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East End Health Plan
Coordination of Benefits

Agenda

- Who Pays First?
- Total Allowable Expense
- Types of Medicare Providers
- Come Out Whole Approach
- Come Out Whole with Benefit Bank

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Who Pays First?

Who Pays First?

Situation	Pays First	Pays Second
Employees are 65 or older and covered by a group health plan because you or your spouse are still working	Group Health Plan	Medicare
Have an Employer Group Health Plan after you retire and are 65 or older	**Medicare**	**Group Health Plan**

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Types of Medicare Providers

Types of Medicare Providers

- **Provider who Accepts Assignment of Benefits:** Assignment means that your doctor, provider or supplier has signed an agreement with Medicare to accept the Medicare approved amount as full payment for covered services.

- **Provider who does NOT Accepts Assignment of Benefits:** These types of providers may charge you more than the Medicare approved amount. They can only charge you up to 15% over the Medicare approved amount. This is known as the Medicare Limiting Charge.

- **Provider who Opts Out of Medicare:** These providers do not accept Medicare at all. If a member sees a provider who opts out of Medicare, he/she could be responsible for most, if not all, of the cost of services. When a member see a Medicare Opt Out provider, they will be responsible to sign awritten agreement between them and the doctor or other health care provider who has decided not to provide services to anyone through Medicare. The contract states that the provider does not accept Medicare and the claim cannot be submitted to Medicare.

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Come Out Whole

East End Health Plan Coordination Approach

- The intent of the East End Health Plan Coordination Approach is to reimburse the patient in full between both plans. The secondary plan first determines the amount it would have paid had it been the only carrier paying the claim. It then compares this figure to the amount outstanding after the primary carrier has paid. The secondary plan will pay 100% of the outstanding covered expenses – as long as that amount is not more than it would have paid had it been the only carrier involved in this claim. This is the most generous of all types of Coordination of Benefits.

- If the amount that is outstanding after the primary carrier has paid is more than what the secondary plan would have paid had it been the only carrier, the secondary plan pays its normal benefit.

Coordination Approach Example #1 – Member Responsibility

Situation	Primary Plan - Medicare	Secondary Plan's Normal Benefit
$100 Office Visit Bill	$100	$100
Plan Deductible/Co-payment	$100	$20
Balance after Deductible/Co-pay	$0.00	$80
Plan Benefit	80%	100%
Amount Payable	$0.00	$80
Outstanding Amount	$100	Since the amount the secondary plan would have paid is less than the amount outstanding after Medicare paid, the secondary plan will pay its normal liability of $80. This leaves the member responsible for a $20 co-payment.

Coordination Approach Example #2 – No Member Responsibility

Situation	Primary Plan - Medicare	Secondary Plan's Normal Benefit
$200 Office Visit Bill	$200	$200
Plan Deductible/Co-payment	$147	$20
Balance after Deductible/Co-pay	$53	$180
Plan Benefit	80%	100%
Amount Payable	$42.40	$180
Outstanding Amount	$157.60	The Secondary Plan was able to cover the entire outstanding balance of $157.60 because this amount is less than what the secondary plan would have paid had it been primary