progyny
Smarter Fertility Benefits

QUICK TIPS:

# Progyny COB Process

The Coordination of Benefits (COB) process is triggered when a Progyny patient, who is a claimed dependent, is a subscriber on a non-Progyny eligible plan, in addition to Progyny coverage. Progyny will not create an appointment record until the patient's fertility benefit has been exhausted on their primary plan; this can be done one of two ways, a denial Explanation of Benefits (EOB) or letter from primary insurance stating no coverage for fertility. For more information, please refer to the provider manual.

Patient is the subscriber on a non-Progyny eligible plan and a depended on a Progyny eligible plan.


**Plan 1/PRIMARY**

**Subscriber** on a **non-Progyny** eligible health plan

**Plan 2/SECONDARY**

**Dependent** on a **Progyny** eligible health plan

### 1 Primary Insurance plan is billed first:

***If primary plan covers the full cost of treatment*** the member cannot submit the portion of the treatment that was covered by their primary insurance to Progyny. ***If only a portion of the treatment is covered by the primary insurance plan***, the member will pay their primary insurance's cost share and for all services not covered by their primary plan to the clinic directly. Member can submit the amount which was paid to the clinic, including the cost share and OOP costs, to Progyny for reimbursement – clinic not required to coordinate. The member must provide EOB from the primary insurance and the invoice of charges paid to the clinic in order for the reimbursement to be processed. Reimbursement will be subject to their secondary insurance's deductible and co-insurance and may not be less than what was submitted. Smart Cycle deduction may apply depending on the amount submitted for reimbursement.

### 2 Primary insurance is first payor until benefit is exhausted:

Clinic will submit all claims to primary insurance plan only until benefit is exhausted. Progyny will not authorize services until this has been completed. The member or the clinic should obtain the denial EOB received from primary insurance in response to claims submitted and submit that to Progyny for review. If the denial EOB contains the necessary information to coordinate benefits, then Progyny can become the primary payor for the remainder of that plan year. A letter from the primary insurance plan may also be accepted, given it includes patient demographics, ID, services not covered, etc.

### 3 If the primary insurance denies claims due to provider being out-of-network for the primary insurance, or due to services being denied 100% in full:

Progyny becomes payor when primary insurance has been exhausted: Progyny is not the determining party for whether primary insurance has been exhausted- Progyny submits the denial EOB/letter of no coverage to the Progyny carrier who in turn determines if the necessary information has been received for Progyny to become primary payor. Progyny can retro-authorize services, within timely filing limits, which were 100% denied by the primary insurance.

NOTE: The benefits must be coordinated at the beginning of each plan year if the member has primary insurance and remains as a dependent on a Progyny plan.

NOTE: Provider is responsible for any prior authorization and timely filing rules required by the primary insurence.

Please reach out to the Provider Relations Team, at auths@progyny.com, with any questions.