



WHEN YOU HAVE MEDICAID AND OTHER INSURANCE

**Balance Billing, Choosing Providers
and Other Advice on Third Party Liability (TPL)**

**A guide to understanding health coverage in New Jersey
if you have Medicaid and Medicare and/or Other Health Insurance.**

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INTRODUCTION

If you have Medicaid and other health insurance coverage, each type of coverage is called a “payer.” When there is more than one payer, there are rules that decide how payments are coordinated and how much each payer pays for each service. In some cases, a member may have only one payer, Medicaid. In some cases, a member may have a second or third payer, which may include but not be limited to Medicare, or other health insurance.¹

Many members have other health insurance or Medicare as their primary payer, as well as Medicaid Fee-for-Service (FFS) as their secondary or tertiary payer. This includes people who belong to a Medicare Advantage (MA) Health Plan² as their primary insurance.

In New Jersey, Medicaid Health Plans are replacing Medicaid FFS as the secondary (or tertiary) payer. When you enroll in a Medicaid Health Plan, **MEDICAID IS GENERALLY THE PAYER OF LAST RESORT**. This means that Medicare and/or your other health insurance pay for covered services first, and your Medicaid Health Plan generally pays for covered services last.

YOU CAN NEVER BE DENIED MEDICALLY NECESSARY COVERED SERVICES BECAUSE OF ISSUES OR CONFUSION WITH MULTIPLE PAYERS.

If you receive a bill for any services, you should contact your Medicaid Health Plan member services department right away:

Amerigroup	1-800-600-4441	TTY/TDD 1-800-855-2880
Healthfirst NJ	1-888-464-4365	TTY/TDD 1-800-852-7897
Horizon NJ Health	1-877-765-4325	TTY/TDD 1-800-654-5505
UnitedHealthcare	1-800-941-4647	TTY/TDD 711

The TPL Coverage Guide is meant to assist Medicaid Health Plan members and families in understanding the details with service payments. If you need assistance understanding some of the information, please share this guide with a family member, friend, and healthcare provider or call your Medicaid Health Plan with any questions.

¹ Examples of other health insurance: employee health insurance, automobile insurance, Veteran’s benefits

² Medicare Advantage is a Medicare Health Plan which includes benefits covered under Medicare Parts A and B, and may include Medicare Part D and additional benefits.

WHEN YOU HAVE MEDICARE AND MEDICAID

CHOOSING PROVIDERS

You may continue to see your Medicare providers for Medicare covered services, even when those providers are not in the Medicaid health plan provider network. **TO ENSURE THAT YOU WILL NOT BE BILLED, YOU MAY WANT TO CHOOSE MEDICARE PROVIDERS THAT ARE ALSO IN YOUR MEDICAID HEALTH PLAN PROVIDER NETWORK.**

There are some services which are covered by your Medicaid Health Plan, but not by Medicare. For example, dental services, vision services, hearing aids and incontinence supplies are covered by your Medicaid Health Plan, but not by Medicare. **YOU SHOULD ONLY USE MEDICAID HEALTH PLAN PROVIDERS FOR THESE SERVICES/SUPPLIES. MEDICAID HEALTH PLAN PROVIDERS ARE PROHIBITED FROM BILLING YOU FOR MEDICAID COVERED SERVICES.**

Please note: Medicare providers who do not participate with Medicaid have the right not to accept you as a patient. You must find Medicare providers who are willing to treat patients who have Medicare and Medicaid.

HEALTH INSURANCE CARDS

When you enroll in a Medicaid Health Plan, you will receive a Medicaid Health Plan identification (ID) card. All Medicaid Health Plan ID cards will list a Medicaid Health Plan primary care provider (PCP). **YOU SHOULD CONTINUE TO SEE YOUR MEDICARE PCP, REGARDLESS OF THE INFORMATION ON THE MEDICAID HEALTH PLAN ID CARD.** You are only required to see your Medicaid Health Plan PCP when the needed service is not covered by Medicare, but is covered by your Medicaid Health Plan.

If you have Medicare and Medicaid, you should show all health insurance cards any time you visit a doctor, hospital, pharmacy, lab or other service provider. This will ensure that all providers know how to bill for that particular service, supply or prescription.

BALANCE BILLING

All providers who accept Medicare and Medicaid cannot bill individuals who have dual coverage (both Medicare and Medicaid) for the balance of a bill. Individuals with dual coverage are protected from being billed for the balance due on a medical claim for medically necessary, covered services. If a provider does not know you have Medicaid, they may send you a bill to pay the balance of the claim in error. Therefore, always present your **Medicare, Medicaid Health Plan, and plastic Medicaid Health Benefits Identification (HBID) cards** when you check in for a medical visit.

The medical office, hospital or pharmacy will need to know all of the health insurance coverage you have to know how to submit the claim for payment.

