Coordination of Benefits (COB)

Coordination of Benefits (COB) occurs when a patient is entitled to benefits from more than one dental plan. The ADA policy is based on a simple premise that the patient should get the maximum allowable benefit from each plan. This guide is intended as a quick reference for the most frequently asked COB questions and where to find available ADA resources.

General Coordination of Benefits Guidelines

Employee/Main Policyholder - When both plans have COB provisions, the plan in which the patient is enrolled as an employee or as the main policyholder is primary. The plan in which the patient is enrolled as a dependent would be secondary.
Current Employment – When an employed patient has coverage through an employer that plan is primary over a COBRA or a retiree plan.
More than One Employer Plan – When a patient has plans provided by more than one employer, the plan that has covered the patient the longest is primary.
Dependent Children - The typical rules for dependents of parents with overlapping coverage rely on the birthday rule, that is, the parent with the earliest birthday in a calendar year is primary. In the case of divorced/separated parents, the court's decree would take precedence.
Medical/Dental Plan – When a patient has coverage under both a medical and dental plan, typically the medical plan is primary; however, it is recommended that the office verify which plan is primary.
Longer or Shorter Length of Coverage – The plan that covered the patient longer is the primary plan and the plan that covered the patient the shorter period of time is the secondary plan.

Network Plan Write-Offs

The difference between the dentist's full fee and the sum of all dental plan payments and patient payments is the amount of the write-off. Write-offs should not be posted until all plans have paid accordingly. If a write-off is posted after the primary pays and then posted again based on the secondary payment, it is possible the dental office may incorrectly apply a credit to the patients' balance. *You will want to be careful not to do this!* Remember to always submit your full fee on the dental claim form.

Non-Duplication of Benefits

In the case of non-duplication of benefits, if the primary plan paid the same or more than what the secondary plan would have paid had it been primary, then the secondary plan is not responsible for any additional payment at all. Non-duplication of benefits is typically used in self-funded dental plans. The following is ADA policy on COB.

Taken from Guidelines on Coordination of Benefits for Group Dental Plans (Trans.1996:685; 2009:423)

When a patient has coverage under two or more group dental plans the following rules should apply:

a. The coverage from those plans should be coordinated so that the patient receives the maximum allowable benefit from each plan.
b. The aggregate benefit should be more than that offered by any of the plans individually, allowing duplication of benefits up to the full fee for the dental services received.

Summary

Coordination of benefits can be a frustrating and time consuming endeavor for dental offices. State laws and regulations often mandate coordination of benefits. If after the claim payment has been made and it appears to have been incorrectly adjudicated, it is recommended that the claim determination be appealed; and if necessary the state insurance commissioner's office be contacted for assistance.

Guidance on coordination of benefits and other valuable educational ready-to-use resources on innovative dental insurance solutions for dentists can be found at ADA.org/dentalinsurance.