A black and white photograph of a man and a woman sitting at a desk, looking at a laptop screen. The man is on the left, looking down at the screen. The woman is on the right, looking at the screen with her hand near her chin. A calculator is visible on the desk in the foreground.

A GUIDE TO THE COORDINATION OF BENEFITS

This booklet is designed to help you understand how insurance companies coordinate the payment of a claim when it can be submitted to more than one group health or dental plan. More information – and help – is available from your group benefits administrator and insurance company.

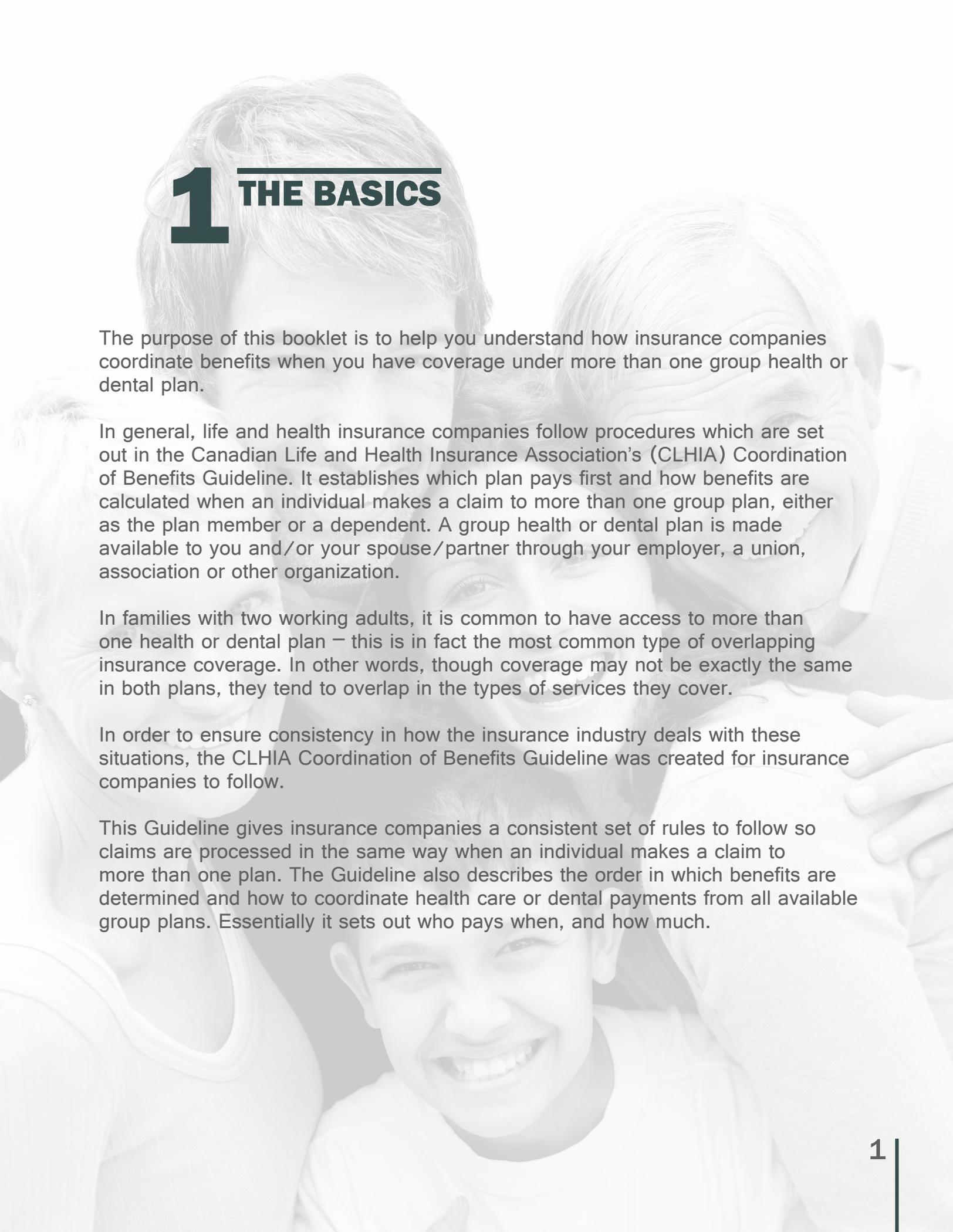
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Caution:

