Guideline G17
COORDINATION OF BENEFITS FOR OUT-OF-COUNTRY/OUT–OF-PROVINCE/TERRITORY MEDICAL EXPENSES

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.

Guideline G17
OUT-OF-COUNTRY/OUT–OF-PROVINCE/TERRITORY COORDINATION OF BENEFITS

1. INTRODUCTION

Many Canadians have more than one plan providing coverage for out-of-country/out-of-province/territory medical expenses. For example, an individual may have coverage through a group plan, individual travel health plan and a credit card.

While benefit plans may include provisions indicating that they will be last payer after claim payment has been made under all other plans, often it is not readily apparent which plan should pay first. This Guideline describes the coordination of payments from plans under which an individual is covered for out-of-country/out-of province/ territory medical expenses and helps ensure that the total payments from such plans do not exceed the total expenses incurred.

There are two components to an out-of-country claim:

1) Emergency Assistance: The insurer or plan administrator who is contacted first will generally initiate the case management in the event of a medical emergency.
2) Claim Payment: Coverage varies from plan to plan. Covered Individuals should check with their insurer or plan administrator before starting their trip. Regardless of which insurer is first contacted at the time of loss, this Guideline will assist in identifying what if any liability exists under a plan to pay all or a portion of the expenses claimed.

It is in the interest of both travelers and insurers to be as clear as possible about how benefits are paid so that claims can be processed quickly and efficiently.

2. PURPOSE

This Guideline describes how to coordinate the payments from all plans under which an individual is covered, and help ensure that the total payments from all plans do not exceed the total expenses incurred.

The intent is to provide for effective claims management; minimize claims assessment and payment delays; provide assistance to the Covered Individual in resolving the claim; fairly coordinate benefits among all plans involved; and identify and discourage duplicate or fraudulent claim submissions.

3. SCOPE

This Guideline applies to insured and uninsured medical coverage in Out-of-Country/Out-of-province/territory medical plans and travel plans for both insured and uninsured plans.

Medical coverage includes but is not limited to expenses in excess of the GHIP resulting from health care provided outside Canada or outside the province or territory of residence. It may also include:

- medical/surgical procedures;
- physicians' services;
- confinement and hospital charges;
- repatriation costs, including air ambulance and medical attendants; and
- prescription drugs, paramedical services, etc.

If trip cancellation or trip interruption is covered under more than one plan, the Guideline will apply.

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

4. DEFINITIONS

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

"Credit Card Coverage" means emergency Out-of-Country benefits available to cardholders for a limited time period under specific credit cards. This includes but is not limited to trip cancellation, interruption, and baggage loss.

"Excess Coverage Provision" means a stipulation in a plan that it will only provide coverage for an amount that is in excess of the coverage provided by a Primary Plan.

"First Carrier" means the insurer or plan administrator that is first contacted in the event of a claim. An insurer or plan administrator acting as First Carrier may or may not provide Primary Plan coverage.

"GHIP" (Government Health Insurance Plan) means a public health plan or program that is legislated, funded or administered by a federal, provincial or territorial government.

"GHIP Reimbursement Schedule" means the government reimbursement schedule of benefit allowances utilized in the estimation of Out-of-Country/Out-of-Province/Territory medical service fees eligible for coverage. Insurers and plan administrators may coordinate benefits according to the schedule in effect on the date of service.

"Group Plan" means a group health plan or any other similar arrangement that provides a number of persons with coverage for losses related to travel 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 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.
"Individual Plan" is insurance that is purchased on an individual basis, covering only one person, or in some cases, members of his or her family as well.

"Other Carrier(s)" means any insurer(s) and plan administrator(s), other than the First Carrier, that provides coverage for the same covered individual.

"Out-of-Country/Out-of-Province/Territory Medical Plan" means a plan that covers medical expenses, whether on an insured or uninsured basis, while a person is away from their province or territory of residence. Coverage may be restricted to emergency medical expenses only or may include broader coverage for elective or non-emergency expenses, i.e., medical expenses not resulting from an emergency.

