Coordination of Benefits (COB)

If the spouse of an employee hired on or after August 1, 2003, is covered by any PEBTF health care plans, and he/she is eligible for coverage under another employer's plan(s), the spouse shall be required to enroll in each such plan, which shall be the spouse's primary coverage, as condition of the spouse's eligibility for coverage by the PEBTF plan(s), without regard to whether the spouse's plan requires cost sharing or whether the spouse's employer offers and incentive to the spouse not to enroll.

In addition to the new hire spousal eligibility rule, mentioned above, effective October 1, 2003, if the spouse of any Commonwealth employee (excluding new hires) covered by any PEBTF health plan also is eligible for coverage under another employer's plan(s), the spouse shall be required to enroll in each such plan, provided that the plan in question does not require an employee contribution by the spouse or the spouse's employer does not offer an incentive to the spouse not to enroll.

If a spouse has other employer coverage, regardless of whether they pay for that coverage or not, that plan will be the primary coverage and the PEBTF plan will be secondary.

Note: This does not apply to those employees who have other coverage through the PEBTF. For example, if two PEBTF members are married and have elected coverage under their own PEBTF policy, there is no coordination of benefits. Children of those employees may only be covered under one of the PEBTF contracts.

Primary dependent coverage will be determined by the COB rules currently outlined in the contracts that the PEBTF has with the various health care plans. In most cases, it is the parent that is born earlier in the year who is primary for dependents.

In order to make the appropriate determination as to which plan is primary for dependents; employees must complete the PEBTF-2a form.

Section (1) – This section is to be completed with the Employee's information

Section (2) – This section should be completed with the spouses information and list those dependents currently covered under the spouse's policy. If other coverage exists for dependents, which is not provided by the employee's current spouse, please complete section 3.

Section (3) – This section should be completed for dependents that have additional coverage provide by someone other than the Employee or employee's spouse.

COB information should be reported to your Human Resources Office at the time of enrollment and whenever there is a change to you or your dependents coverage.

PEBTF Coordination of Benefits Form

This form should be completed by the employee

(1) Employee Data

Social Security #	Name (Last plus suffix, First, MI)	Date of Birth

Does your spouse have other insurance coverage? *Yes* ☐ *No* ☐ *If you answered yes , please complete the following:*

(2) Spouse's Data

Social Security #	Name (Last plus suffix, First, MI)	Date of Birth

Spouse's Medical

Policy Holder #	Carrier Name		Carrier Address
Coverage Start Date	Coverage End Date	Carrier Phone # ( )	Carrier Contact Name

List the names (Last, First, MI) , and effective dates of those enrollees who are covered under the spouse's policy and who are also covered under the PEBTF:

Name: ____________________ Relationship: __________ Effective Date: __________
Name: ____________________ Relationship: __________ Effective Date: __________
Name: ____________________ Relationship: __________ Effective Date: __________

Spouse's Dental

Policy Holder #	Carrier Name		Carrier Address
Coverage Start Date	Coverage End Date	Carrier Phone # ( )	Carrier Contact Name

List the names (Last, First, MI) , and effective dates of those enrollees who are covered under the spouse's policy and who are also covered under the PEBTF:

Name: ____________________ Relationship: __________ Effective Date: __________
Name: ____________________ Relationship: __________ Effective Date: __________
Name: ____________________ Relationship: __________ Effective Date: __________

Spouse's Prescription Drug

Policy Holder #	Carrier Name		Carrier Address
Coverage Start Date	Coverage End Date	Carrier Phone # ( )	Carrier Contact Name

List the names (Last, First, MI) , and effective dates of those enrollees who are covered under the spouse's policy and who are also covered under the PEBTF:

Name: ____________________ Relationship: __________ Effective Date: __________
Name: ____________________ Relationship: __________ Effective Date: __________
Name: ____________________ Relationship: __________ Effective Date: __________

Complete the following section if the parents are single, divorced or legally separated and you are reporting COB information for dependent children which is provided by someone other than the Employee or spouse.

