

Policy 1211

NHP/NHIC ~ Coordination of Benefits Policy

Purpose: This policy provides guidelines that define the order of coverage where other insurance companies and Network Health Plan/Network Health Insurance Corporation (NHP/NHIC) coordinate coverage and payment of medical services for NHP/NHIC members covered under more than one plan.

Policy and 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 NHP/NHIC 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

NHP/NHIC ensures the accuracy of COB information by establishing who is the primary payer for the family or member 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 NHP/NHIC 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 NHP/NHIC is Secondary: NHP/NHIC prior authorization, coverage, and criteria requirements apply; regardless of whether NHP/NHIC is the primary or secondary health plan. Because NHP/NHIC 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 NHP/NHIC is Secondary: NHP/NHIC will apply these provisions to allowable expenses payable under both NHP/NHIC and any other plan. To be eligible, members must incur the allowable expenses while they are an NHP/NHIC member and claims must be submitted to NHP/NHIC 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 NHP/NHIC covers for allowable expenses under NHP/NHIC 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.

NHP/NHIC will cover allowable expenses incurred by our members while they are an NHP/NHIC member as follows:

- a) If NHP/NHIC is primary, NHP/NHIC will pay benefits without regard to any other plan.
- b) If another plan is primary, NHP/NHIC 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 NHP/NHIC 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: NHP/NHIC does not coordinate benefits with workers compensation. If workers compensation denies the services NHP/NHIC will review services for benefits.

To be eligible, members must incur the allowable expenses while they are an NHP/NHIC member. Claims denied by workers compensation must be submitted to NHP/NHIC via a 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).

NHP/NHIC will cover allowable expenses incurred by our members while they are an NHP/NHIC member as follows:

- a) If NHP/NHIC is primary, NHP/NHIC will pay benefits without regard to any other plan.
- b) If another plan is primary, NHP/NHIC 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 an NHP/NHIC member is eligible for Medicare benefits, but not enrolled, NHP/NHIC will coordinate benefits as if they were covered by Medicare.

NOTE: Except as required by Federal Statutes and Regulations, NHP/NHIC is secondary to Medicare.

Right to Necessary Information: NHP/NHIC may need information to determine proper payment. NHP/NHIC 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. NHP/NHIC may also give necessary information to another organization or person in order to coordinate benefits.

NHP/NHIC uses and discloses confidential medical and patient information only as State and Federal law allows.

Facility of Payment: NHP/NHIC may directly pay another plan that pays an amount NHP/NHIC should have paid.

Right to Recovery: NHP/NHIC may recover payments NHP/NHIC makes that are in excess of the amount owed.

This policy is not a guarantee of coverage or payment. The claim(s) will be denied if it does not meet with all the terms and provisions of the members Certificate of Coverage. Actual benefits will be determined when the claim(s) or bill(s) are submitted to NHP/NHIC. NHP/NHIC reserves the right to periodically review and update all claims policies and procedures.

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