Guideline G4
COORDINATION OF BENEFITS-GROUP HEALTH AND DENTAL

This Guideline has been approved by the Board of Directors of the Canadian Life and Health Insurance Association Inc. (CLHIA). Member companies are expected to adopt this CLHIA Guideline having regard to the company's structure, products and business processes, including distribution channels. Member Companies are urged to incorporate this Guideline into the company's ongoing compliance program.

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COORDINATION OF BENEFITS-GROUP HEALTH AND DENTAL

1. INTRODUCTION

The Coordination of Benefits (COB) Guideline was developed to help foster consistency within the industry in situations where a Covered Individual can submit a Group Health or Group Dental claim to more than one plan.

2. PURPOSE

The CLHIA has developed this Guideline for the health and dental benefits industry to help promote consistency in determining the priority in which payments are made and to outline the minimum amount payable by each Group Plan in situations where a Covered Individual can submit a claim to more than one Group Plan. This Guideline describes the order in which benefits are determined and how to coordinate health or dental payments from Group Plans available to the Covered Individual.

The combined payment from all Group Plans for a particular item cannot exceed 100% of the Eligible Medical Expense or Eligible Dental Expense. In some cases, the combined payment from all Group Plans on a particular item may be less than the submitted amount.

3. SCOPE

This Guideline applies to both insured and uninsured plans that provide Group Health and Dental benefits.

This Guideline does not address out-of country/out-of-province/territory coordination of benefits.

In the event of any conflict between the provisions of this Guideline and any applicable law, the law takes precedence over this Guideline to the extent of the conflict.

4. DEFINITIONS

In this Guideline,

"Automobile Insurance Plan" refers to the mandatory automobile insurance coverage that is required for drivers in all provinces. It may be offered through a plan made available by the provincial government, but is not considered a Government Health Plan or Program (as defined below), as it is purchased on an individual basis. Provincial legislation determines whether coverage available under Automobile Insurance Plans is first or second payer to coverage under Group Plans. When automobile insurance is first payer, benefits may be integrated with a Group Plan, if legally permitted. (See "Integration")

"Capitation or Prepaid Plan" is an arrangement in which a treatment provider is paid a flat amount per year, per patient who has elected to use that provider. For that amount, the provider must treat the patient as often as necessary during that year. (See "Coordination of Benefits with Capitation or Prepaid Dental Plans")

"Covered Individual" means the primary Covered Individual under the Group Plan, such as the employee, union member or association member, but does not include a person insured through the primary person.

"Custody Arrangement" for the purpose of this Guideline, means Single Custody or Joint Custody as described below.

> **"Single Custody"** is an arrangement in which only one parent has both physical and legal custody of the child. Physical custody means that the child resides with the parent.
>
> **"Joint Custody"** is an arrangement other than "Single Custody".

"Dependent Child" is as defined in the applicable Group Plan.

"Eligible Expense" is as defined in the applicable contract/plan documents for the Group Plan before payment limitations such as the deductible, coinsurance, lagging fee guides and applicable maximums are applied. Eligible Expenses are calculated separately for each item of expense when more than one item of expense is listed on the submitted claim.

> **"Eligible Medical Expense"** is 100% of the reasonable and customary amount as determined by each insurer or plan administrator.
>
> **"Eligible Dental Expense"** is 100% of the fee listed in the appropriate current provincial general practitioner's or specialist's fee guide, regardless of the fee guide applicable to the plan.
>
> Where no provincial, federal or other industry accepted fee guide exists, the Eligible Dental Expense is 100% of the reasonable and customary amount as determined by each insurer or plan administrator.

"Full-Time Employment" is as defined in the applicable Group Plan.

"Government Health Plan or Program" is a public health plan or program that is legislated, funded or administered by a federal, provincial or territorial government. Coverage available under a Government Health Plan or Program is provided first before coverage available under a private Group Plan, except where legislation, the plan or program provides otherwise. When coverage is available under a Government Health Plan or Program, benefits may be integrated, if legally permitted. (See "Integration")

"Group Plan" is a group health or dental plan or any other similar arrangement that provides a number of persons with health or dental coverage under a single contract between an insurer or third party administrator and a Plan Sponsor, whether on an insured or uninsured basis. This includes a Group Plan administered by an insurer or plan administrator on behalf of an employer, union, association or other entity according to a legal agreement, and any Capitation or Prepaid Plan.

It does not include Individual Plans, School Accident Plans, cost plus plans and Health Care Spending Accounts.

"Health Care Spending Account (HCSA)" is an arrangement where the Plan Sponsor allocates credits to a Covered Individual's account which can be used, at that Covered Individual's discretion, to reimburse the cost of health and/or dental expenses.

