SENTARA HEALTH PLANS COORDINATION OF BENEFITS POLICY

Other Plans Coordination of Benefits (COB) Policy

When Sentara Health Plans is the **primary** plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When Sentara Health Plans is the **secondary** carrier:

Sentara Health Plans waives the Copayment during the claims adjudication process. The Provider should not collect a Copayment.

- Claims must be submitted with Explanation of Benefits (EOBs) attached and must show exactly the same information as the original claim. Providers may not bill one insurance carrier for one charge amount and Sentara Health Plans for another charge amount.
- Sentara Health Plans will not coordinate in cases where services are not covered under the Member's Sentara Health Plans plan or when the Member's maximum benefit level has been met.
- If a claim is filed for a Member whose primary insurance is not a plan of Sentara Health Plans, the Provider must submit an EOB with the claim within 18 months of the date of service. If an EOB is not submitted, the claim will be denied pending receipt of primary's EOB. The name of the primary carrier and the policy number will be recorded in the "Comments" field of the remittance. This indicates that the claim must have an EOB from the primary insurer before it can be resubmitted.
- Transplants always require pre-authorization, even when Sentara Health Plans is the secondary carrier.
- If the primary carrier denies the claim because the service was not pre-authorized, the Provider must exhaust the appeals process of the primary carrier prior to submission of the claim to Sentara Health Plans as secondary payer. Documentation from the primary carrier indicating that the claim was appealed and that the denial was upheld is required when the claim is submitted to Sentara Health Plans.

Please keep your records updated so they reflect current COB information.

Coordination of Benefits (COB) Exceptions

Certain insurance plans or polices are exceptions and are always considered secondary payers (by law) regardless of the primary payer. All Sentara Health Plans products would be considered primary payers for a Member with two plans (a Sentara Health Plans product and a secondary product). The following is a listing of Secondary Payers:

- AARP
- TRICARE. IF TRICARE and Medicaid/Sentara Community Plan cover the Member, TRICARE assumes the position of primary carrier.
- CHAMPVA
- Courtesy or Courtesy Adjustment (not an insurance)
- Medicaid
- Medical Assistance

National Association of Insurance Commissioners (NAIC) Guidelines to Determine Payment Order

The NAIC provides guidelines to determine the order in which benefits will be paid when an individual is covered under more than one Group health plan:

No Coordination of Benefits (COB):

The plan that does not include a COB provision will always be considered the primary payer.

Employee:

The plan, which covers the individual as an employee, Member or subscriber other than a dependent, is considered primary.

Children of Parents who are not divorced or separated:

- Under the birthday rule the benefits of the plan of the parent whose birthday falls earlier in the year will be primary before those of the parent whose birthday falls later in the year. The term “birthday” only refers to the month and day rather than the year of birth.
- If both parents have the same date of birth, the benefits of the plan that has covered the child as a dependent for the longer period of time is considered primary.
- The gender rule states that the benefits of the plan covering the child as a dependent of a male are primary before those of the plan that covers the child as a dependent of a female.
- When one plan contains the gender rule and the other plan contains the birthday rule, and the two plans differ on the order of benefit payment, the birthday rule is used to determine the order of payment.

Children of Parents who are Divorced or Separated:

- The order is as follows:
  1. The plan of the parent with custody
  2. The plan of the spouse of the parent with custody
  3. The plan of the parent without custody
  4. The plan of the spouse of the parent without custody

- If the terms of the court decree specify that one parent is responsible for the healthcare expenses of a child then that plan is primary.
- If the terms of the court decree that the parents share joint custody and neither parent is specified as responsible for the healthcare expenses of the child, the rules which apply to parents who are not separated or divorced will be used to determine which plan pays first (birthday rule).

Retired or Laid-Off Member:

- If the order of benefits is being determined for an individual with coverage under one plan as a laid-off or retired employee, the benefits provided by the plan which covered the individual as an active employee or as a dependent of that employee are determined

before those of the plan that covers the individual as a laid-off or retired employee. This is referred to as the active/inactive provision.
- For determining the benefits for a retiree who is also covered as a dependent of an active employee, the plan that covered the person as a non-dependent pays before the plan that covers the person as a dependent. This rule is referred to as the non-dependent/dependent rule (which supersedes the active/inactive rule).

Active Duty Military:

Tricare is always primary for active duty military.

Medicare Eligible Member:

- If the Member is over age 65 and is not actively employed, Medicare may be primary for the subscriber and spouse.
- If the Member is over age 65 and is actively employed by an employer with less than 20 employees, Medicare is primary for the subscriber and spouse.
- If the Member is over age 65 and is actively employed by an employer with more than 20 employees, the employer Group health carrier is primary for the subscriber and family.
- If the Member is under age 65, disabled, and is not actively employed, Medicare is primary for the subscriber.
- If the Member is under age 65, disabled, and is actively employed by an employer with less than 100 employees, Medicare is primary for the subscriber.
- If the Member is under age 65, disabled, and is actively employed by an employer with more than 100 employees, the employer Group health carrier is primary for the subscriber.
- If the Member has End Stage Renal Disease (ESRD) and is not covered by an employer health carrier, Medicare is primary.
- If the Member has End Stage Renal Disease (ESRD) and is covered by an employer Group health carrier, the employer Group health carrier is primary for the first 30 months. At the 31st month, Medicare is primary.
- If the Member has Medicare and Medicaid (“dual eligible”), Medicare is primary and should be billed first. Medicaid should be billed after the Remittance is received indicating the Member responsibility.

Default:

If none of the above rules apply to the situation, the plan that has covered the individual for the longest continuous period of time will be considered primary. The length of time an individual is covered under a plan is determined from the individual’s first date of coverage under the plan. If that date is not available, the date that the individual first became a Member of the Group is used to measure the length of time that the individual has been covered under the present plan.

Continuation of Coverage

- The benefits of the plan covering the person as an employee will pay first.
- The benefits of the plan providing continuation of coverage will pay second.