COORDINATION OF BENEFITS

Some patients have vision coverage from more than one benefits plan, either multiple VSP plans or a VSP plan and a medical plan. In these situations, coordinating benefits will help your patients maximize their coverage and lower costs. This section includes guidelines for coordinating benefits for your VSP patients. Every practice and patient is unique, and these guidelines are intended to provide best practices to help realize the full value of your patient's coverage. You can also find guidelines for supplemental plans under that plan's information in **Plans and Coverages section**.

Please discuss billing options, including coordination of benefits (COB), with your VSP patient to identify ways to maximize value for them and create additional revenue opportunities for your practice.

If your patient requests COB, the following guidelines apply when your patient's coverage is with two VSP plans or when a non-VSP plan is primary and a VSP plan is secondary.

If your patient's VSP plan is primary and any other insurance plan is secondary, call VSP at **800.615.1883** to request a letter detailing your patient's out-of-pocket expenses that can be shared with the secondary insurer.

DETERMINING AND APPLYING BENEFITS

There are several common COB situations, including VSP primary to another carrier, multiple VSP plans, routine versus medical services, health plan or Medicare with VSP coverage, and VSP secondary to another vision carrier. This section includes guidelines for coordinating benefits for your VSP patients.

Administering Coordination of Benefits

Use the following to assist your patient in maximizing the eyecare benefits (vision or medical).

1. Based on your professional judgment, determine if the service is routine or medical.
2. Determine the primary and secondary plans.
3. Verify eligibility and available services under each plan.
4. Determine patient responsibility, based on primary insurance.
5. Submit the primary and secondary claims, following the appropriate Submitting Claim instructions.
6. Apply total COB secondary allowance, less any secondary copays, to patient's total primary out-of-pocket expense. Patient pays remaining balance.

Determining Primary and Secondary Plans

Review the scenarios below to help determine your patient's primary and secondary plans, if your patient is covered under multiple plans and isn't a dependent child. If none of the scenarios fit, the plan that's covered your patient longest is primary.

Patient has	and	then
VSP coverage	the spouse has non-VSP coverage	the patient's VSP plan is primary.
VSP coverage	the spouse has VSP coverage	the patient's VSP plan is primary.
non-VSP coverage	the spouse has VSP coverage	the patient's non-VSP plan is primary. The spouse's VSP plan is secondary.

VSP and non-VSP coverage	none of the Coordination of Benefits Rules listed below apply	the plan covering your patient longest is primary.*
Medicaid coverage through VSP	has other coverage (through a health plan or Medicare)	Medicare or the other coverage is primary. The VSP Medicaid plan is secondary
one or more VSP plans	is not eligible for Medicare	the plan covering your patient longest is primary.*
VSP coverage as an active employee	VSP coverage as a retiree under another VSP plan	the active employee VSP plan is primary. The VSP retiree plan is secondary.
COBRA coverage (a continuation plan)	is active with another plan as an employee or dependent	the active employee or dependent VSP plan is primary. The COBRA VSP plan is secondary.
VSP coverage as a retiree	is active under a COBRA plan	the COBRA plan is primary. The retiree plan is secondary.
VSP coverage as a dependent of a retired employee	is an active employee in another VSP plan	the plan covering the patient as an active employee is primary. The VSP plan covering the patient as a dependent is secondary.
VSP or non-VSP coverage through self or spouse	is covered under parents' plan	patient's or spouse's plan is primary. Parents' plan is secondary.

Use the following chart if your patient is a dependent child with VSP coverage as primary and secondary.

Patient is	and	then
dependent child	the parents are NOT separated or divorced	The plan of the parent whose birthday is first in the year is primary.* If both parents have the same birthday, the plan that's covered a parent longer is primary.* If the other plan doesn't have a birthday rule, the gender rule applies (the father's plan is primary).
dependent child	the parents ARE separated or divorced with NO court decree	the custodial parent's plan is primary.* The plan of the custodial parent's spouse (if any) is secondary. Followed by the plan of the non-custodial parent, and then the plan of the non-custodial parent's spouse.
dependent child	the parents ARE separated or divorced WITH a court decree	the plan decreed by the court as primary is primary.* If the decree states both parents have joint custody without stating who's responsible for healthcare expenses, follow the birthday rule.

*Important! Obtain the length of coverage or custody information from your patient or member. Parental custody information may apply when determining coverage for a child.

Applying Benefits

VSP PRIMARY TO ANOTHER CARRIER

When a VSP plan is primary, apply benefits as you would in the absence of any other plan.

QUICK TIP: If your patient isn't eligible for a service under the primary plan, the secondary plan may be used as primary for that service.

MULTIPLE VSP PLANS FOR ROUTINE SERVICES:

1. Determine the primary and secondary plans.
2. Review Coordination of Benefits between Multiple VSP Plans **to verify VSP plans can coordinate.**
3. Verify eligibility and if any services are exhausted under either plan.