Coverage available under all Group Plans will be considered first, before coverage available under a HCSA, unless the HCSA specifies otherwise.

Example

First Payer –	Covered Individual Group Plan coverage
Second Payer –	Dependent coverage under Spouse's Group Plan
Third Payer –	At the Covered Individuals discretion - Either the Covered Individual's HCSA coverage or the dependent coverage under a Spouse's HCSA.

Requests from the Covered Individual to reimburse expenses under the HCSA, instead of the Group Plan, will be considered according to the administrative practices of each insurer or plan administrator.

"Individual Plan" is coverage that is issued on an individual basis. For the purposes of COB, an Individual Plan may be considered second payer to coverage available under a Group Plan according to the Individual Plan provisions.

"Integration" is a method of calculating liability under a Group Plan which is different than coordination. When the Group Plan covered expense amount is reduced by the payment made by a Government Health Plan or Program, this process is commonly referred to as Integration**.**

Example

Claimant purchases a wheelchair costing $8,000.00.

The Government Health Plan or Program allows $5,600.00 towards the cost of the wheelchair.

The Group Plan considers the covered expense amount to be $2,400.00.

The Group Plan deductible and coinsurance are applied to the covered expense amount of $2,400.00.

"Part-time Employment" is as defined in the applicable Group Plan.

"Plan Sponsor" is an employer, union, association or other entity that provides group health or dental benefits to its Covered Individuals.

"Proration" is an equitable method of calculating shared liability between two or more Group Plans, when COB is not possible. Benefits are prorated by calculating the contractual liability under each Group Plan as if no other coverage exists. If the combined total benefit amount available from both Group Plans exceeds the Eligible Expense, each Group Plan pays a proportionate share of the Eligible Expense. Each Group Plan's share is the ratio of the Group Plan's liability if it had been the first payer, to the total amount payable from both Group Plans. (See example of proration on page 9.)

"School Accident Plan" is accident only insurance available to students attending a specific educational facility or institution. Although offered on a group basis, coverage is purchased and funded on an individual basis. Coverage may be optional or mandatory. For the purposes of this Guideline, a School Accident Plan is always second payer to coverage available under a Group Plan.

"Social Assistance Program" is a government program which provides financial support for low income individuals. For the purposes of this Guideline, a Social Assistance Program is always second payer to coverage available under a Group Plan.

"Spouse" is as defined in the applicable Group Plan.

"Student Health or Dental Plan" is comprehensive group health or dental coverage offered to students attending a specific educational facility. When available, a Student Health or Dental Plan is always the first payer for the student, if all other plans cover the student as a dependent.

"Surviving Spouse or Dependent Child" is a person who continues to be eligible for coverage under a Group Plan following the death of the Covered Individual.

"Travel Plan " means a group or individual plan specifically marketed to travelers which covers losses arising during the course of travel, or from the cancellation of travel or travel arrangements. This includes coverage for emergency hospital/medical costs incurred while travelling and coverage such as trip cancellation and baggage loss insurance.

5. ORDER OF BENEFIT DETERMINATION

Where a Covered Individual has more than one Group Plan, this Guideline establishes the priority in which the Group Plans pay benefits.

This section addresses how priority is established in the following situations:

(i) Group Plan does not have a COB provision
(ii) Group Plan includes a COB provision - claims for Covered Individuals
(iii) Group Plan includes a COB provision - claims for Spouses
(iv) Group Plan includes a COB provision - claims for Dependent Children
(v) Group Plan includes a COB provision - Single Custody situations
(vi) Dental Accidents
(vii) All other situations

(i) Group Plan does not have a COB Provision

The Group Plan without a COB provision is considered to be the first payer and therefore pays benefits before a Group Plan which includes a COB provision.

(ii) Group Plan includes a COB Provision - Claims for Covered Individuals

When both Group Plans include a COB provision, priority for payment is established as follows:

First – The Group Plan of the Covered Individual
Second – The Group Plan where the Covered Individual is a dependent

If the Covered Individual has more than one Group Plan, priority for payment is established as follows, regardless of the effective date of the Covered Individual's coverage under each Group Plan:

First – The Group Plan where the Covered Individual is an active full-time employee
Second – The Group Plan where the Covered Individual is an active part-time employee
Third – The Group Plan where the Covered Individual is a retiree

If a Covered Individual has the **same** eligibility status under more than one Group Plan priority for payment is established as follows:

Example 1 - part-time employee under two Group Plans
First – The Group Plan under which the Covered Individual's coverage as a ***part-time employee*** has been in effect the longest
Second – The other Group Plan

Example 2 - retiree under two Group Plans
First – The Group Plan under which the Covered Individual's coverage as a ***retiree*** has been in effect the longest
Second – The other Group Plan

A Student Health or Dental Plan, where the student is considered to be the Covered Individual, will be the first payer to a Group Plan where the student is eligible as a dependent.

