Coordination of Benefits

Coordination of Benefits (COB) is a process where individuals are covered under more than one health plan combine their coverage to maximize their benefits. One plan becomes the primary plan and pays benefits first while the other plan becomes the secondary plan and pays the balance for eligible expenses, subject to its plan benefits, networks, and limitations.

How Does Coordination of Benefits Work?

When you or a family member are covered by more than one health plan (for example, when you are under your group plan as well as a spouse’s health plan), one plan is considered to be the primary carrier and the other is considered to be 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 subject to your benefit plan, provider network, and limitations as long as the primary payment does not exceed the Total Health Care allowable.

The COB provisions of your policy or plan determine which plan is primary. Benefits are thus "coordinated" among all of the health plans, and payments do not exceed 100% of charges for the covered services.

What other important information should I know?

Often, some or all of the costs of medical care are the responsibility of an insurance party other than us:

- Members who are injured or become ill as a result of work-related accidents or environment are eligible for benefits under the Workers’ Compensation Law. If Workers’ Compensation denies all or part of a claim, we will review the claim to determine whether to pay benefits as the secondary carrier.
- We will not pay for benefits if coverage would be available to the member under government programs, with the exception of Medicaid.
- In certain situations, Medicare may be a participant’s primary or secondary coverage. We will coordinate benefits with Medicare according to the Medicare Secondary Payer rules.
- Total Health Care will pay benefits based on the provider network status (e.g. in or out of network) of the provider. To receive the maximum benefit level you should choose a provider that is in network for both plans. Services provided by an out of network provider are subject to denial if prior authorization is not obtained prior to services being rendered.
- You must always follow the rules of the primary plan in order for Total Health Care to consider paying as secondary.

Example – If the primary plan requires you to obtain pre-approval for a procedure or see an in network provider to receive coverage and he or she fails to do so, Total Health Care will pay nothing for that expense, regardless of it being a covered service under the benefit plan of Total Health Care.

- Any visit limits that apply to a plan will be counted towards the limit of both plans, regardless of which plan pays.

Updating Members’ COB Information

Information about other insurance coverage is requested at the time you enroll. If there is new coverage or changes to your existing primary carrier, please call our Coordination of Benefits Department to inform us anytime there is a change in other coverage.