Quick Tip: If your patient isn't eligible for a service under the primary plan, the secondary plan may be used as primary for that service.

4. Determine the patient's out-of-pocket expenses from the primary plan.
5. Refer to the Secondary Allowances schedule to determine the COB amount for each service payable under the primary plan that is also available under the secondary plan.

QUICK TIP: Be sure to review COB rules on primary and secondary authorizations prior to calculating COB secondary allowance.

6. Deduct total available COB secondary allowance from patient's total primary out-of-pocket expense. Patient pays remaining balance.

QUICK TIP: You can also access the COB Calculator on VSPOnline to help determine the amounts a patient can coordinate for routine services when VSP is secondary.

7. Bill VSP using the primary plan authorization number and reference the secondary plan's authorization. See Submitting COB Claims for detailed instructions.

WHEN A VSP PLAN IS SECONDARY, FOLLOW THESE STEPS:

1. Verify eligibility and if any services are exhausted under either plan

Quick Tip: If your patient isn't eligible for a service under the primary plan, the secondary plan may be used as primary for that service.

2. Determine whether your patient is eligible for benefits under the secondary plan.
3. Refer to the Secondary Allowances schedule to determine the COB amount for each service payable under the primary plan that is also available under the secondary plan.
4. Deduct total available COB secondary allowance from patient's total primary out-of-pocket expense. Patient pays remaining balance.

QUICK TIP: You can also access the COB Calculator on VSPOnline to help determine the amounts a patient can coordinate for routine services when VSP is secondary.

5. Bill VSP as secondary. See Submitting COB Claims for detailed instructions.

Members may have coverage under both VSP and a health plan or Medicare.

If you participate on the patient's health plan and the exam is medical, bill the health plan or Medicare as primary. If the exam is routine, bill VSP as primary unless the patient has routine coverage through their health plan.*

If the health plan covers the exam only, submit the exam claim to the health plan as primary and the materials claim to VSP as primary.

Quick Tip: Be sure to obtain two separate authorizations – one to electronically submit your exam to coordinate benefits and one to submit the materials to VSP as primary.

6. Medical plans generally have higher copays than VSP and may have deductibles. They also don't typically cover a refraction. To save money for your patient, coordinate benefits with VSP to cover the unpaid portion of the exam, if any, including the refraction.

Quick Tip: Be sure to include applicable medical diagnosis codes for the exam and routine diagnosis codes for the refraction.

*Patients covered under the Federal Employees Dental and Vision Insurance Program may have routine coverage through their health plan. For more information, check the Federal Government Client Details in the Choice Network Manual.

Common Scenarios: Routine vs. Medical Services

Description	Coverage	Billing
Patient comes in for routine exam and is also seen for a medical eye issue. Provider determines chief complaint is medical. Refraction is performed with medical and routine diagnosis.	Medical and Routine	Bill the health plan or Medicare as primary. • Use WellVision as the secondary VSP benefit to coordinate benefits if routine

Member has both VSP and coverage through a health plan or Medicare.		dx code is billed, including refraction. • Exam only claims can be submitted electronically on eClaim. See Submitting COB Claims instructions.
Patient comes in for routine exam and is also seen for a medical eye issue. Provider determines chief complaint is medical. Refraction is performed with medical diagnosis, no routine diagnosis. Member has both VSP (PEC/DEP Plus) and coverage through a health plan or Medicare.	Medical only	Bill the health plan or Medicare as primary. • Use PEC/DEP Plus as secondary benefit for medical only exam, refraction will be denied. • Claim must be submitted on paper. See Submitting COB Claims instructions.
Patient comes in for routine exam and a medical condition is identified. Provider performs medical exam. Refraction is performed with medical diagnosis, no routine diagnosis. Member has two VSP plans with routine and medical eyecare plan (PEC/DEP Plus).	Medical only	Determine primary VSP plan. • Bill VSP under the primary plan's PEC/DEP Plus claim electronically with the secondary authorization to coordinate benefits. • Use PEC/DEP Plus as the secondary VSP benefit for medical only exam, refraction will be denied.

Coordination of Benefits between Multiple VSP Plans

IMPORTANT: The primary and secondary plans must be under different ID numbers or different clients, unless there are special comment codes, or if COB rule 11 applies.

Interim benefits are not available for coordination under any plan benefit type whether considered primary or secondary.

