# Illinois Insurance Facts

**Illinois Department of Insurance**

# COB – Coordination of Benefits

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Note: This information was developed to provide consumers with general information and guidance about insurance coverages and laws. It is not intended to provide a formal, definitive description or interpretation of Department policy. For specific Department policy on any issue, regulated entities (insurance industry) and interested parties should contact the Department.

If you are covered by two or more group health insurance policies, you may be familiar with the term COB, short for coordination of benefits. Group insurance was designed to cover major medical expenses; however, it was never intended to pay in excess of 100% of incurred charges. For this reason, COB was established as a method by which two or more carriers or plans could coordinate their respective benefits so the total benefit paid does not exceed 100% of the total allowable expenses incurred. In Illinois, the COB Regulation specifies how benefits are to be coordinated by insurance companies issuing group policies in the state.

**NOTE: Individual health insurance policies do not have to comply with the COB rules. Those policies may have special provisions in place if you have more than one policy. You should review your individual health insurance policy to see how it pays if other insurance is involved.**

## Who Pays First? Who Pays Second?

The first question when there are two or more group carriers involved is "Who is Primary Carrier, Who is Secondary Carrier" and so on? The primary carrier is the plan that pays first, the secondary carrier pays second and on down the line. The COB Regulation provides guidelines for the general order by which the primary carrier and secondary carrier(s) are determined as follows:

**Employee, Member or Subscriber**

- The plan that covers you as an employee, member or subscriber is primary over the plan that covers you as a dependent.

- The plan that covers you as an active employee (not as a laid-off employee or retiree) is primary over the plan that covers you as a laid-off employee or retiree.

- If you are covered as an employee, member or subscriber under more than one plan, but are covered under state or federal continuation (COBRA) under one of the plans, then:

  The plan covering you as an employee, member or subscriber is primary over the plan covering you under state or federal continuation (COBRA).

- If you are covered as an employee, member or subscriber under more than one plan, and none of the above rules apply, then:

  The plan that has been in effect the longest is primary, back to your original effective date under your employer group, whether or not the insurance company has changed over the course of coverage.

**Dependent Children of Parents Not Separated or Divorced**

- Birthday Rule – The plan covering the parent whose birthday falls earlier in the year is the primary carrier.

  If both parents have the same birthday, the plan that has provided coverage longer is the primary carrier.

**NOTE: Birthday refers only to the month and day in a calendar year, not the year in which the person was born.**

**NOTE: Some plans not covered by state law may go by the Gender Rule for dependent children. This rule states that the father's coverage is the primary carrier. In the event of a disagreement between two plans, the gender rule applies.**

**Dependent Children of Separated or Divorced Parents**

If your child is covered by more than one group plan and you are separated or divorced from the other parent, the plans must pay in the following order:

- First, the plan of the parent with custody of the child;
- Then, the plan of the spouse of the parent with custody of the child;
- Finally, the plan of the parent not having custody of the child.

However, if terms of a court decree state that one parent is responsible for the health care expenses of the child, and the insurance company has been advised of the responsibility, that plan is primary carrier over the plan of the other parent.

**Dependent Children of Parents With Joint Custody**

The birthday rule applies in this situation.

## Medicare and COB

If you are covered by Medicare and have other group insurance as well, the COB rules are set by the Centers for Medicare & Medicaid Services (CMS). The following table provides general guidelines for Medicare and COB.