"Primary Plan" means the plan that provides coverage first before any other plan. See "Secondary Plan" below.

"Secondary Plan" means a plan that only provides coverage for any outstanding balance on a claim after the Primary Plan or Plans have paid eligible expenses. In order to be considered a Secondary Plan, the coverage must include a provision which stipulates it is 'excess to all others.' If the Primary Plan or Plans have sufficient limits to cover the loss, the Secondary Plan or Plans will not provide coverage.

"Travel Plan" means group or individual coverage specifically marketed to travellers 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 traveling and coverage for trip cancellation.

"Unit of Co-ordination" means a portion of the loss that is assigned to a plan or plans.

5. DETERMINATION OF UNITS OF COORDINATION

For the purposes of this Guideline and subject to the exception noted below, a Unit of Coordination will be established for each plan.

The exception is when an individual is a Covered Individual or a dependent under more than one Group Plan. In this case, all such Group Plan coverages will be

combined and considered a single Unit of Coordination. Guideline G17 is used to determine the amount of coverage determined by the unit. Guideline G4 is used to determine the priority of payment between Group Plans that contribute to the unit.

6. FIRST CARRIER

Identification of First Carrier

The First Carrier is the insurer or plan administrator that is first contacted in the event of a claim. An insurer or plan administrator acting as First Carrier may or may not provide Primary Plan coverage.

An insurer or plan administrator is expected to make a good faith effort to accept and begin acting on a claim as a First Carrier. However, if the First Carrier determines that its claim assistance services, coverage(s) or benefits are not adequate to respond to the particular situation, it may negotiate with the Other Carriers as to which Other Carrier should assume responsibility for the case management and payment of claims. This would be particularly appropriate if the insurer or plan administrator recognizes that its liability under its plan for the claim is limited (for example, if the First Carrier's potential liability will be $10,000 and the claim is expected to be $50,000 or more).

If the insurer first contacted determines it has no liability for the claim (for example, if a pre-existing condition has been clearly established), or it can clearly identify the Primary Plan, its responsibilities as First Carrier cease once it informs the Covered Individual and instructs him or her to contact the Other Carrier(s), if any, to pursue the claim. To speed up the adjudication process, the First Carrier should still provide notification to any Other Carrier(s) known at that time.

In general, even if the insurer or plan administrator first contacted has an Excess Coverage Provision in its contract making it a Secondary Plan, it will act as the First Carrier.

Responsibilities of the First Carrier

The First Carrier will:

- Handle the case management. This includes, but is not limited to taking the initiative to involve an assistance group or service provider, choosing a preferred provider organization, monitoring medical care and/or repatriation.
- Notify the Other Carriers (see Initial Notification of Other Carrier(s) section for details).
- Pay the claim with an amount that is equal to the coverage determined by the terms and conditions of its contract. In paying this amount, the First Carrier reserves all rights to reimbursement from the Other Carriers and from

GHIP. The First Carrier is never expected to pay more than the liability under its contract (see Payment Process section for details).
- Forward claims documents to the Other Carriers.
- Receive assessments from the Other Carriers Based on these assessments; allocate liability (see Section 8) amongst itself and the Other Carriers.
- As applicable, recover amounts owing from Other Carriers and GHIP.

In carrying out these responsibilities, the First Carrier should make reasonable efforts to make the claims process transparent to the Covered Individual so the individual is aware that the plans will coordinate payment of the claim.

Initial Notification of Other Carrier(s)

Notification by the Covered Individual to the First Carrier is deemed notification to all Other Carriers that are known and identified at the time and will serve as notification to Other Carriers.

Where additional insurers or plan administrators are identified at a later date, the process of initial notification described immediately below is repeated for those insurers or plan administrators.

The First Carrier should:

- Establish as quickly as possible whether Other Carrier(s) exist.
- Notify Other Carrier(s) as their prompt notification is critical to the coordination of benefits.
- Provide notification for all in-patient hospitalization claims immediately. For all other claims, notification should be as soon as possible.