Example 1
Group Plan A – student has health or dental coverage through educational institution
Group Plan B – student has coverage as a dependent under parent's plan
Group Plan A is the first payer.

Example 2
When a Dependent Child is employed on a part-time basis and eligible for coverage as a Covered Individual, the Group Plan which covers the Dependent Child as a Covered Individual will be the first payer to a Group Plan where the Dependent Child is covered as a dependent.

Group Plan A – Dependent Child has own coverage as a part-time employee
Group Plan B – Dependent Child has coverage as an eligible dependent under parent's plan
Group Plan A is the first payer.

(iii) <u>Group Plan includes a COB Provision - Claims for a Spouse</u>

When both Group Plans include a COB provision, priority for payment is established as follows:

First **–**	The Group Plan of the Covered Individual
Second **–**	The Group Plan where the Covered Individual is a dependent

If a person has coverage as a Spouse or Surviving Spouse under more than one Group Plan, priority for payment is established as follows:

First **–**	The Group Plan under which the Covered Individuals coverage took effect most recently
Second **–**	The other Group Plan

Example 1

Surviving Spouse becomes covered as common-law spouse -
Group Plan A - Surviving Spouse coverage effective May 1, 2009
Group Plan B- common-law spouse coverage effective January 1, 2012
Group Plan B is the first payer.

Example 2
Ex-spouse remarries and becomes legal spouse -
Group Plan A – ex-spouse coverage effective May 1, 2008
Group Plan B - legal spouse coverage effective January 1, 2012
Group Plan B is the first payer.

(iv) Group Plan includes a COB Provision - Claims for Dependent Children

This includes all Joint Custody arrangements and Surviving Dependent Child claims. For details on Single Custody situations, please see Section (v).

Priority for payment is established as follows:

1. The Group Plan of the parent with the earlier birthdate (month/day) in the calendar year,
2. The Group Plan of the parent with the later birthdate (month/day) in the calendar year,
3. If the parents have the same birthdate, the alphabetical order of the parents' first names.

Where coverage is available for a Dependent Child under a survivor benefit arrangement, the order of payment for the Group Plans which were in effect prior to the parent's death will remain unchanged, unless additional parental coverage becomes effective. If additional parental coverage becomes effective, the survivor plan becomes last payer.

Example

Group Plan A provides survivor benefits. Deceased parent had earlier birthdate in the calendar year.

Group Plan B, which was already in effect, provides coverage to the living parent whose birthdate is later in the calendar year than that of the deceased parent.

Group Plan A is the first payer.

(v) Claims for Children - Single Custody Situations

Priority for payment is established as follows:

1. The Group Plan of the parent with custody of the Dependent Child
2. The Group Plan of the Spouse of the parent with custody of the Dependent Child
3. The Group Plan of the parent not having custody of the Dependent Child
4. The Group Plan of the Spouse of the parent in 3, above.

Note: Where the order of payment rules as outlined in sections (iv) and (v) above are detrimental to the effective application of the COB provision, the order may be changed provided a request is made in writing by the Plan Sponsor of the second Group Plan to the second insurer or plan administrator, and the second insurer or plan administrator is in agreement.

Example

A parent who has incurred children's expenses is having difficulty recovering payment from the parent whose Group Plan is the first payer. Provided that the Plan Sponsor and insurer or plan administrator of the parent who incurred the expenses are in agreement, the order of payment may be changed.

(vi) Dental Accidents

Priority for payment is established as follows:

1. Group Health plans with dental accident coverage
2. Group Dental plans

If dental accident coverage is available under a Group Plan that provides health coverage, expenses are considered first under the Group Plan that provides health coverage before any payment is considered under any Group Plan that provides dental coverage. When coverage is available under more than one Group Plan that provides health coverage, priority for payment between these Group Plans will be established in the usual manner.

Example

1. Covered Individual's Group Plan that provides health coverage including dental accident coverage
2. Spouse's Group Plan that provides health coverage including dental accident coverage
3. Covered Individual's Group Plan that provides dental coverage
4. Spouse's Group Plan that provides dental coverage

(vii) Other Situations

Proration of Benefits - If priority cannot be established in the manner outlined above, the payment of benefits will be shared amongst the Group Plans in proportion to the amount that would have been payable under each Group Plan had it been the first payer.

Example

Eligible Expense is $70.00

Group Plan A (90% coinsurance) - liability if first payer = $63.00
Group Plan B (80% coinsurance) - liability if first payer = $56.00

Note: When determining "liability if first payer," in addition to coinsurance, any other payment limitations such as deductibles and internal limits must also be taken into account.

