



# **ADMINISTRATION MANUAL**

**Extended Health Care and Dental Benefits**

***TABLE OF CONTENT***

**INTRODUCTION.....3**

**WHO TO CONTACT .....3**

**CLAIMSECURE RESPONSIBILITIES.....3**

**ADMINISTRATION GUIDELINES.....4**

Enrolling a New Member to Your Group Plan..... 4

Reporting of Additions, Changes & Terminations..... 4

Waiving the Waiting Period..... 4

Reinstatements..... 4

**GENERAL INFORMATION.....5**

Date of Employment..... 5

Discrepancies..... 5

ClaimSecure Cards..... 5

**SCHEDULE OF BENEFITS.....6**

Extended Health..... 6

Dental..... 7

**OVERALL INFORMATION .....8**

Overage Students..... 8

CO-Ordination of Benefits ..... 8

Claims Procedures..... 9

**INVOICE PAYMENT OPTIONS.....10**

## INTRODUCTION

This administration manual will assist you in the daily administration of your ClaimSecure Benefit Program.

This manual has been developed with variable plan designs in mind. We wish to stress the importance of reviewing the contents of this manual to understand the procedural requirements that will ensure efficient administration of your Employee Benefit Plan.

In the event you require clarification on any item contained in this manual, please contact your Client Services Representative.

## WHO TO CONTACT

There are a number of individuals involved in the design and maintenance of your Employee Benefit Program. As such, you will be provided with a dedicated Client Service representative who will be ultimately responsible for your group. You will also be provided with a toll-free number to call for day-to-day administrative and claims information.

## CLAIMSECURE RESPONSIBILITIES

ClaimSecure's responsibilities **may** include the following, depending upon the options chosen in your contract.

- Coordinate the administration function as perceived by the broker/consultant and Insurer(s) based on the needs of the client.
- Assist the client with the initial enrollment.
- Provide claims assistance for all insured employees.
- When Claims Management has been selected, receive and verify all claims on the employer's behalf and forward them to the appropriate Insurer for payment.
- Provide annual statistical data for calculation of renewal information.
- Provide ongoing servicing which includes a dedicated Client Services Associate, a toll-free line for day-to-day administrative inquiries.
- Process drug, vision, hospital, major medical and dental claims as directed by the client.

## ADMINISTRATION GUIDELINES

### Enrolling a New Member to Your Group Plan

In order to be eligible for insured benefits under your Group Plan, a new member must meet the following requirements: Note: **For ASO benefits you may choose to use the following requirements, or design your own.**

- Must be a full-time active member. Permanent part-time employees/members are rarely permitted coverage unless there has been a contractual agreement made with your Insurer(s).
- Must be in a classification of employees eligible for coverage under your group master policy with your Insurer(s).

### Reporting of Additions, Changes & Terminations

**For ASO benefits you may choose to use the following requirements, or design your own.**

- a) Additions, changes and terminations can be keyed in by the employer, if Internet access has been selected, or can be reported to ClaimSecure and will be updated within 24 hours. A schedule of production dates has been included with your ClaimSecure package and this list will be updated on an annual basis.
- b) To remain consistent with Insurance industry procedures, transactions of any nature **MAY NOT** be processed where the effective date is more than 3 months prior to the date the transaction is to be implemented, without prior approval from your Insurer(s) for your benefits. Should a situation of this nature arise, your Insurer(s) must be advised in writing, providing all pertinent information for the Insurer(s) decision.
- c) The only situations where the employee must sign and date enrollment forms is upon initial enrollment or when changing their beneficiary.

### Waiving the Waiting Period

**For ASO benefits you may choose to use the following requirements, or design your own.**

If you hire an Executive or “key employee” and you wish to offer them immediate coverage, a written request must be forwarded to ClaimSecure, within seven (7) days of the employee’s date of hire. The request to waive the waiting period for insured benefits will be decided by the Insurer(s). This is **NOT** an automatic privilege.

### Reinstatements

**For ASO benefits you may choose to use the following requirements, or design your own.**

- a) APPLYING FOR COVERAGE WITHIN THE REINSTATEMENT PERIOD

If a member is terminated from your Group Plan and then returns to work within the specified reinstatement period (refer to your Benefit Plan Document) his/her insurance coverage may be reinstated from the date of re-employment and the usual waiting period is waived.

The member **MUST** return to work with the same benefits they had prior to terminating employment. In the event the member returns in a different classification due to a promotion or requires the addition of health and/or dental benefits since spousal exemption is no longer in effect, the Underwriter of your Group Plan should be advised of same in writing at the time of reinstatement. The member's signature is not required on the enrollment form provided the beneficiary is the same as prior to termination of employment.