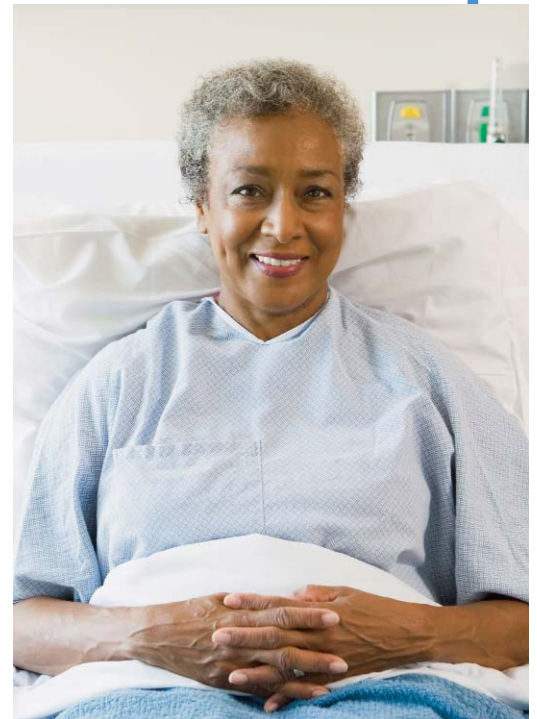
Here are examples of how a Medicare and Medicaid provider should handle the balance on a medical bill when you have Medicare and Medicaid:

For an office visit:

If the charge for a service is \$80.00 and the Medicare payment is \$64.00 (80% of the charge), your Medicaid Health Plan will pay the 20% co-insurance or the difference between the Medicare reimbursement and the Medicaid Health Plan rate, whichever is less. In this example, let's say the Medicaid Health Plan reimbursement rate for the service is \$70.00. In that case, the Medicaid Health Plan would pay \$6.00 toward the bill (The difference between the \$70.00 Medicaid Health Plan rate and the amount Medicare paid \$64.00 = \$6.00). **You are not responsible for any additional payment.** If the Medicaid Health Plan rate is lower than the Medicare 80% payment, no payment is made to the Medicare/Medicaid provider. **As long as you have informed the Medicare/Medicaid provider of your Medicaid Health Plan status, the doctor will know that you are not responsible for a co-insurance payment.**

For a hospital stay:

If the charge for a hospital stay is \$500.00 and the Medicare payment is \$400.00 (80% of the charge), your Medicaid Health Plan will pay the 20% co-insurance or the difference between the Medicare reimbursement and the Medicaid Health Plan rate, whichever is less. In this example, let's say the Medicaid Health Plan reimbursement rate for the hospital stay is \$350.00. In that case, the Medicaid Health Plan would pay \$0.00 toward the bill (The cost of the hospital stay exceeds the Medicaid Health Plan rate). **You are not responsible for any additional payment.** **As long as you have informed the Medicare/Medicaid provider of your Medicaid Health Plan status, the hospital/doctor will know you are not responsible for a co-insurance payment.**



FOR ALL SCENARIOS, MEDICAID HEALTH PLANS WILL FOLLOW THE SAME PAYMENT RULES THAT MEDICAID FFS DID IN DETERMINING THE PAYMENT OF THE CO-INSURANCE AMOUNT.

COVERAGE RESPONSIBILITY

Based on a regulation that has been in effect since January 2006, you can be billed for services rendered by a provider if the following criteria exist:³

1 – You have been paid for the service by a health insurance company or other third party and you have failed or refused to remit to the provider that portion of the third party’s payment to which the provider is entitled by law.

You may also be billed for services if the following criteria exist:

1 – Either:

A – The service is not covered by any of your payers; **OR**

B – The service is determined to be medically unnecessary before it is rendered; **OR**

C – The provider does not participate with the Medicaid Health Plan, either generally or for that service;

AND

2 – You are informed in writing before the service is rendered that either A, B or C above exists and you voluntarily agree in writing before the service is rendered to pay for all or part of the provider’s charges; **AND**

3 – The service is not an emergency service as defined in State and Federal law; **AND**

4 – The service is not a trauma service as defined by State law; **AND**

5 – The additional protections under Federal and State law⁴ do not apply; **AND**

6 – The provider has received no program payment from either Medicaid FFS or your Medicaid Health Plan.

Example:

If you have Medicare and Medicaid and receive a cosmetic surgery from a Medicare provider who is also in your Medicaid Health Plan provider network, this service will not be paid for by Medicare or your Medicaid Health Plan. Cosmetic surgeries are not covered by Medicare or your Medicaid Health Plan. However, the service must meet the criteria listed above and you must agree in writing to pay for the service prior to the service being rendered.

³ Adapted from N.J.A.C. 10:74-8.7

⁴ 42 U.S.C. § 1396u-2(b)(6), 42 CFR 438.106, N.J.A.C. 11:24-9.1(d)9 and/or 15.2(b)7ii

REFERRALS

WHEN YOUR MEDICARE PCP REFERS YOU TO SEE A MEDICARE SPECIALIST FOR A MEDICARE-ONLY COVERED SERVICE OR FOR A MEDICARE AND MEDICAID HEALTH PLAN COVERED SERVICE, YOU DO NOT NEED TO OBTAIN A REFERRAL FROM YOUR MEDICAID HEALTH PLAN PCP. The same billing standards apply and you cannot be billed for a Medicare only or for a Medicare and Medicaid Health Plan covered service, when that service is received from a Medicare provider.

However, if you need health services that are not covered by Medicare, you may need a referral from your Medicaid Health Plan PCP. These are examples of services that are not covered by Medicare, but are covered by your Medicaid Health Plan: hearing aids, vision exams, incontinence supplies, and personal care assistance services.

Each Medicaid Health Plan has established different guidelines regarding referrals to see specialists within the Medicaid Health Plan network. Please contact your Medicaid Health Plan for more information:

Amerigroup	1-800-600-4441	TTY/TDD 1-800-855-2880
Healthfirst NJ	1-888-464-4365	TTY/TDD 1-800-852-7897
Horizon NJ Health	1-877-765-4325	TTY/TDD 1-800-654-5505
UnitedHealthcare	1-800-941-4647	TTY/TDD 711

REMEMBER:

YOU CAN NEVER BE DENIED MEDICALLY NECESSARY COVERED SERVICES BECAUSE OF ISSUES OR CONFUSION WITH MULTIPLE PAYERS.

