

Coordination of Benefits – Fairfax County Government Plan



Covered Under More Than One Health Insurance Plan

Most group health care plans, including your BlueChoice POS Plan, contain a coordination of benefits provision. This provision applies when you, your spouse or your covered family members are eligible for benefits under more than one group health program. Coordination of benefits prevents duplicate payments for the same expenses, and helps to hold down the cost of health care coverage and your group’s premiums.

In-Network

How Coordination of Benefits Works

Whether the BlueChoice POS or BluePreferred PPO Plan is primary or secondary, you would be responsible for no more than your In-Network copayments and/or coinsurance.

Out-of-Network

How Coordination of Benefits Works

The BlueChoice POS or BluePreferred PPO Plan provides benefits for BlueCross and BlueShield Participating Providers as well as non-participating providers up

to the Allowed Benefit, but not to exceed the normal Out-of-Network benefits that would have been paid had you not had other insurance coverage. Benefits will be calculated by taking the Allowed Benefit minus what the other carrier paid. This amount is then compared to the normal benefits the BlueChoice POS or BluePreferred PPO Plan would have paid if primary. The BlueChoice POS or BluePreferred PPO payment is either the normal benefits or the Allowed Benefit minus what the other carrier paid, whichever amount is less. In other words, when the BlueChoice POS or BluePreferred PPO Plan is your secondary insurance, the combined benefits of both your other health plan and your BlueChoice POS or BluePreferred PPO Plan will never be more than what the BlueChoice POS or BluePreferred PPO Plan would have paid had it been your primary carrier.

To see how this system works, let’s say you are covered under two plans that pay for surgery. (For these examples, we’ll assume that the BlueChoice POS or BluePreferred PPO Plan is your secondary plan.) Suppose you have an operation for which the Out-of-Network surgeon charges \$1,000. We’ll also assume that the Allowed Benefit for the surgery is also \$1,000.

Example 1: If your primary plan’s payment for this surgery is \$600, and the BlueChoice POS or BluePreferred PPO Plan’s maximum payment for this surgery is \$700 (or 70% of the \$1,000 Allowed Benefit—this example assumes that you have met your calendar year deductible), here’s how much you would have to pay:

Total surgery bill	\$1,000
Less benefits paid by primary plan	- \$600
Less benefits payable by the BlueChoice POS or BluePreferred PPO Plan (the \$700 BlueChoice POS or BluePreferred PPO Plan’s maximum payment, less your primary plan’s payment of \$600)	- \$100

Amount you have to pay	\$300
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Example 2: The same as above, but your primary plan’s payment for this surgery is \$900, here’s how much you would have to pay:

Total surgery bill	\$1,000
Less benefits paid by primary plan	- \$900
Less benefits payable by the BlueChoice POS or BluePreferred PPO Plan (the \$800 BlueChoice POS or BluePreferred PPO Plan’s maximum payment, less your primary plan’s payment of \$900)	- \$0

Amount you have to pay	\$100
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Deciding Which Health Plan is Primary

There are standard rules used throughout the insurance industry to determine which plan is primary. It’s important to know which of your plans is primary and which is secondary because your claims will be paid more quickly and accurately if you submit them in the right order. Please keep in mind that the primary/secondary order may be different for different family members. Here are the rules we use to determine which plan is primary for a member with double coverage:

- When your other group coverage does not coordinate benefits, then that coverage pays first. You should submit your claims to the other carrier first. If the other group carrier does not pay the full claim, submit the balance to the BlueChoice POS or BluePreferred PPO Plan. Claims payments will be made according to your BlueChoice POS or BluePreferred PPO Plan terms.
- When the person who received care is covered as an employee under one group contract, and as a dependent under another group contract, then the employee’s coverage pays first. Submit a claim first to the health insurance plan for the patient’s employer first, and then submit any unpaid balance to the other plan.

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- When a dependent child is covered under two group contracts, the contract that will pay first for dependent children will be that of the parent with the earlier birth date (in other words, the earlier month and date, regardless of the birth year). However, if the other carrier uses gender to determine who would pay first, then your BlueChoice POS or BluePreferred PPO Plan will follow suit and use the gender rule. If the parents are born on the same day, the contract that has been in force longer will pay first for dependent children. Submit your child's claim to whichever health insurance coverage pays first and any unpaid balances to the other plan.
- When the parents are separated or divorced and the eligible child(ren) are covered by more than one health insurance plan, then the following rules apply:
 - If the parent with custody of the child has not remarried, the coverage of the parent with custody pays first.
 - If the parent with custody of the child has remarried, that parent's coverage pays first. The step-parent's coverage pays second, and the coverage held by the parent without custody of the child pays third.
 - Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent pays first.
 - When none of the above can be applied, the benefits of the plan that has covered the child longer pays first.