- b) **APPLYING FOR COVERAGE AFTER THE REINSTATEMENT PERIOD**  
**For ASO benefits you may choose to use the following requirements, or design your own.**

If the member returns to work after the specified reinstatement period which is reflected on your Benefit Plan Document, the member is treated as a new applicant and the normal waiting period must be satisfied. Such reinstatements are treated as an addition.

## **GENERAL INFORMATION**

### *1. Group and Member Identification Number*

Your group number is the ClaimSecure designated number assigned to your specific Company or Organization. Individual members are identified by their own unique numbers. These numbers are unique to your Group Plan and should be referred to in all correspondence.

### **Date of Employment**

The date of employment is always required when enrolling a new member to your Group Plan.

### **Discrepancies**

Upon receipt of your current month's billing, it is a requirement of your contract with ClaimSecure that you review all transactions (including transactions that were keyed by the Employer over the Internet) which were processed for the billing period. If there are any discrepancies, please make the appropriate corrections.

### **ClaimSecure Cards**

When a member terminates employment, their ClaimSecure identification cards must be retrieved by the employer/association to avoid fraudulent use of the cards. It is always the Policyholder's responsibility to retrieve such material and eliminate possible fraud, the cost of which is charged against your claims experience or billed directly by the Insurer(s).

**Your policy(ies) may contain a pre-existing condition clause or other restrictive clauses which could limit or exclude benefit entitlement. If applicable, such details regarding this clause(s) may be found in your master policy(ies).**

## **SCHEDULE OF BENEFITS**

When enrolling employees/members for benefits in your Group Plan, **ALWAYS REFER TO YOUR CONTRACT** to properly complete your enrollment form.

Your contract identifies Health and Dental benefit information, eligibility, waiting period, changes in classification, and termination provisions, Insurer(s), master policy numbers, and premium rates.

Your contract will provide a breakdown of the division and units applicable to your Group Plan. Please ensure that when enrolling/updating a member, that they are allocated to the correct division/unit according to their employee classification.

### **Extended Health**

#### **A) Pay-Direct Drugs**

No forms are required. The member presents his/her ClaimSecure card to the pharmacist each time a prescription is filled. The member is to pay to the pharmacist the deductible according to your group insurance plan. The pharmacy will then invoice ClaimSecure directly. ClaimSecure will reimburse the pharmacy for the eligible cost of the prescription less the deductible amount.

In the unlikely event that the pharmacy is a non-participating ClaimSecure pharmacy or the member is abroad, the member or dependent must pay for the prescription and attach the original receipt(s) to the ClaimSecure Claims Transmittal Form. This form must be completed in full and forwarded by the member to ClaimSecure. ClaimSecure will reimburse the member directly

#### **B) Reimbursement Drug Plan**

With a reimbursement drug plan, the member must first pay for the prescription in full to the professional providing the service. It is then the responsibility of the individual to submit the claim(s) to ClaimSecure for assessment. Claims should be documented on the transmittal form in order of occurrence. The drug name should be indicated and the original receipts attached.

Payment will be made directly to the employee, after adjustment has been made for the deductible amount and any portion of the claim that is not insured under your group plan.

#### **C) Major Medical**

In instances where services have been provided by a physiotherapist, speech therapist, chiropractor, etc., original receipts are to be submitted along with the completed claim form. A portion of such services may be an allowable expense under the provincial Health Plan, and as such must be initially directed to their attention for consideration. Claims should only be submitted to your Insurer/Claims Processor after the Provincial Health Plan has considered these expenses.

#### **D) Hospital**

When a member has been hospitalized, they must present their ClaimSecure card as proof of coverage. The hospital will complete a standard Hospitalization Claim Form and forward it directly to your Insurer/Claims Processor or your company. The hospital will be reimbursed directly.

However, if a claim form is not completed for any reason, the hospital will invoice the member directly, and he/she must then submit the hospital receipt, along with a completed claim form to ClaimSecure for processing.

**E) Visioncare**

The member must present their ClaimSecure card as proof of coverage. The standard visioncare claim form is completed by the supplier and forwarded to either your Insurer/Claims Processor or your company. Payment will be returned directly to the member or, if benefits are assigned, directly to the supplier.

**For ASO benefits you may choose to use the above requirements, or design your own.**

**Dental**

Where the dentist will accept assignment, the member must present their ClaimSecure Card as proof of coverage.

The assignment portion of the dental claim form should be signed by the member if payment is to be made directly to the dentist. Otherwise, the member is to pay the dentist for the services and submit the claim to the processor for processing.