If you receive a bill for any services, you should contact your Medicaid Health Plan member services department right away:

Amerigroup	1-800-600-4441	TTY/TDD 1-800-855-2880
Healthfirst NJ	1-888-464-4365	TTY/TDD 1-800-852-7897
Horizon NJ Health	1-877-765-4325	TTY/TDD 1-800-654-5505
UnitedHealthcare	1-800-941-4647	TTY/TDD 711

WHEN YOU HAVE BOTH MEDICARE AND MEDICAID

If you have both Medicare and Medicaid, you should always choose providers in your Medicare provider network for Medicare covered, medically necessary services. When receiving Medicare covered services, all Medicare guidelines must be followed to ensure Medicare coverage. See <http://www.medicare.gov> for more information.

IF SERVICE IS	THEN	PROVIDER GUIDANCE
An approved, Medicare covered benefit (Examples: outpatient hospital service, primary care, specialists, lab tests, radiology)	Medicare is the primary payer and Medicaid Health Plan is the secondary payer.	Use a Medicare provider who does not need to be in your Medicaid Health Plan's provider network.
Inpatient hospital care	Medicare is the primary payer and Medicaid Health Plan is the secondary payer.	Use a hospital that is affiliated with Medicare. If possible, use a hospital that is also in your Medicaid Health Plan provider network.
Emergency care received at a hospital emergency department	Medicare is the primary payer and Medicaid Health Plan is the secondary payer.	Go to the nearest hospital.
A medically necessary service which is not covered by Medicare but is covered by your Medicaid Health Plan (Examples: dental services, hearing aids, personal care assistant services, medical day care services, incontinence supplies, family planning services)	Medicaid Health Plan is the only payer.	Use a provider in your Medicaid Health Plan provider network.

IF SERVICE IS	THEN	PROVIDER GUIDANCE
Rendered by a provider who has opted out of Medicare for Medicare Parts A and B members ⁵ and is not in your Medicaid Health Plan provider network	Member is responsible for payment if properly informed and signed private contract. ⁶	To avoid being responsible for medical bills, be sure to use providers who participate in Medicare.
Rendered to a Medicare Advantage Health Plan ⁷ member by an unapproved, uncovered out-of-network provider	Member is responsible for payment.	To avoid being responsible for medical bills, be sure to use providers who are in the Medicare Advantage Health Plan's provider network.
A prescription drug covered under Medicare Part D	Medicare is the primary payer. Member must pay a small prescription co-pay, if applicable.	Use a Medicare participating pharmacy to receive prescription drugs.
A prescription drug not covered under Medicare Part D or creditable drug coverage ⁸	Member is responsible for payment. ⁹ Some exceptions apply. See footnote at the bottom of this page.	N/A

⁵ A provider who has opted out of Medicare is one that does not accept Medicare beneficiaries for any services.

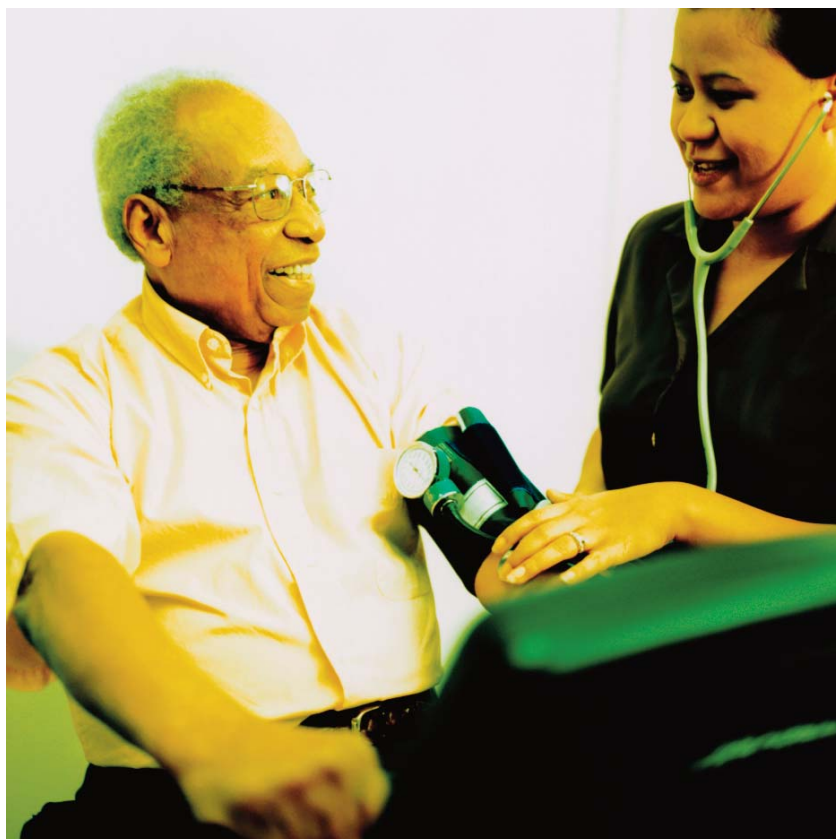
⁶ Generally, when a service is rendered by a provider who has opted out of Medicare, and is not in your Medicaid Health Plan network, the service will not be covered by Medicare or your Medicaid Health Plan.