If the primary plan is	Then COB is allowed with the following plans as secondary.																	
	Not allowed	Access Indemnity	Advantage	Covered Contacts	Diabetic EyeCare Plus	Elements	Exam Only	Exam Plus, Choice Exam Plus, and Advantage Exam Plus	Exam Plus w/ Allowances, Choice Exam Plus w/ Allowance, and Advantage Exam Plus w/ Allowances	Medicaid	Primary EyeCare	Second Pair	Signature	Choice	LVC Preferred	Low Vision	Vision Therapy
Access	•																	
Access Indemnity		•	•	•			•	•	•	•		•	•	•			
Advantage		•	•	•			•	•	•	•		•	•	•			
Covered Contacts		•	•	•					•	•		•	•	•			
Elements		•	•				•	•	•	•		•	•	•			
Exam Plus, Choice Exam Plus, Advantage Exam Plus and Exam Only		•	•				•	•	•	•			•	•			
Exam Plus w/ Allowances, Choice Exam Plus w/ Allowances and Advantage Exam Plus w/ Allowances		•	•	•			•	•	•	•		•	•	•			
Diabetic EyeCare Plus					•						•						
LVC Preferred															•		
Low Vision																•	•
Medicaid	•									•							
Primary EyeCare					•						•						
Repair and Replace	•																
Safety EyeCare/ProTec Safety	•																
Second Pair		•	•	•	•		•	•	•	•	•	•	•	•			
Signature		•	•	•	•		•	•	•	•	•	•	•	•			
Choice		•	•	•	•		•	•	•	•	•	•	•	•			
CVC	•																
Vision Savings Pass	•																
Vision Therapy																•	•

Note: If your patients have plano coverage available on the primary benefit, they must have plano coverage available on the secondary benefit to coordinate both plans when receiving plano materials.

COB ROUTINE SECONDARY ALLOWANCES

Signature, Choice and Advantage Secondary Allowances

Service	VSP Signature and VSP Choice	Advantage
Eye exam	$66 less secondary plan copays	$50 less secondary plan copays
Lenses	$51 less secondary plan copays	$36 less secondary plan copays
Frame	$76 less secondary plan copays	$58 less secondary plan copays
Maximum for Exam, Lens and Frame	$193 less secondary plan copays	$144 less secondary plan copays

Secondary allowances are less secondary plan copays and are cumulative.

Other Secondary Allowances:

- For patients with an Elective Contact Lens Benefit, refer to the Patient Record Report for the contact lens allowance. (Note: A covered-in-full contact lens exam does not have a secondary COB dollar value).
- For patients with allowance plans, refer to the Patient Record Report for the material allowance.
- You can coordinate the secondary exam allowance with the exam, refraction and/or retinal screening out-of-pocket expense from the primary plan.

MEDICAID NETWORK COORDINATION OF BENEFITS SECONDARY ALLOWANCES

Refer to your Medicaid Manual for state-specific Medicaid COB guidelines.

Applying Allowance Examples

VSP to VSP for Exam, Lens and Frame

Here's a VSP Signature Plan example:		
Calculate the patient's out-of-pocket expenses under their primary plan		
Exam copay	$10	
Lens copay + lens enhancements	+ $133	
Frame overage:	+ $122	=$265
VSP will COB the patient's out-of-pocket expenses up to secondary allowance:		
Maximum for Exam, Lens and Frame secondary allowance:	$193	
Lens secondary plan copay	- $20	-$173
Patient pays remaining balance		= $92

Health Plan or Medicare, VSP secondary for Exam and Refraction

Here's a VSP Choice Plan example:	Exam	Refraction
Bill the health plan or Medicare your U&C fee	$100	$35
Subtract the amount paid by the primary insurance carrier:	- $75	$0

VSP will COB the patient's out-of-pocket expenses up to this amount:	= $25	= $35
Total submits secondary claim to VSP		$60
VSP pays up to the secondary allowance $66, less secondary plan copays		- $60
Patient pays remaining balance		= $0
Note: Provider is paid **$135 for exam and refraction** ($75 from health plan/Medicare + $60 VSP). If the primary plan's allowed amount is lower than U&C, subtract the primary plan's paid amount from allowed amount to determine the patient's responsibility.		

Coordination of Benefits by Network Participation

With the exception of the secondary allowances, the VSP Advantage Plan and VSP Essentials Plan COB guidelines are the same as the VSP Signature Plan and VSP Choice Plan. If you're not participating in the Advantage Network and the member wants to use their secondary plan to coordinate benefits, we'll reimburse the patient based on their non-VSP provider reimbursement schedule (if out-of-network coverage is available).

Patient's primary plan	Patient's secondary plan	Your network participation is	Then
VSP Advantage Plan or VSP Essentials Plan	VSP Signature Plan or VSP Choice Plan	Advantage Network	You'll be reimbursed based on the VSP Signature and Choice COB allowances. (See COB Client Exception Rules for exceptions).
VSP Advantage Plan or VSP Essentials Plan	VSP Signature Plan or VSP Choice Plan	Non-Advantage Network	We'll reimburse the patient based on their non-VSP provider reimbursement schedule if out-of-network coverage is available.
VSP Signature Plan or VSP Choice Plan	VSP Advantage Plan or VSP Essentials Plan	Advantage Network	You'll be reimbursed according to the Advantage Secondary Allowances.
VSP Signature Plan or VSP Choice Plan	VSP Advantage Plan or VSP Essentials Plan	Non-Advantage Network	We'll reimburse the patient based on their non-VSP provider reimbursement schedule if out-of-network coverage is available.