Personal information held by one insurer or plan administrator cannot be disclosed to another insurer or plan administrator without the consent of the Covered Individual. The First Carrier should seek such consent on its claim form or other initial contact.

Consultations/Second Opinions

In assessing complex claims, and with express consent, the First Carrier may contact the Other Carrier(s) sharing in the claim liability.

Upon receipt of notification, the Other Carrier(s) may offer to provide consultation on case management to the First Carrier.

Consultation may include, but is not to be limited to, the involvement of an assistance group or service provider, the choice of a preferred provider organization, monitoring medical care and/or repatriation. Ultimate decisions for the case management remain the responsibility of the First Carrier.

7. PAYMENT PROCESS

Generally, the First Carrier will pay to the Covered Individual or service providers up to its usual liability as if no other coverage exists. While insurers and plan administrators are only responsible for providing coverage of claims net of GHIP coverage, to expedite the payment process the First Carrier may reimburse the GHIP portion upfront and then seek reimbursement from the GHIP.

The First Carrier will advise the Other Carriers of the amount of their liability and each of the Other Carriers will make payment for the amount owing under their plan to the appropriate party.

Payment by Other Carriers may be made to the First Carrier where the First Carrier has paid the full claim and this amount is greater than its share.

8. DETERMINING THE AMOUNT PAYABLE

The following is a description of the process for determining the amount payable when a Covered Individual has Out-of-Country/Out-of-Province/Territory coverage under more than one plan. The process described below applies regardless of which insurer or plan administrator is First Carrier and pays the claim.

Process

The First Carrier will:

1) Calculate its liability for the claim as if no other coverage exists. Issue payment to the Covered Individual or to service providers if benefits are assigned. If the Covered Individual has already been reimbursed by GHIP, the payment amount will be net of the GHIP payment.
2) Send copies of the claim documents and details of the payments made to each of the Other Carrier(s) involved. These documents should include:
   - Claim form or relevant documentation, with the privacy authorization included or as a separate document
   - Copy of the original bills (Electronic-bills are acceptable)
   - Explanation of Benefits (EOB), or Proof of Payment
   - Proof of GHIP recovered amount, or estimate of the GHIP amount payable according to the GHIP Reimbursement Schedule.

Specific Considerations

In general, where there is more than one Primary Plan, each of the Primary Plans will pay an equal share of eligible expenses, subject to deductibles or limitations.

Similarly, where there is more than one Secondary Plan, each of the Secondary Plans will pay an equal share of excess eligible expenses not covered by the Primary Plans, subject to deductibles or limitations.

Where a portion of the claim is not covered by any of the Primary or Secondary Plans due to exclusions or limitations, the Covered Individual is responsible for this amount.

Exceptions for Group Plan Retirees

This exception relates to extended health coverage for retirees. Where a group retiree plan has a lifetime limit of $50,000 or less, this group retiree plan will always be secondary to other plan coverage without a lifetime limit, to avoid eroding this benefit.

Where the group retiree plan provides for a lifetime limit in excess of $50,000, coordination of benefits will only be done for amounts of the lifetime limit remaining that are in excess of $50,000. If the Covered Individual is deceased, this limit no longer needs preserving, unless it extends to a survivor. Therefore, full coordination will apply to the entire retiree coverage.

If the claimant has already used up all other coverage sources, the group retiree coverage will be responsible for any remaining expenses covered under the retiree plan.

9. FIRST CARRIER RECOVERY FROM GHIP

If the First Carrier is recovering the GHIP amount on behalf of the Covered Individual, the payment amount may include an estimate of the GHIP recovery amount.

In the interest of efficiency, if the actual amount paid by a GHIP is different from the amount estimated in the GHIP Reimbursement Schedule, the First Carrier will not adjust the allocation in the coordination of benefits to make up this difference.

10. ADJUSTMENTS

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

11. ORIGINAL CLAIM DOCUMENTS

In most situations, The First Carrier will retain the original or imaged documents, and provide proof of payment (example, EOB).