⁷ Medicare Advantage is a Medicare Health Plan which includes benefits covered under Medicare Parts A and B, and may include Medicare Part D and additional benefits.

⁸ Creditable drug coverage is coverage from an employer or union plan in place of Medicare Part D.

⁹ Exceptions: benzodiazepines, barbiturates, smoking cessation drugs, and certain vitamins are not covered by Medicare Part D but are covered by your Medicaid Health Plan. Co-pays do not apply.

IF SERVICE IS	THEN	PROVIDER GUIDANCE
For nursing facility care, including short-term in-patient rehabilitation settings	Medicare and Medicaid cover some days in a nursing facility. For more information, contact SHIP at 1-800-792-8820 (TTY 711), Medicare at 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048) or your Medicaid Health Plan member services department.	Contact the State Health Insurance Assistance Program (SHIP) at 1-800-792-8820 (TTY 711), Medicare at 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048) or your Medicaid Health Plan member services department for guidance.



WHEN YOU HAVE OTHER HEALTH INSURANCE AND MEDICAID

CHOOSING PROVIDERS

You should always choose providers in your other health insurance provider network for services covered by your other health insurance. You may continue to see your other health insurance provider, even when those providers are not in your Medicaid Health Plan provider network. When possible, if you are choosing new providers, you may want to choose providers that are in your other health insurance provider network and also in your Medicaid Health Plan provider network. **GENERALLY, WHEN YOU CHOOSE PROVIDERS IN BOTH NETWORKS FOR MEDICAID HEALTH PLAN COVERED SERVICES, YOU CANNOT BE BILLED.**

Under limited circumstances, you may be responsible for a portion of the payment. See pages 10-11 for details and billing examples.

There are some services which are covered by your Medicaid Health Plan, but may not be covered by your other health insurance. For example, private duty nursing, personal care assistance and incontinence supplies are covered by your Medicaid Health Plan, but may not be covered by your other health insurance. **WHEN YOU USE MEDICAID HEALTH PLAN PROVIDERS FOR THESE SERVICES/SUPPLIES, YOU CANNOT BE BILLED FOR THE BALANCE.**

HEALTH INSURANCE CARDS

When you enroll in a Medicaid Health Plan, you will receive a Medicaid Health Plan identification (ID) card. All Medicaid Health Plan ID cards will list a Medicaid Health Plan primary care provider (PCP). **YOU SHOULD CONTINUE TO SEE YOUR OTHER HEALTH INSURANCE PCP, REGARDLESS OF THE INFORMATION ON THE MEDICAID HEALTH PLAN ID CARD, EVEN WHEN THE OTHER HEALTH INSURANCE PCP DOES NOT PARTICIPATE WITH THE MEDICAID HEALTH PLAN.** You are only required to see your Medicaid Health Plan PCP when the needed service is not covered by your other health insurance, but is covered by your Medicaid Health Plan.

If you have other health insurance and Medicaid, we recommend you show all health insurance cards anytime you visit a doctor, hospital, pharmacy, lab or other service provider. However, if you have other health insurance and Medicaid, **AND YOU CHOOSE NOT TO SHOW A PROVIDER YOUR MEDICAID HEALTH PLAN ID CARD, YOU MAY BE HELD RESPONSIBLE FOR ANY APPLICABLE CO-INSURANCE PAYMENTS FOR THE SERVICE RENDERED.** By showing both cards, you should not be responsible for any payments; however under limited circumstances, you may be responsible for a portion of the payment. See pages 10-11 for details and billing examples.

BALANCE BILLING

Providers who are in your other health insurance provider network and your Medicaid Health Plan provider network are prohibited from billing individuals for the balance of a bill for Medicaid Health Plan covered services. In order to prevent being billed for Medicaid Health Plan covered services, providers in your other health insurance network who are not in your Medicaid Health Plan network must be informed of your Medicaid status. Individuals on Medicaid are protected from being billed for the balance due on a medical claim for medically necessary, covered services. If a provider does not know you have Medicaid, they may send you a bill to pay the balance of the claim in error. Therefore, always present your **Other Health Insurance, Medicaid Health Plan, and plastic Medicaid HBID cards** when you check in for a medical visit. The medical office, hospital or pharmacy will need to know all of the health insurance coverage you have to know how to submit the claim for payment.

After a other health insurance provider bills your other health insurance and receives payment, they will submit a claim for the unpaid balance to your Medicaid Health Plan. In the past, if the provider was not also a Medicaid provider, they may have been unable to bill Medicaid because they were not set up in the Medicaid FFS claims system. **The Medicaid Health Plan can process claims of providers who are not in their provider network.**

At the same time, Medicaid Health Plans cannot exceed the maximum reimbursement that the Medicaid Health Plan would have covered if it had been the primary payer.



Children under agreement with the Department of Children and Families/Division of Youth and Family Services (DCF/DYFS) who have other health insurance and Medicaid do not pay any co-insurance.