COB CLIENT EXCEPTION RULES

There may be a client exception to how you would handle your patient's COB. Before providing services to your patient, please obtain a **Patient Record Report** from **eClaim** on **eyefinity.com**. The Patient Record Report will highlight the rules from the following list that may apply to your patient's coverage and ability to coordinate benefits. Call VSP at **800.615.1883** if you have questions.

- **COB rule 1:** If both members are covered by the same client, COB isn't allowed for either of the members or their children. If the member is covered twice by the same client, COB isn't allowed.
- **COB rule 2:** If both members are covered by the same client, children are covered only under one parent's plan. COB can't be applied and the child may only receive one set of services. This applies both to biological parents and step-parents.
- **COB rule 3:** If both members are covered by the same client, the secondary plan can be used to cover copays only, which will use all service areas.
- **COB rule 4:** This rule applies only when the patient has an insurance carrier other than VSP as primary. If both plans are through VSP, this rule doesn't apply. However, other COB rules may still apply. COB reimbursement is calculated by subtracting what the primary carrier paid from what VSP would have paid as primary.

Here's an example:	
Calculate the amount VSP would pay your practice if VSP was primary:	$100
Subtract the amount paid by the primary insurance carrier:	- $75
VSP will COB the patient's out-of-pocket expenses up to this amount:	= $25

- **COB rule 5:** A married couple, or domestic partners, who are covered by the same client may coordinate benefits, but can't receive two sets of services.
- **COB rule 6:** COB isn't allowed for Computer Vision Care (CVC), Repair, Safety Eyecare, or ProTec Safety benefit types.
- **COB rule 7:** A married couple, or domestic partners, who work for the same client may either use both of their benefit plans separately to receive two sets of services, **OR** COB their secondary benefits to pick up only the primary copays (using all services).
- **COB rule 8:** If a member's dependents have vision coverage through their own employment, coverage through that employment is primary. If dependents have coverage under Medicaid State Children's Healthy Insurance Program (SCHIP), there's no COB.
- **COB rule 9:** COB isn't allowed. Call VSP at 800.615.1883 for client exceptions and specific instructions.
- **COB rule 10:** A child covered under both parents' plans will always use the father's plan as primary.
- **COB rule 11:** Employees and dependents can use their second-pair coverage towards overages from their first-pair coverage.
- **COB rule 12:** If both members are covered by the same client, COB is allowed to cover out-of-pocket expenses only, but the patient can't receive two sets of services.

SUBMITTING COB CLAIMS

When a VSP plan is primary, submit the claim as you would in the absence of any other plan.

QUICK TIP: If your patient isn't eligible for a service on the primary plan, the secondary plan may be used as primary for that service

When VSP is Both Primary and Secondary

Submitting the claim electronically:

- Get authorizations for both primary and secondary benefits.
- Submit the claim using the primary authorization. Mark "No" for question 11D on the "Diagnosis and Services" page.

IMPORTANT: Enter the secondary authorization number in the "VSP COB Secondary Authorization Number" field.

- Complete the Diagnosis and Services and Invoice Services pages as you normally would.

QUICK TIP: Be sure to enter the patient's chronic health conditions to VSP, we'll reimburse* you for the additional education and services you provide to patients.

For each patient identified, you can earn:
$5 for reporting diabetes and/or diabetic retinopathy.
$2 for reporting hypertension and/or high cholesterol.

*Payment won't exceed $5 and isn't cumulative. Additional reimbursement only applies to VSP Signature Plan® and VSP Choice Plan® claims billed with one of the following exam codes: 92002, 92004, 92012, 92014, S0620, or S0621.

Submitting the claim on paper:

Write the primary plan's authorization number in Box 23 and write "COB with ######## (secondary authorization #)" in Box 19, and submit the claim to VSP.

If materials are ordered, submit the claim form with a Materials Invoice Form to a contract lab. If no materials are ordered, send the claim directly to VSP at:

In-Network Claims	Out-of-Network Claims
VSP	VSP
PO Box 385020	PO Box 385018
Birmingham, AL 35238-5020	Birmingham, AL 35238-5018

VSP is Secondary to Another Vision Plan

If we're the secondary payor, bill us for your patient's out-of-pocket expenses. Examples are copays, coinsurance or charges for non-covered services by the primary carrier. We follow plan policies for reimbursing these charges. However, we don't pay more for approved services than what you would have received if we were the primary carrier.