Determining what percentage each Group Plan should allow:

- Determine the total amount available from both Group Plans by adding the first payer liability amounts: $63.00 + $56.00 = $119.00
- Group Plan A's usual benefit is **52.9%** of the total amount available (Dividing $63 by $119 = 0.529 or 52.9%)
- Group Plan B's usual benefit is **47.1%** of the total amount available (Dividing $56 by $119 = 0.471 or 47.1%)

With proration

Group Plan A pays **52.9%** of the $70.00 expense, or **$37.03**
Group Plan B pays **47.1%** of the $70.00 expense, or **$32.97**

Note - The total paid from both Group Plans does not exceed the Eligible Expense of $70.00.

6. HOW ARE BENEFITS CALCULATED?

The Group Plan that determines benefits first will calculate its benefits as though duplicate coverage does not exist.

The Group Plan that determines benefits second limits its benefits for each individual item of expense listed on the claim, to the lesser of

1. The amount that would have been payable had it been the Group Plan that determines benefits first, or
2. 100% of the Eligible Expense reduced by all other benefits payable by the Group Plan that determines benefits first for the same expense.

The combined payment from all Group Plans for a particular item cannot exceed 100% of the Eligible Medical or Dental Expense.

In some cases the combined payment from all Group Plans on a particular item may be less than the actual expense incurred.

Where a visit or expense is paid in part by a Group Plan, the visit will count as one visit, or the expense will accumulate towards any cumulative maximums applicable to that expense.

Where the Eligible Expense for a submitted claim is paid in full by the Group Plan that determines benefits first, submission to the Group Plan that determines benefits second is not required unless the Covered Individual wishes to count that expense towards any applicable deductibles or maximums.

7. ADMINISTRATIVE PROCEDURES

Covered Individual's Responsibility

It is the Covered Individual's responsibility to retain a copy of the original claim form and receipts to apply for the COB provision, if claims are submitted by paper.

For electronic claim submissions, it is the responsibility of the Covered Individual to identify to the provider all available Group Plan coverage for the purpose of COB.

First Group Plan's Responsibility

The first Group Plan to determine benefits will provide the Covered Individual with a complete Explanation of Benefits (EOB) with service details, charges and amounts paid. The EOB may be provided in paper format or electronically.

Second Group Plan's Claim Submission Requirements

Electronic Claims Submission to the Second Group Plan - If the first payment was made electronically and if the second Group Plan to determine benefits has the ability to process coordination of benefits on an electronic basis, the second Group Plan will require electronic submission of complete details of the claim submitted to the Group Plan that determines benefits first including service details, charges and amounts paid.

In all other situations, the second Group Plan to determine benefits will require a paper EOB.

Paper Claims Submission to the Second Plan - The Group Plan to determine benefits second will require a completed claim form and a copy of the EOB produced by the Group Plan that determines benefits first, along with copies of any applicable receipts. Photocopies are acceptable to the Group Plan that determines benefits second.

Adjustment Provision

It is at the discretion of each insurer or plan administrator to adjust payments which are made in error by the Group Plan that determines benefits first. This situation may occur if the Covered Individual fails to disclose the coverage available under all Group Plans.

It is at the discretion of each insurer or plan administrator to adjust the payment of a previously assessed COB claim when requested to do so by the Covered Individual or by the Plan Sponsor on behalf of the Covered Individual.

8. COORDINATION OF BENEFITS WITH CAPITATION OR PREPAID DENTAL PLANS

The coordination of benefits between Capitation Plans and fee-for-service Group Plans with dental coverage shall be determined in the same manner as between fee–for-service plans.

The order of benefit determination (OBD) rules outlined in this Guideline apply. If a person with dual coverage is insured under a Capitation Plan and is treated by a dentist who is the Covered Individual under that plan, priority is established by following the OBD rules.

When one of the dental plans is a Capitation or Prepaid dental Plan, all persons must be treated in a participating dental office in order to be entitled to COB. If the person is treated in a non-participating dental office, there will be no COB with the Capitation Plan since the Capitation Plan would not reimburse the fee-for-service provider or the Covered Individual for any expense incurred. This is considered a fundamental principle of Capitation Plans.

Capitation companies audit the dental services provided by their practitioners and they consider the COB payment as part of the dentist's payment when the capitation fee is established.

When the Capitation Plan determines benefits first, the dentist may collect the co-payment from the Group Plan that determines benefits second by assignment or directly from the patient.

When the Capitation Plan determines benefits second, the dentist should receive payments from the Group Plan that determines benefits first, but the dentist must waive the patient's capitation plan co-payment. If the Group Plan that determines benefits first pays less than the Capitation Plan's co-payment, the patient will be required to pay the difference.