Here are examples of how a provider should handle the balance on a medical bill when you have other health insurance and Medicaid:

For an office visit:

If the charge for a service is \$80.00 and the other health insurance payment is \$64.00 (80% of the charge), your Medicaid Health Plan will pay the 20% co-insurance or the difference between the other health insurance reimbursement and the Medicaid Health Plan rate, whichever is less. In this example, let's say the Medicaid Health Plan rate for the service is \$70.00. In that case, the Medicaid Health Plan would pay \$6.00 toward the bill (The difference between the \$70.00 Medicaid Health Plan rate and the amount your other health insurance paid \$64.00 = \$6.00). **Generally, if the provider is in your other health insurance network AND your Medicaid Health Plan network, you are not responsible for any additional payment. If the provider is in your other health insurance network, but NOT your Medicaid Health Plan network, you may be responsible for a portion of payment.** If the Medicaid Health Plan rate is lower than the other health insurance 80% payment, no payment is made to the other health insurance provider. **If the provider is in your other health insurance network AND your Medicaid Health Plan network, you are not responsible for any additional payment. If the provider is in your other health insurance network, but NOT your Medicaid Health Plan network, you may be responsible for a portion of payment.**

For a hospital stay:

If the charge for a hospital stay is \$500.00 and the other health insurance payment is \$400.00 (80% of the charge), your Medicaid Health Plan will pay the 20% co-insurance or the difference between the other health insurance reimbursement and the Medicaid Health Plan rate, whichever is less. In this example, let's say the Medicaid Health Plan rate for the hospital stay is \$350.00. In that case, the Medicaid Health Plan would pay \$0.00 toward the bill (The cost of the hospital stay exceeds the Medicaid Health Plan rate). **Generally, if the provider is in your other health insurance network AND your Medicaid Health Plan network, you are not responsible for any additional payment. If the provider is in your other health insurance network, but NOT your Medicaid Health Plan network, you may be responsible for a portion of payment.**

FOR ALL SCENARIOS, MEDICAID HEALTH PLANS WILL FOLLOW THE SAME PAYMENT RULES THAT MEDICAID FFS DID IN DETERMINING THE PAYMENT OF THE CO-INSURANCE AMOUNT.

COVERAGE RESPONSIBILITY

Based on a regulation that has been in effect since January 2006, you **can** be billed for services rendered by a provider if the following criteria exist:¹⁰

1 – You have been paid for the service by a health insurance company or other third party and you have failed or refused to remit to the provider that portion of the third party's payment to which the provider is entitled by law.

You may also be billed for services if the following criteria exist:

1 – Either:

A – The service is not covered by any of your payers; **OR**

B – The service is determined to be medically unnecessary before it is rendered; **OR**

C – The provider does not participate with the Medicaid Health Plan, either generally or for that service;

AND

2 – You are informed in writing before the service is rendered that either A, B or C above exists and you voluntarily agree in writing before the service is rendered to pay for all or part of the provider's charges; **AND**

3 – The service is not an emergency service as defined in State and Federal law; **AND**

4 – The service is not a trauma service as defined by State law; **AND**

5 – The additional protections under Federal and State law¹¹ do not apply; **AND**

6 – The provider has received no program payment from either Medicaid FFS or your Medicaid Health Plan.

Example:

If you have other health insurance and Medicaid and receive medically necessary knee replacement surgery by a provider in your other health insurance provider network, and the service is covered by your other health insurance, your other health insurance will be the primary payer for the surgery and the inpatient hospital stay. Your Medicaid Health Plan will pay the difference for any Medicaid covered services received during the surgery and inpatient hospital stay, provided that the total reimbursement does not exceed the pre-determined Medicaid Health Plan rate for that/those service(s).

¹⁰ Adapted from N.J.A.C. 10:74-8.7

¹¹ 42 U.S.C. § 1396u-2(b)(6), 42 CFR 438.106, N.J.A.C. 11:24-9.1(d)9 and/or 15.2(b)7ii

REFERRALS

WHEN YOUR OTHER HEALTH INSURANCE PCP REFERS YOU TO SEE A OTHER HEALTH INSURANCE SPECIALIST FOR A OTHER HEALTH INSURANCE-ONLY SERVICE OR FOR A OTHER HEALTH INSURANCE AND MEDICAID HEALTH PLAN COVERED SERVICE, YOU DO NOT NEED A REFERRAL FROM YOUR MEDICAID HEALTH PLAN PCP. The same billing standards apply and you can only be billed for services when the service meets the criteria discussed in the sections on Balance Billing (pages 10-11) and Coverage Responsibility (page 12).

However, if you need health services that are not covered by your other health insurance, you may need a referral from your Medicaid Health Plan PCP. These are examples of services that may not be covered by your other health insurance, but are covered by your Medicaid Health Plan: incontinence supplies, private duty nursing, medical day care and personal care assistance services.

Each Medicaid Health Plan has established different guidelines regarding referrals to see specialists within the Medicaid Health Plan network. Please contact your Medicaid Health Plan for more information:

Amerigroup	1-800-600-4441	TTY/TDD 1-800-855-2880
Healthfirst NJ	1-888-464-4365	TTY/TDD 1-800-852-7897
Horizon NJ Health	1-877-765-4325	TTY/TDD 1-800-654-5505
UnitedHealthcare	1-800-941-4647	TTY/TDD 711

REMEMBER:

YOU CAN NEVER BE DENIED MEDICALLY NECESSARY COVERED SERVICES BECAUSE OF ISSUES OR CONFUSION WITH MULTIPLE PAYERS.

