Definition:

When a patient has more than one health plan that covers their medical expenses, a "coordination of benefits" divides the responsibility of payment between the health plans so that together they will pay up to 100% of hospital and professional services. The total amount covered will be addressed in your contract.

For further information, or if you have questions about what is covered, what is not covered, and what your co-pay responsibilities are, please contact your employer and/or the health plan administrator. The detailed rule (R590-131) for the coordination of benefits process can be found at: https://adminrules.utah.gov/public/rule/R590-131/Current%20Rules

Questions regarding coordination of benefits and other health insurance issues may be directed to the Health Division within the Utah Insurance Department at 801-957-9280, toll free in Utah at 800-439-3805, or online at: https://insurance.utah.gov or email us at: health.uid@utah.gov.

Disclosure:

These rules apply only to fully insured health plans. If any of the coordinated health plans are not fully insured, these rules may be different. Contact your health plan administrator to determine if they are fully insured.

Different coordination of benefit processes apply to:

- Medicare coverage
- Self Insured Employers
- Health plans outside of Utah

Coordination of Benefits in Utah

A brief overview

UTAH INSURANCE DEPARTMENT

Updated December 2023

What is this and how does it work?

If you are covered under two health plans that cover Medical, Dental and/or Vision (i.e. through your employer and through your spouse's employer) most likely, you will be subject to a coordination of benefits when you file a claim. This means that your health plans will need to determine the order of benefits. Your health plan, through your employer will be the Primary Health Plan and will pay its portion of the claim first. Then your insurance through your spouse's employer, the Secondary Health Plan, will pay its portion of the claim. For your spouse, the Primary Health Plan will be their employer plan, and your employer will be their Secondary Health Plan. Both payments may equal up to 100% of the claim, but will not surpass the cost of the full medical expense or negotiated rate if you see a preferred provider. If you are not sure how your insurance works, or how much they will pay, please contact the administrator in charge of your health plan by calling the phone number on your health plan identification card.

Will both of my health plans pay for everything?

No. Each health plan has basic requirements and most include a co-pay that may or may not have to be paid before they will make any payments on your behalf. Additionally, the coordination process will not provide benefits for non-covered services or items. There may also be a deductible that needs to be met before payment may take place. For a full explanation of the requirements of your policy or policies, please speak with the administrator in charge of your health plan.

What about my children, how does my health plan cover them?

If both parents have health insurance through their employers, generally the health plan of the parent whose birthday comes first in the calendar year is considered the Primary health plan and the health plan of the parent whose birthday comes second is considered the Secondary health plan. (See Example 1) If both parents share the same birthday, then the parent whose coverage has been in effect the longest is considered the Primary. (See Example 2)

Example 1:
Jane Doe's birth date is January 19 and her employee coverage is "Insure-Me-Now" through Employer A.

John Doe's birth date is April 1 and his employee coverage is "Health-Be-Mine" through Employer B.

Their two children, Abby and Andy, are covered under Jane's health coverage with John's as the Secondary, since Jane's birth date comes first in the calendar year.

Example 2:
Jane Doe's birth date is January 19, and she has been employed by Employer A and covered by "Insure-Me-Now" since 2001.

John Doe's birth date is also January 19 and he has been employed by Employer B and covered by "Health-Be-Mine" since 1997.

Their children are covered under John's health coverage with Jane's as the Secondary, as John's coverage has been in effect longer.

What if I am divorced, how does it work then?

If the divorce decree specifies a parent to provide health coverage for the children, then you must follow the terms of the decree, and that parent's plan is primary. (See Example 3) However, if the decree does not address health coverage for your children, then in most cases, the "custodial" parent's insurance is considered Primary and the "non-custodial" parent's insurance is considered Secondary. (See Example 4)

If the parent with the Primary plan remarries, their insurance remains the Primary plan for his/her children, however the custodial parents spouse's insurance then becomes the Secondary coverage. The non-custodial parent's insurance is now the Tertiary insurance coverage followed by the non-custodial parent's spouse's insurance.

Example 3:
Jane and John divorce and the divorce decree specifies that John is responsible for insurance coverage for his children. Jane is still covered under "Insure-Me-Now" coverage through her employer, but she no longer has a Secondary coverage through John, due to the divorce.

Their children, Abby and Andy, are covered under "Health-Be-Mine" through John's employer and Jane's coverage is their Secondary coverage.

Example 4:
Jane and John divorce, but the divorce decree does not address insurance coverage for their children. Jane is still covered under "Insure-Me-Now" coverage through her employer, and John is still covered under "Health-Be-Mine" through his employer but neither has a Secondary coverage due to the divorce.

Andy and Abby live with Jane more than 50% of the year so she is designated as the "custodial" parent, therefore her insurance coverage is Primary and John's insurance coverage is Secondary.