Coordination of Benefits Example*

Scenario A: High Deductible Primary, Low Deductible Secondary

John has two insurance plans, one through his own employment at 4J and one through his wife's employer. He's elected a plan with $1000 deductible and 80% co-insurance through 4J, which is primary (your own employer's plan is always primary). His wife's plan (secondary coverage) has $100 deductible and 90% co-insurance.

Claim #1: John's first claim for the year is in the amount of $200. His primary plan looks at it as if they were the only plan and determine that this $200 claim should get applied toward his deductible. They pay nothing, and John has $800 left to meet of his deductible. The secondary plan then looks at the claim as if THEY were the only coverage and determine they would normally apply $100 of this toward the deductible, which would meet it, leaving the remaining $100 of the cost to co-insurance. Since this plan pays 90% co-insurance, this company would pay $90 and John would be expected to pay the remaining $10, plus the $100 deductible. **Claim #1 result:** John pays $110 out-of-pocket, he's credited $200 toward his primary plan's deductible and he has met his secondary plan's deductible.

Claim #2: Shortly after the above scenario occurs (within the same plan year) John has a larger claim of $2800. Again the primary plan looks at it as if they are the only coverage and processes accordingly. He's already met $200 of his deductible with Claim #1 (even though he only paid $110 out of his pocket, that is not their concern) so they apply the first $800 of this claim toward his remaining deductible, which he's now met. They look at the remaining $2000 of charges which are subject to co-insurance. They pay 80% of this amount, meaning they pay $1600 to the provider, labeling the remaining $1200 as "patient responsibility" ($800 the remaining deductible, $400 the patient part of the co-insurance -- 20% of $2000). Then the secondary plan looks at this claim as if THEY were only coverage and determine that since John has already met his deductible with the first claim, this entire charge is subject to co-insurance. They determine if they were the primary coverage they would pay 90% of the total bill (90% of $2800 = $2520). Then, because they are the secondary plan, they look to see how much of the bill is remaining as "patient responsibility" after the primary plan did their part. The amount remaining is only $1200, less than they would have had to pay if they were primary; therefore, they simply pay the remaining patient responsibility amount in full ($1200). **Claim #2 result:** John pays nothing out-of-pocket for this claim and he's met his deductible under both plans. Even though he has a plan with $1000 deductible and another with $100 deductible, he only had to pay $110 out-of-pocket and both of his deductibles are now met.

Now let's look at how these claims would be processed for John's wife, Sally, where her employer's plan is primary.

Scenario B: Low Deductible Primary, High Deductible Secondary

Claim #1: Sally's first claim for the year is in the amount of $200. Her primary plan looks at it as if they were the only plan and determine that they need to apply $100 of this toward the deductible, which would meet it, leaving the remaining $100 of the cost to co-insurance. Since this plan pays 90% co-insurance, this company would pay $90 and Sally would be expected to pay the remaining $10, plus the $100 deductible. The secondary plan then looks at the claim as if THEY were the only

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coverage and determine this entire $200 claim should get applied toward her deductible. They pay nothing, and Sally has $800 left to meet of this deductible. **Claim #1 result:** Sally pays $110 out-of-pocket, she's met her primary plan's deductible, and has credited $200 toward her secondary plan's deductible.

Claim #2: Shortly after the above scenario occurs (within the same plan year) Sally has a larger claim of $2800. Again the primary plan looks at it as if they are the only coverage and processes accordingly. She's already met her primary plan's deductible with Claim #1 so they apply co-insurance to the entire bill and pay their 90% (90% of $2800 = $2520) leaving the other 10% ($280) as "patient responsibility". Then the secondary plan looks at this claim as if THEY were the only coverage and determine that since Sally has already credited $200 toward her deductible with Claim #1, they apply the first $800 of this claim toward her remaining deductible, which she has now met. They look at the remaining $2000 of charges which are subject to co-insurance. If they were primary they would pay 80% of this amount, meaning they would pay $1600 to the provider, labeling the remaining $1200 as "patient responsibility" ($800 the remaining deductible, $400 the patient part of the co-insurance -- 20% of $2000). Then, because they are the secondary plan, they look to see how much of the bill is remaining as "patient responsibility" after the primary plan did their part. The amount remaining is only $280, less than they would have had to pay if they were primary; therefore, they simply pay the remaining patient responsibility amount in full ($280). **Claim #2 result:** Sally pays nothing out-of-pocket for this claim and she has met her deductible under both plans. Even though she has a plan with $100 deductible and another with $1000 deductible, she only had to pay $110 out-of-pocket and both of her deductibles are now met.

Compare the Results of Both Scenarios A & B

When you look at what each party paid in these scenarios, you can see it makes no difference to the patient (John or Sally) which plan is primary -- the patient pays the same $110 either way.

Scenario A: High Deductible Plan Primary			
Responsible Party	**Claim #1**	**Claim #2**	**Total Paid**
Patient	$110	$0	**$110**
4J Plan - *primary*	$0	$1600	**$1600**
Spouse's Plan - *secondary*	$90	$1200	**$1290**
Total Paid to Provider	*$200*	*$2800*	*$3000*

Scenario B: Low Deductible Plan Primary			
Responsible Party	**Claim #1**	**Claim #2**	**Total Paid**
Patient	$110	$0	**$110**
4J Plan - *secondary*	$0	$280	**$280**
Spouse's Plan - *primary*	$90	$2520	**$2610**
Total Paid to Provider	*$200*	*$2800*	*$3000*

It only matters to the insurance companies, which is why the government regulates this, making it fair to all parties and preventing the patient from getting caught in the middle.

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