If you receive a bill for any services, you should contact your Medicaid Health Plan member services department right away:

Amerigroup	1-800-600-4441	TTY/TDD 1-800-855-2880
Healthfirst NJ	1-888-464-4365	TTY/TDD 1-800-852-7897
Horizon NJ Health	1-877-765-4325	TTY/TDD 1-800-654-5505
UnitedHealthcare	1-800-941-4647	TTY/TDD 711

WHEN YOU HAVE BOTH OTHER HEALTH INSURANCE AND MEDICAID

If you have both Other Health Insurance and Medicaid, you should always choose providers in your other health insurance provider network for other health insurance covered, medically necessary services. If possible, finding providers in both your other health insurance provider network and your Medicaid Health Plan provider network should eliminate any chance of being billed for other health insurance and Medicaid covered services. There are many different types of other health insurance and each type of other health insurance will have different guidelines and types of coverage. Refer to your other health insurance member materials for more information. Generally, when your other health insurance covers a Medicaid Health Plan covered service, your Medicaid Health Plan will also cover the service, provided the service does not exceed the Medicaid Health Plan reimbursement rate for that service. See [Balance Billing](#) on pages 10-11 for more information.

IF SERVICE IS	THEN	PROVIDER GUIDANCE
An approved, other health insurance covered benefit, including referrals from your other health insurance PCP	Other health insurance is the primary payer and Medicaid Health Plan is the secondary payer. A Medicaid Health Plan referral is not required.	Use a provider in your other health insurance provider network. Your Medicaid Health Plan ID card will have a Medicaid Health Plan PCP on it. You should still use your other health insurance PCP for all other health insurance covered services regardless of the Medicaid Health Plan PCP listed on your Medicaid Health Plan ID card.
A medically necessary service which may not be covered by other health insurance but is covered by your Medicaid Health Plan (Examples: incontinence supplies, personal care assistant services, medical day care services, family planning services)	Medicaid Health Plan is the primary payer.	Use a provider in your Medicaid Health Plan provider network.

IF SERVICE IS	THEN	PROVIDER GUIDANCE
Rendered by a provider that is not in your other health insurance provider network and is not in your Medicaid Health Plan provider network and was not authorized by your other health insurance	Member is responsible for payment.	To avoid being responsible for medical bills, be sure to use providers who are in your other health insurance's provider network.
A prescription drug covered by your other health insurance	Other health insurance is primary payer. Medicaid Health Plan is secondary payer and covers the drug co-pay.	Use a other health insurance participating pharmacy to receive prescription drugs.
A prescription drug not covered by your other health insurance, but covered by your Medicaid Health Plan	Medicaid Health Plan is only payer.	Use a pharmacy in your Medicaid Health Plan provider network.
A prescription drug not covered by your other health insurance or your Medicaid Health Plan.	Member is responsible for payment.	N/A
An inpatient stay in a other health insurance provider hospital	Other health insurance is the primary payer. Medicaid Health Plan is the secondary payer.	Use a hospital that is in your other health insurance provider network. If possible, use a hospital that is also in your Medicaid Health Plan provider network
Emergency care received at a hospital emergency department	Other health insurance is the primary payer and Medicaid Health Plan is the secondary payer.	Go to the nearest hospital.
For nursing facility care	Other health insurance and your Medicaid Health Plan may both cover nursing facility care. For more information about payments, contact your other health insurance service representative or your Medicaid Health Plan member services department.	Use a facility that is in your other health insurance and Medicaid Health Plan provider networks.

WHEN YOU HAVE OTHER HEALTH INSURANCE, MEDICARE AND MEDICAID

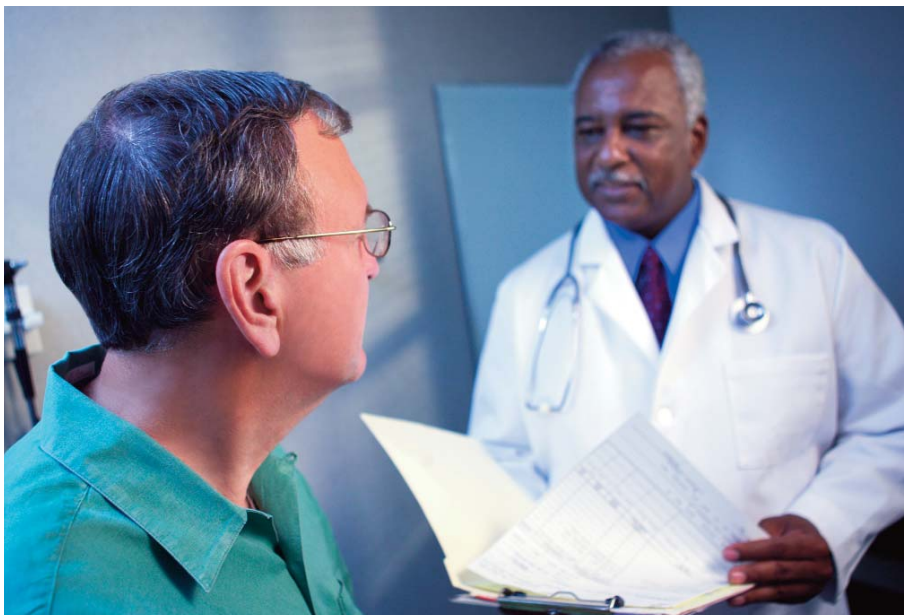
CHOOSING PROVIDERS

When you have other health insurance, Medicare and Medicaid, either your other health insurance or Medicare is the primary payer for most covered services. To determine which health coverage is your primary payer, please use the following resources:

