions, limitations and conditions that are available for or applicable to coverage under the Plan.

Rider: A rider is a policy provision that adds benefits to the terms of a Member's policy to provide additional coverage.

Related Policies:
Claims Submission Policy
Workers' Compensation Submission

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