1570 Midway Pl.
Menasha, WI 54952
920-720-1300

Procedure 1211- Coordination of Benefits

Lines of Business: All

Purpose: This guideline provides the process that defines the order of coverage where other insurance companies and Network Health coordinate coverage and payment of medical services for Network Health members covered under more than one plan.

Procedure: Coordination of Benefits (COB) is a provision which establishes the order in which insurance plans pay 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 more than a single plan's benefit, but not more than the total amount of the allowable expenses incurred. Allowable expenses are services that Network Health or another group health plan covers. 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.

COB applies when:

- Both spouses cover their family through their employers
- Both spouses are covered by the same insurance carrier but work for different employers
- Member is Federal Medicare eligible
- Member is retired from one job and actively employed elsewhere
- 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 process member's claims accurately.

COB Order of Determination:

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.

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.

Dependent children with unmarried, separated or divorced parents: The rules below determine which group health plan is primary for a child for whom a court order awards custody to one parent.

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.

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.

Note: The rules for dependent children of divorced or separated parents only apply after Network Health has been informed of the court ordered terms.

Active/Inactive Employee: 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.

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.

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.

Authorization Requirement when Network Health is Secondary: Network Health's prior authorization, coverage, and criteria requirements apply regardless of whether Network Health is the primary or secondary health plan. 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.

Effect on Benefits When Network Health is Secondary: Network Health will apply these provisions to allowable expenses payable under both Network Health and any other plan. 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 90 days of receipt of the primary group health plan's explanation of benefits. These provisions apply only when the sum of the amount Network Health covers for allowable expenses under Network Health and the amount of allowable expense any other plan covers, in the absence of this COB section or any similar provision in the other plan, exceed the amount of allowable expenses.

Network Health will cover allowable expenses incurred by our members while they are a Network Health member as follows:

a) If Network Health is primary, Network Health will pay benefits without regard to any other plan.
b) If another plan is primary, Network Health will reduce benefits so that total benefits payable by all plans will not exceed the total of allowable expenses.

Maximum Allowable Amount as Primary and Secondary Carriers: If it is determined that Network Health is both 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.

Effect on Benefits with Workers Compensation: Network Health does not coordinate benefits with workers compensation. If workers compensation denies the services Network Health will review services for benefits.

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 via paper claim and must include the workers compensation denial letter. This information must be received within 90 days of the date listed on the workers compensation denial letter.

Note: All claims are subject to the provisions outlined in the Certificate of Coverage (COC), including the Exclusions and Limitations and any applicable Rider(s).

Network Health will cover allowable expenses incurred by our members while they are a Network Health member as follows:

a) If Network Health is primary, Network Health will pay benefits without regard to any other plan.
b) If another plan is primary, Network Health will reduce benefits so that total benefits payable by all plans will not exceed the total of allowable expenses.

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.

Note: Except as required by Federal Statutes and Regulations, Network Health is secondary to Medicare.

Right to Necessary Information: Network Health may need information to determine proper payment. Network Health may obtain that information from any organization or person without the members consent, but will do so only as needed to apply the COB rules. Network Health may also give 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.

Facility of Payment: Network Health may directly pay another plan that pays an amount Network Health should have paid.

Right to Recovery: Network Health may recover payments Network Health made that are in excess of the amount owed.

Revised/approved: 04/2011; 04/2012; 11/2012; 02/2014; 10/2014; 05/2016