- 1) Call Medicare's State Health Insurance Assistance Program (SHIP) at 1-800-792-8820 (TTY 711)
- 2) Call Medicare at 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048)
- 3) The Medicare Guide to Who Pays First:
<http://www.medicare.gov/Publications/Pubs/pdf/02179.pdf>

You should always choose providers from your primary provider network for services covered by your primary health coverage. When possible, it is recommended that you choose providers that are in your other health insurance provider network that are also Medicare providers. **WHEN YOU CHOOSE PROVIDERS IN BOTH NETWORKS FOR MEDICAID HEALTH PLAN COVERED SERVICES, YOU CANNOT BE BILLED.**

There are some services which are covered by your Medicaid Health Plan, but may not be covered by your other health insurance or Medicare. For example, dental services, personal care assistance services, medical day care and incontinence supplies are covered by your Medicaid Health Plan, but may not be covered by your other health insurance or Medicare. **WHEN YOU USE MEDICAID HEALTH PLAN PROVIDERS FOR THESE SERVICES/SUPPLIES, YOU CANNOT BE BILLED FOR THE BALANCE.**



HEALTH INSURANCE CARDS

When you enroll in a Medicaid Health Plan, you will receive a Medicaid Health Plan identification (ID) card. All Medicaid Health Plan ID cards will include a Medicaid Health Plan primary care provider (PCP). **YOU SHOULD CONTINUE TO SEE YOUR OTHER HEALTH INSURANCE OR MEDICARE PCP, REGARDLESS OF THE INFORMATION ON THE MEDICAID HEALTH PLAN ID CARD.** You are only required to see your Medicaid Health Plan PCP when the needed service is not covered by your other health insurance but is covered by your Medicaid Health Plan.

If you have other health insurance, Medicare and Medicaid, we recommend you show all health insurance cards anytime you visit a doctor, hospital, pharmacy, lab or other service provider. However, if you have other health insurance, Medicare and Medicaid, you can choose if you prefer **NOT TO SHOW A PROVIDER YOUR MEDICAID HEALTH PLAN ID CARD, IN WHICH CASE YOU MAY BE HELD RESPONSIBLE FOR ANY APPLICABLE CO-INSURANCE PAYMENTS FOR THE SERVICE RENDERED.** By showing all cards, you should not be responsible for any payments; however under limited circumstances, you may be responsible for a portion of the payment. See below for details.

BALANCE BILLING

If you have other health insurance, Medicare and Medicaid, the rules that apply to members with Medicare and Medicaid apply to you as well. Members with both Medicare and Medicaid **cannot be billed for services rendered by providers that accept Medicare.** It is recommended that you receive services from providers in your other health insurance network that accept Medicare. For any service which is covered by your other health insurance, your other health insurance is the primary payer, Medicare is the second payer, and your Medicaid Health Plan is the last payer. Contact the Medicare Coordination of Benefits Call Center at 1-800-999-1118 (TTY 1-800-318-8782) to determine if, in your situation, Medicare or the other health insurance is the primary payer.

FOR ALL SCENARIOS, MEDICAID HEALTH PLANS WILL FOLLOW THE SAME PAYMENT RULES THAT MEDICAID FFS DID IN DETERMINING THE PAYMENT OF THE CO-INSURANCE AMOUNT.



COVERAGE RESPONSIBILITY

Based on a regulation that has been in effect since January 2006, you **can** be billed for services rendered by a provider if the following criteria exist:¹²

1 – You have been paid for the service by a health insurance company or other third party and you have failed or refused to remit to the provider that portion of the third party’s payment to which the provider is entitled by law.

You may also be billed for services if the following criteria exist:

1 – Either:

A – The service is not covered by any of your payers; **OR**

B – The service is determined to be medically unnecessary before it is rendered; **OR**

C – The provider does not participate with the Medicaid Health Plan, either generally or for that service;

AND

2 – You are informed in writing before the service is rendered that either A, B or C above exists and you voluntarily agree in writing before the service is rendered to pay for all or part of the provider’s charges; **AND**

3 – The service is not an emergency service as defined in State and Federal law; **AND**

4 – The service is not a trauma service as defined by State law; **AND**

5 – The additional protections under Federal and State law¹³ do not apply; **AND**

6 – The provider has received no program payment from either Medicaid FFS or your Medicaid Health Plan.

¹² Adapted from N.J.A.C. 10:74-8.7

¹³ 42 U.S.C. § 1396u-2(b)(6), 42 CFR 438.106, N.J.A.C. 11:24-9.1(d)9 and/or 15.2(b)7ii

REFERRALS

WHEN YOUR OTHER HEALTH INSURANCE OR MEDICARE PCP REFERS YOU TO SEE A OTHER HEALTH INSURANCE OR MEDICARE SPECIALIST FOR A OTHER HEALTH INSURANCE OR MEDICARE ONLY OR FOR A OTHER HEALTH INSURANCE /MEDICARE AND MEDICAID HEALTH PLAN COVERED SERVICE, YOU DO NOT NEED TO OBTAIN A REFERRAL FROM YOUR MEDICAID HEALTH PLAN PCP. The same billing standards apply and you generally cannot be billed for a other health insurance/Medicare and Medicaid Health Plan covered service, when that service is received from an other health insurance /Medicare provider. Additionally, you can only be billed for services received from a non other health insurance /Medicare and non Medicaid Health Plan provider when the service meets the criteria discussed in the sections on Balance Billing (page 17) and Coverage Responsibility (page 18).