When the BlueChoice POS or BluePreferred PPO Plan is Primary

When the BlueChoice POS or BluePreferred PPO Plan is your primary insurer, you or the provider of care should submit your claims to us first, in the same way you would if you had no other coverage. Then, if balances remain, you should submit a claim to your secondary plan.

When the BlueChoice POS or BluePreferred PPO Plan is Secondary

When the BlueChoice POS or BluePreferred PPO Plan is your secondary health plan, you should submit your claims to your other primary health plan first. Once the claim has been processed, you should receive a form—often called an Explanation of Benefits or Notice of Benefits—showing the amount paid, or, if benefits were denied, the reason for the denial.

If your claim was not paid in full by your primary plan, you may then submit a claim for consideration of the balance to the BlueChoice POS or BluePreferred PPO Plan. You or the provider should submit the claim to us in the same way you would have if we were the primary plan, with one difference: In addition to sending us the information required for a claim (date of service, provider's name, type of service and diagnosis), you should attach the Explanation of Benefits or Notice of Benefits you or the provider received explaining the other plan's payment. This information will enable us to process your claim quickly and accurately.

No-Fault Exclusion

If you or a member of your family are in a motor vehicle accident which is covered under a state or federal no-fault motor vehicle insurance law, your BlueChoice POS or BluePreferred PPO Plan coverage will not duplicate medical benefits payable by a no-fault insurance carrier.

As a cost savings measure, you must first claim benefits for your medical expenses from the motor vehicle insurer. BlueChoice POS or BluePreferred PPO Plan coverage may help pay for any covered expenses which exceed your motor vehicle insurance benefit limits. This provision assures that you will receive maximum protection for your accident-related medical expenses and that the cost of your health care coverage will be kept as low as possible.

Workers' Compensation

If you are injured while at work or require medical care as a result of your work, you should obtain benefits for such injuries through Workers' Compensation. Your BlueChoice POS or BluePreferred PPO Plan coverage does not provide benefits for expenses which are eligible under Workers' Compensation laws.

Medicare and Your BlueChoice POS or BluePreferred PPO Plan Benefits

Covered medical expenses will be reduced by any Medicare benefits available for those expenses before the BlueChoice POS or BluePreferred PPO Plan benefits are determined. Medicare benefits will be taken into account for any member while he or she is eligible for Medicare, whether or not he or she enrolled (or is entitled to) Medicare benefits. Coordination of benefits with Medicare works the same way as described earlier under **"Covered Under More Than One Health Insurance Plan."** Please contact the Department of Human Resources to determine how Medicare may affect your eligibility under the BlueChoice POS or BluePreferred PPO Plan.

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How BlueChoice POS or BluePreferred PPO Plan Coordinates With Medicare

Three months before your 65th birthday, you are eligible to apply for Medicare. You may also be eligible for Medicare before age 65 if you have been entitled to Social Security disability benefits for 24 months or have end-stage renal disease.

If You Are a Retiree Age 65 and Older

If you are a retiree who is eligible for Medicare, Medicare pays benefits first and then you may submit your Explanation of Medicare Benefits (EOMB) and a copy of your bill to Health Choice for reimbursement. *Please note that BlueChoice POS or BluePreferred PPO will pay benefits based on Medicare's payment—whether or not you claim or receive the benefits available under Medicare.* Remember to bring your Medicare ID card with you when you visit your physician.

- Medicare provides your primary coverage, and
- BlueChoice POS or BluePreferred PPO Plan provides secondary coverage.

Please Note: Members age 65 and over (Medicare eligible) are not required to obtain referrals to see a Specialist in the BlueChoice POS plan.

Medicare Basics

Medicare Hospital Insurance

This is Part A of Medicare. It helps pay for medically necessary inpatient care in a hospital, skilled nursing facility or psychiatric hospital, and for hospice and home health care.

Medicare Medical Insurance

This is Part B Medicare. This part helps pay for medically necessary physician services and many other medical services and supplies not covered by Part A.