| If you | Situation | Pays first | Pays second |
|---|---|---|---|
| Are age 65 and older and covered by a group health plan because you or your spouse is are still working | Entitled To Medicare<br>---<br>The employer has 20 or more employees<br>---<br>The employer has less than 20 employees* | Group health plan<br>---<br>Medicare | Medicare<br>---<br>Group health plan |
| Have an employer group health plan after you retire and are age 65 or older | Entitled to Medicare | Medicare | Retiree Coverage |
| Are disabled and covered by a large group health plan from your work, or from a family member who is working | Entitled to Medicare<br>---<br>The employer has 100 or more employees<br>---<br>The employer has less than 100 employees | Large group health plan<br>---<br>Medicare | Medicare<br>---<br>Group health plan |
| Have End-Stage Renal Disease and group health plan coverage (including a retirement plan) | First 30 months of eligibility or entitlement to Medicare<br>---<br>After 30 months | Group health plan<br>---<br>Medicare | Medicare<br>---<br>Group health plan |
| Have End-Stage Renal Disease and COBRA coverage | First 30 months of eligibility or entitlement to Medicare<br>After 30 month | COBRA<br>Medicare | Medicare<br>COBRA |
| Are covered under worker's compensation because of a job-related injury or illness | Entitled to Medicare | Workers' compensation for worker's compensation related services | Usually doesn't apply. However Medicare may make a conditional payment. |
| Have black lung disease and are covered under the Federal Black Lung Program | Entitled to Medicare and Federal Black Lung Program | Federal Black Lung Program for black lung related services | Medicare |
| Have been in an accident where no-fault or liability insurance is involved | Entitled for Medicare | No-fault or Liability insurance for, for accident related services | Medicare |
| Are age 65 or over OR disabled and covered by Medicare and COBRA | Entitled for Medicare | Medicare | COBRA |
| Are a Veteran and have Veteran's benefits | Entitled to Medicare and Veteran's Benefits | Medicare pays for Medicare-covered services<br>Veteran's Affairs pays for VA-authorized services<br>**NOTE**: Generally, Medicare and VA can't pay for the same service | Usually doesn't apply |
| Are covered under TRICARE | Entitled to Medicare and TRICARE | Medicare pays for Medicare-covered services<br>---<br>Tricare pays for services from military hospital or any other federal provider. | TRICARE may pay second.<br>--- |

* If your employer participates in a plan that is sponsored by two or more employers, the rules are slightly different.

This information was accurate as of May 2008. For additional information, you may view the Medicare publication, *Medicare and Other Benefits: Your Guide to Who Pays First* on-line at http://medicare.gov/Publications/Pubs/pdf/02179.pdf. Questions about COB and Medicare should be directed either to the Senior Health Insurance Program at (800) 548-9034 or the Medicare Coordination of Benefits Contractor at (800) 999-1118.

## Allowable Expenses

Once it is determined which company is the primary carrier and which company is the secondary carrier, claims can be processed. The primary carrier pays your claims as if there is no other insurance involved. The COB law requires the secondary carrier to calculate what the benefit would have been for the claim if there were no other carrier involved. The company then looks at the amount paid on the claim by the primary carrier. The secondary carrier then pays the claim up to 100% of the **allowable expense** if the benefit contained in the policy is great enough.

An **allowable expense** is defined as the necessary, reasonable and customary item of expense for health care when the item is covered at least in part under any of the plans involved.

**The following items are not required to be considered "allowable expenses":**

- The extra cost of a private hospital room versus a semi-private room, unless medically necessary according to the insured's physician;

- Dental care, vision care, prescription drug or hearing aid programs;

- The amount of a benefit reduction under the primary carrier because a covered person does not comply with plan provisions, such as second surgical opinions, pre-certification of admissions or services, or preferred provider arrangements.

**NOTE: This is not true when the primary carrier is an HMO. When an HMO is the primary carrier and the covered person does not utilize the HMO providers, resulting in denial of the claim by the HMO, the secondary carrier must pay the claim as if it is the primary carrier. When an HMO is the secondary carrier and the covered person does not use the HMO providers or does not get a referral from an HMO provider, the HMO must pay as secondary carrier only if there are savings in the benefit reserve account.**

## How Does COB Work?

Under the rules of COB, a secondary carrier may reduce its benefits so that the total benefits paid or provided by all plans during a contract year are not more than the total allowable expenses. The secondary carrier usually saves money on claims due to the other plan paying first. These savings are placed in a benefit reserve account or savings bank for the covered person and are used to pay allowable expenses that would have not been paid otherwise. For example, deductibles, copayments and coinsurance can be reimbursed to the covered person if there are savings available.

Following are simple examples of how claims should be paid in a COB situation. Plan A is primary and Plan B is secondary. Both plans pay claims at 80%; the insured is responsible for 20% coinsurance. For illustrative purposes, Plan A has a $25.00 deductible and Plan B has a $100.00 deductible. Claims have occurred in one contract year and in consecutive order.

**CLAIM #1**

Actual Charge = $100.00

| **Plan A** | **Plan B** |
|---|---|
| $100.00 | $100.00 |
| -25.00 Deductible | -100.00 Deductible |
| $ 75.00 | 0.00 Payable |
| 80% | |
| $ 60.00 | |

Plan A must pay $60.00. Plan B would make no payment because it had no liability under the terms of the policy if it had been primary. Also, there was no money available from the benefit reserve account or savings bank.