However, if you need health services that are not covered by your other health insurance or by Medicare, you may need a referral from your Medicaid Health Plan PCP. These are examples of services that may not be covered by your other health insurance or Medicare, but are covered by your Medicaid Health Plan: incontinence supplies, private duty nursing, medical day care and personal care assistance services.

Each Medicaid Health Plan has established different guidelines regarding referrals to see specialists in the Medicaid Health Plan network. Please contact your Medicaid Health Plan for more information:

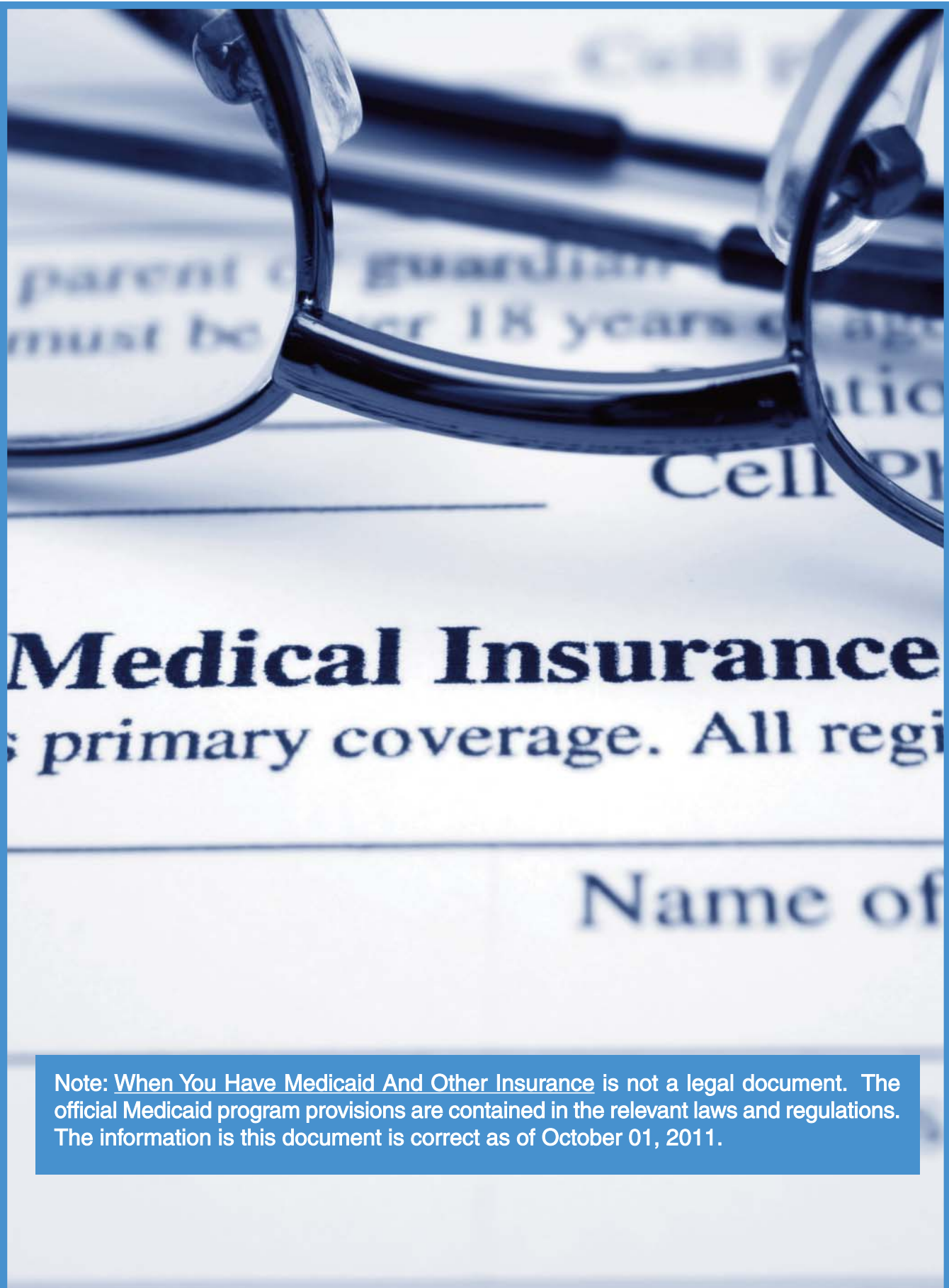
Amerigroup	1-800-600-4441	TTY/TDD 1-800-855-2880
Healthfirst NJ	1-888-464-4365	TTY/TDD 1-800-852-7897
Horizon NJ Health	1-877-765-4325	TTY/TDD 1-800-654-5505
UnitedHealthcare	1-800-941-4647	TTY/TDD 711

REMEMBER:

YOU CAN NEVER BE DENIED MEDICALLY NECESSARY COVERED SERVICES BECAUSE OF ISSUES OR CONFUSION WITH MULTIPLE PAYERS.

If you receive a bill for any services, you should contact your Medicaid Health Plan member services department right away:

Amerigroup	1-800-600-4441	TTY/TDD 1-800-855-2880
Healthfirst NJ	1-888-464-4365	TTY/TDD 1-800-852-7897
Horizon NJ Health	1-877-765-4325	TTY/TDD 1-800-654-5505
UnitedHealthcare	1-800-941-4647	TTY/TDD 711



Note: When You Have Medicaid And Other Insurance is not a legal document. The official Medicaid program provisions are contained in the relevant laws and regulations. The information in this document is correct as of October 01, 2011.