Here's an example:

Let's assume that you incur a \$250 expense from a specialist for a consultation. Let's also assume that you have met any BlueChoice POS and BluePreferred PPO Plan and Medicare deductibles. Here's how your bill would be paid if you receive care from an in-network and out-of-network provider.

In-Network Coverage:

Medicare pays first, then BlueChoice POS or BluePreferred PPO pays the difference between what Medicare pays and what BlueChoice POS or BluePreferred PPO would normally pay for in-network benefits. Remember, that you will always be responsible for the appropriate in-network copayment. Here's how benefits would be paid if you receive in-network coverage:

Expense	\$250
Medicare Allowance	\$200
Medicare pays 80% of Allowed Benefit	-\$160
	\$ 40
BlueChoice POS or BluePreferred PPO normally pays 100% of the Allowed Benefit* or the Medicare Allowance, whichever is less	\$200
You pay a specialist copay	\$ 10
Less Medicare's 80% of Medicare allowance	-\$160
So, BlueChoice POS or BluePreferred PPO pays	\$ 30

Out-of-Network Coverage:

Medicare pays first, then BlueChoice POS or BluePreferred PPO pays the difference between what Medicare pays and what BlueChoice POS or BluePreferred PPO would normally pay for out-of-network benefits. Here's how benefits would be paid if you receive out-of-network coverage assuming that your BlueChoice POS or BluePreferred PPO deductible has been satisfied:

Expense	\$250
Medicare Allowance	\$200
Medicare pays 80% of Allowed Benefit	-\$160
	\$ 40
BlueChoice POS normally pays 80% of the Allowed Benefit* (\$210) or the Medicare Allowance, whichever is less	\$160
Medicare pays 80% first	-\$160
So, BlueChoice POS or BluePreferred PPO pays	\$ 0
You pay	\$ 40

*Allowed Benefit is the amount established for payment of services. The member is responsible for any charges that exceed the Allowed Benefit unless the services are rendered by a Blue Cross and Blue Shield Participating Provider. Blue Cross and Blue Shield Participating Providers will not bill the member for balances above the Allowed Benefit.

Note: These examples assume that the specialist accepts assignment of Medicare benefits, which means that he/she agrees to accept the Medicare allowance as payment in full.

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Accepting Assignment

To avoid having to pay excess charges, always ask your physicians and medical suppliers whether or not they accept assignment. Some do on a case-by-case basis while others sign participation agreements with Medicare and accept the Medicare-approved amount as full payment on all Medicare claims.

Besides avoiding excess charges, another advantage of using physicians or suppliers who accept assignment is that they are paid directly by Medicare, except for the deductible and coinsurance amounts that you must pay. Those who

do not accept assignment collect the full amount of the bill from you. Medicare then reimburses you its share of the approved amount for the services or supplies received.

Physician Charge Limits

While physicians who do not accept assignment of Medicare claims can charge more than physicians who do, there is a limit to the amount they can charge for services covered by Medicare. They are permitted to charge you only 15% more than the Medicare-approved amount, and you must pay that extra amount. This is called the “limiting charge” and you do

not have to pay more than this amount.

To determine the limiting charge for particular services, contact the Medicare carrier for your area. Limiting charge information also appears on the Explanation of Medicare Benefits (EOMB) form generally sent to you by the carrier after you receive a Medicare-covered service. If your physician has exceeded the charge limit, contact the physician and ask for a reduction in the charge, or a refund if you have paid the bill. If you cannot resolve the issue with the physician, call your Medicare carrier.

Directory of State Insurance Departments and Agencies on Aging

Insurance Departments

Bureau of Insurance
1300 E. Main Street
Richmond, VA 23219
(804) 371-7945

Insurance Department
Consumer & Profession Service Bureau
441 4th Street, NW
Suite 850 North
Washington, DC 20001
(202) 727-8000

Insurance Administration
Complaints and Investigation Unit
Life & Health
501 St. Paul Place
Baltimore, MD 21202-2272
(410) 333-2793
(410) 333-2770

Insurance Counseling

Virginia
(800) 552-3402

District of Columbia
(202) 676-3900

Maryland
(800) 243-3425

Agencies on Aging

Department for Aging
700 Centre, 10th Floor
700 East Franklin Street
Richmond, VA 23219-2327

Office on Aging
441 4th Street, NW
9th Floor
Washington, DC 20001
(202) 724-5622

Office on Aging
301 W. Preston Street
Room 1007
Baltimore, MD 21201
(410) 225-1100