(3) Other coverage for dependent children provided by someone other than the individuals listed in Sections 1 or 2. (see other side if reporting on more than one child)

Social Security #	Name (Last plus suffix, First, MI)	Date of Birth

Natural/Adoptive Mother's Birthdate: Natural/Adoptive Father's Birthdate:

Who has primary custody of the child? ☐ Mother ☐ Father ☐ Joint ☐ Guardian

Has a court order established that one parent has primary responsibility for the child's health care expenses? ☐ Yes ☐ No

Name of Parent/Guardian with primary responsibility:

Medical Coverage

Policy Holder #	Carrier Name		Carrier Address
Coverage Start Date	Coverage End Date	Carrier Phone #	Carrier Contact Name

Dental Coverage

Policy Holder #	Carrier Name		Carrier Address
Coverage Start Date	Coverage End Date	Carrier Phone #	Carrier Contact Name

Prescription Drug Coverage

Policy Holder #	Carrier Name		Carrier Address
Coverage Start Date	Coverage End Date	Carrier Phone #	Carrier Contact Name

All PEBTF contracts with health care plans contain a Coordination of Benefits (COB) provision. I declare that the information being provided on this form is true and accurate. I understand and agree that the PEBTF has the right to suspend or terminate my PEBTF health coverage and/or collect any overpayment of benefits if it concludes I have provided false or misleading information.

______________________________ ______________
Signature *Date*

(3a) Other coverage for dependent children provided by someone other than the individuals listed in Sections 1 or 2.

Natural/Adoptive Mother's Birthdate:	Natural/Adoptive Father's Birthdate:

Who has primary custody of the child? ☐ Mother ☐ Father ☐ Joint ☐ Guardian

Has a court order established that one parent has primary responsibility for the child's health care expenses? ☐ Yes ☐ No

Name of Parent/Guardian with primary responsibility:

Medical Coverage

Policy Holder #	Carrier Name	Carrier Address	
Coverage Start Date	Coverage End Date	Carrier Phone #	Carrier Contact Name

Dental Coverage

Policy Holder #	Carrier Name	Carrier Address	
Coverage Start Date	Coverage End Date	Carrier Phone #	Carrier Contact Name

Prescription Drug Coverage

Policy Holder #	Carrier Name	Carrier Address	
Coverage Start Date	Coverage End Date	Carrier Phone #	Carrier Contact Name

(3b) Other coverage for dependent children provided by someone other than the individuals listed in Sections 1 or 2.

Natural/Adoptive Mother's Birthdate:	Natural/Adoptive Father's Birthdate:

Who has primary custody of the child? ☐ Mother ☐ Father ☐ Joint ☐ Guardian

Has a court order established that one parent has primary responsibility for the child's health care expenses? ☐ Yes ☐ No

Name of Parent/Guardian with primary responsibility:

Medical Coverage

Policy Holder #	Carrier Name	Carrier Address	
Coverage Start Date	Coverage End Date	Carrier Phone #	Carrier Contact Name

Dental Coverage

Policy Holder #	Carrier Name	Carrier Address	
Coverage Start Date	Coverage End Date	Carrier Phone #	Carrier Contact Name

Prescription Drug Coverage

Policy Holder #	Carrier Name	Carrier Address	
Coverage Start Date	Coverage End Date	Carrier Phone #	Carrier Contact Name

(3c) Other coverage for dependent children provided by someone other than the individuals listed in Sections 1 or 2.

Natural/Adoptive Mother's Birthdate:	Natural/Adoptive Father's Birthdate:

Who has primary custody of the child? ☐ Mother ☐ Father ☐ Joint ☐ Guardian

Has a court order established that one parent has primary responsibility for the child's health care expenses? ☐ Yes ☐ No

Name of Parent/Guardian with primary responsibility:

Medical Coverage

Policy Holder #	Carrier Name	Carrier Address	
Coverage Start Date	Coverage End Date	Carrier Phone #	Carrier Contact Name

Dental Coverage

Policy Holder #	Carrier Name	Carrier Address	
Coverage Start Date	Coverage End Date	Carrier Phone #	Carrier Contact Name

Prescription Drug Coverage

Policy Holder #	Carrier Name	Carrier Address	
Coverage Start Date	Coverage End Date	Carrier Phone #	Carrier Contact Name