**CLAIM #2**

Actual Charge = $5300.00

| **Plan A** | **Plan B** |
|---|---|
| $5300.00 | $5300.00 |
| -0.00 Deductible | - 0.00 Deductible |
| $5300.00 | $5300.00 |
| 80% | 80% |
| $4240.00 Payable | $4240.00 Payable |

The deductibles on both plans were calculated in claim #1. Deductibles will not apply from this claim forward. Plan A must pay $4240.00. Plan B must pay the difference between the actual charge and the amount paid by Plan A ($1060.00). Plan B must now establish a benefit reserve account or savings bank. This amount is calculated by subtracting the amount it paid from the amount it would have paid if primary ($4240.00 - $1060.00 = $3180.00 benefit reserve account or savings bank). Now Plan B must go back to Claim #1 and pay the $40.00 balance of the claim out of the benefit reserve account or savings bank ($3180.00 - $40.00 =$3140.00). The balance of the benefit reserve or savings account is $3140.00.

**CLAIM #3**

Actual Charge = $110.00

| **Plan A** | **Plan B** |
|---|---|
| $110.00 | $110.00 |
| 80% | 80% |
| $ 88.00 Payable | $ 88.00 Payable |

Plan A pays $88.00. Plan B pays the difference of the actual charge and the amount paid by Plan A ($22.00). Now Plan B calculates the amount to be put in the benefit reserve account or savings bank. Plan B would have paid $88.00 if primary. It only paid $22.00, so the balance of $66.00 goes into the benefit reserve account or savings bank. (Previous balance $3140.00 + $66.00 = $3206.00).

**CLAIM #4**

Actual Charge = $1500.00

| **Plan A** | **Plan B** |
|---|---|
| $1300.00 U&C | $1100.00 U&C |
| 80% | 80% |
| $1040.00 Payable | $ 880.00 Payable |

The insured is liable for the difference between the actual charge and the highest usual and customary (U&C) amount ($200.00). Plan A pays $1040.00. Plan B pays the difference between the highest U&C amount and the amount paid by Plan A ($1300.00 - $1040.00 = $260.00). The benefit reserve account or savings bank is increased by the difference between what Plan B would have paid if primary and the amount actually paid ($880.00 - $260.00 = $620.00). The benefit reserve account or savings bank increases by $620.00 making the total savings $3826.00.

**CLAIM #5**

Actual Charge = $1500.00

| **Plan A** | **Plan B** |
|---|---|
| $1100.00 U& C | $1300.00 U&C |
| 80% | 80% |
| $ 880.00 Payable | $1040.00 Payable |

The insured is liable for the difference between the actual charge and the highest U&C amount ($200.00). Plan A pays $880.00. Plan B can pay up to what it would have paid if primary. Therefore, Plan B will pay the difference between the highest U&C amount and what Plan A paid ($1300.00 - $880.00 = $420.00). The benefit reserve account or savings bank will increase by the difference between what Plan B would have paid if primary and the amount if actually paid ($1040.00 - $420.00 = $620.00). The prior benefit reserve account or savings bank balance increases by $620.00 to total $4446.00.

**CLAIM #6**

Actual Charge = $2295.00 for 51 visits

This claim involves spinal manipulation. Plan A provides up to 26 visits per year on an 80% / 20% basis. The total actual charge of $45 per visit is within U&C limits.

**Plan A**

$1170.00 U&C for 26 visits

80%

$ 936.00 Payable

Plan B has no coverage for spinal manipulation. However, since Plan A has coverage under its policy, the claim is considered an allowable expense. Plan B must pay the 20% coinsurance ($234.00) amount for the first 26 visits plus 100% of the charges for the additional 25 visits ($1125.00) from the benefit reserve account or savings bank, leaving a final balance in the reserve account of $3087.00.

**NOTE**: **The savings generated by COB can only be used within the contract year (usually a calendar year). At the end of the contract year, the benefit reserve account or savings bank is returned to a zero balance for the new contract year.**

## For More Information

Call our Consumer Services Section at (312) 814-2427 or
our Office of Consumer Health Insurance toll free at (877) 527-9431
or visit us on our website at htttp:\\insurance.illinois.gov