This guide presents a variety of information on the coordination of benefits as simply and accurately as possible, but it is not for legal reference. New legislation and regulations and technological and competitive developments may change some of the rules, conditions and industry practices described. If you have specific questions, check your policy details and contact your group benefits administrator and/or insurance company.



1 THE BASICS

The purpose of this booklet is to help you understand how insurance companies coordinate benefits when you have coverage under more than one group health or dental plan.

In general, life and health insurance companies follow procedures which are set out in the Canadian Life and Health Insurance Association's (CLHIA) Coordination of Benefits Guideline. It establishes which plan pays first and how benefits are calculated when an individual makes a claim to more than one group plan, either as the plan member or a dependent. A group health or dental plan is made available to you and/or your spouse/partner through your employer, a union, association or other organization.

In families with two working adults, it is common to have access to more than one health or dental plan – this is in fact the most common type of overlapping insurance coverage. In other words, though coverage may not be exactly the same in both plans, they tend to overlap in the types of services they cover.

In order to ensure consistency in how the insurance industry deals with these situations, the CLHIA Coordination of Benefits Guideline was created for insurance companies to follow.

This Guideline gives insurance companies a consistent set of rules to follow so claims are processed in the same way when an individual makes a claim to more than one plan. The Guideline also describes the order in which benefits are determined and how to coordinate health care or dental payments from all available group plans. Essentially it sets out who pays when, and how much.

2 WHO PAYS FIRST?

There are a number of rules that set out the order in which claims are to be paid. This section explains that order, taking into account a variety of different circumstances.

If you are covered as a member under a plan, that plan will always pay before a plan that covers you as a dependent. In other words, you must submit the claim to your own plan first.

Example:

If you have coverage with your employer plan and as a dependent with your spouse's employer plan:

- Your employer plan pays your claim first.
- Your spouse's plan pays your claim second.

But if you have the same status under more than one plan, the plan that covered you the longest pays first.

Example:

If you have two plans because of two part-time jobs:

- Job one – member of plan since March 3, 1995
- Job two – member of plan since February 2, 2001

Therefore - The plan with Job one pays first - it has covered you longer.

Claims for Dependent Children

When both parents have plans and their children are covered under both as dependents, the plan of the parent with the earlier birth date in the calendar year pays first.

Example 1:

- Father's birthday – October 11
- Mother's birthday – September 21

Therefore - Mother's plan pays first - Mother's birthdate comes before Father's in the calendar year.

If both parents have the same birth date, the plan paying first is based on the parent's given name that occurs first in the alphabet.

Example 2:

- Mom's given name is Jane
- Dad's given name is Stephen

Therefore - Jane's plan pays first - the name Jane comes first alphabetically.

In cases of **Single Custody** i.e., when one parent has custody of the child(ren), the plan of the parent with whom the child resides, i.e., the plan of the parent with custody, pays first.

The plan of the spouse of the parent with custody pays second.

The plan of the parent **not** having custody pays third.

Example 3:

A child lives with mother and her new spouse.

Therefore - Mother's plan pays first.

Mother's spouse's plan pays second.

Father's plan pays third.

WHO PAYS FIRST?

In cases of **Joint Custody** i.e., when both parents have plans and their children are covered under both as dependents, the plan of the parent with the earlier birth date in the calendar year pays first. (See Example 1 on the previous page.)

Claims for Post-Secondary Students (university/college)

Students may have some form of health or dental coverage through their school or a part-time job. These plans will always pay before any plan where the student is covered as a dependent.

Example:

A student has health coverage through the university plan, but is also still eligible under a parent's plan as a dependent.

Therefore - The school plan pays first.

Retiree Coverage

A retiree plan will always pay second after any group plan that covers the same individual as an active full-time or part-time employee.

Example:

A retired individual has a part-time job with benefits and also has retiree coverage with a previous employer.

Therefore - The plan the individual has with his part-time employer pays first. The retiree plan pays second.

If an individual has retiree coverage with more than one plan, the plan that has been in effect the longest pays first.

Example:

In a case where you may have two retiree plans:

Retiree plan one – member of plan since January 3, 1992

Retiree plan two – member of plan since September 2, 2001

Therefore - Retiree plan one pays first. The more recent retiree plan pays second.

If Both Individual and Group Coverage

If a person has individual coverage (i.e., they have purchased a plan on their own outside of any group coverage), as well as coverage under a group health or dental plan, the group health or dental plan **may** pay first. Please review the provisions in your policy.

3 HOW DO PLANS CALCULATE BENEFITS?

The plan that pays first will calculate benefits as though duplicate coverage does not exist. In other words, it will process the claim as it would any other claim.

The plan that pays second calculates benefits for each individual item on the claim, based on the lowest of:

- The amount that would have been payable had it been the first plan, or
- 100% of the eligible expenses minus the benefits paid by the first plan.

The combined payment from all plans cannot exceed 100% of the eligible medical or dental expenses. In some cases, the combined payment from all plans may be less than what you have paid out of your pocket.

Some plans limit the number of visits per year to a health/dental practitioner (e.g., once per nine months) and some plans have an annual dollar maximum. In these cases, when a plan (first and/or second) pays out any benefit for the visit, it will count as a visit and towards any maximums under both plans.



4 SPECIAL RULES

You should be aware that there are circumstances where this guide does **not** apply such as:

- Auto insurance – provincial legislation determines whether coverage available under automobile insurance is first or second payer to coverage under group health/dental plans.
- Out-of-Country/Province Health Care Expenses – other rules have been developed to coordinate benefits when more than one plan covers these emergencies.
- Workers Compensation

You should check to see what legislation exists in your province of residence if you are making a claim due to an automobile accident or a work-related injury or accident.

5 **USEFUL TERMINOLOGY**

Coinsurance – An arrangement set out in a health or dental insurance plan where the insurance company and the plan member share the expenses according to a specific formula (e.g., 80% covered by the plan and 20% by the member).

Deductible – The amount of the covered expenses that must be paid by the plan member. In other words, the amount that is deducted from the expenses before the claim is paid.

Eligible Expenses – These are costs that will be covered by a health or dental plan as defined in the applicable contract/plan document before payment limitations such as the deductible, coinsurance and applicable maximums are applied.

Health Care Spending Account – An arrangement where the plan sponsor allocates a defined amount of funds to a member's account. These funds can be used to reimburse the cost of health and/or dental claims not otherwise covered under the group benefits plan.

Plan Member – The primary person to whom benefits are provided under the group plan. This is the employee, union member or association member.

Plan Sponsor – This is the employer, union, association or other organization that provides group health or dental benefits to its employees/plan members.

6 QUESTIONS?

If you are having difficulty coordinating benefits with two or more group health or dental plans, the following contacts should be able to assist you with any questions you may have:

- **Your human resources department at work**
- **The insurance company providing your health or dental benefits**
- **Consumer Assistance**

Consumers with questions or complaints about life and health insurance products or services can call the OmbudService for Life and Health Insurance (OLHI) for bilingual information and assistance. The OLHI is an independent service that provides free information and assistance.

Call the OLHI from anywhere in Canada:

In Toronto: **416-777-9002** À Montréal: **514-282-2088**

Toll Free/Sans frais: **1-888-295-8112** Website: **www.olhi.ca**