The top section of the dental claim form is completed and signed by the dentist. The employee section is completed by the member (or dentist) and must be signed by the member.

A predetermination limit is established by the Insurer or Claim Processor to assist the member when contemplating a significant amount of dental work. When the anticipated cost exceeds the predetermination limit, the member should have the dentist complete a predetermination form to be submitted to the Processor. The Insurer or Processor will review the predetermination form and advise the member of all eligible expenses and conversely, any procedures that would not be covered under the plan. Please refer to your master policy to reference the predetermination limit.

**For ASO benefits you may choose to use the above requirements, or design your own.**

## Overall Information

### Overage Students

Over-age students and disabled dependents over the dependent age, indicated in your contract, may apply for coverage by completing the over-age student section of the ClaimSecure enrollment form. It is necessary for all over-age students to re-apply for coverage every year.

### CO-Ordination of Benefits

The Canadian Life and Health Insurance Association (CLHIA) has developed guidelines for insurers to follow in regards to Co-ordination of Benefits. The guidelines were set in order to ensure consistency within the industry and enable a person to submit a claim to more than one group plan. All insurers have agreed to follow the CLHIA Guidelines. The three main rules are as follows:

- 1) If a person is a member of two plans, priority goes to the plan where a member is an active full-time or part-time employee.

If a person is covered under their employer's plan and is also covered under their spouse's employer's plan, the member must submit their claim first to their own employer's plan.

- 2) If a person is a member of two plans, a claim is submitted to the plan where the person is covered as a dependent spouse only after the person has already submitted their claim to a first payor being their employer's plan.

A person covered by two plans can submit their claim to their spouse's plan only if the first payor (being their employer) has not paid the claim in full. The person insured as spouse, can submit the balance owing on the claim to the second payor (the spouse's employer's plan) to cover the portion not paid by their own employer's plan.

- 3) The plan of the parent with earlier birth date (month/day) in the calendar year.

All dependent children's claims are submitted first to the plan of the parent with the earliest birthday in a calendar year. If the claims are not paid in full, then they can be submitted to the other parent's plan to maximize reimbursement.

ClaimSecure has developed software to properly apply Co-ordination of Benefit rules to adjudicate all Extended Health Care and Dental claims.

### **WHAT IS CO-ORDINATION OF BENEFITS?**

This rule of adjudicating family benefits only applies to insured members who have employed spouses that also have an employee benefit plan. Any member whose spouse is not employed, or is employed but does not have access to an employee benefit program would not benefit from Co-ordination of Benefits.

If you and your spouse are both covered by separate health and dental insurance policies, these policies are coordinated with all claims submissions to enable an employee to obtain total maximum reimbursement (up to 100%) on all eligible claimed expenses.

As more plans are introducing co-insurance and higher deductibles, this coordination of benefits will enable the insured individuals to maximize their reimbursements.

## **WHAT IS THE PURPOSE OF CO-ORDINATION OF BENEFITS?**

This practice enables an insured person to submit a claim to more than one group insurance plan. It also identifies duplicate health care coverage and determines who is the primary (1<sup>st</sup>) payor and who is the secondary (2<sup>nd</sup>) payor of all claims.

## **WHAT BENEFIT IS THIS TO THE EMPLOYER?**

First and foremost, it is a cost containment product which will save corporations substantial benefit dollars. COB also allows corporations the opportunity to integrate claims processing between multiple insurers.

By coordinating all claims between several plans, all plans will share a part of the cost significantly. This re-allocation of expenses will ensure no one plan bears the brunt for all of the others.

## **WHAT BENEFIT IS THIS TO THE EMPLOYEE?**

There is no loss to an employee's present coverage. Employees gain knowledge on how to fully utilize duplicate coverage where it exists.

The overall benefit by implementing COB will be a substantial savings in benefit dollars in the future.

By adhering to these rules, the employer will be able to continue sponsorship of your employee health care program even though other expenses cannot be controlled. Without these COB rules, costs could get so high that an employer would have no choice but to pass on the cost to the employees such as higher coinsurances and deductibles. An employer may even have to cut back on the benefits offered due to exorbitant costs.

By participating in Co-ordination of Benefits, you are helping your employer control costs and this in turn is helping yourself, as this may preserve the benefits you are now enjoying.

## **Claims Procedures**

For on-line real-time benefits, your members have been provided with a ClaimSecure identification card. For those members in a reimbursement only plan, claim forms may be retrieved from our ClaimSecure Web site. **[www.claimsecure.com](http://www.claimsecure.com)**

Members of your Company/Association have a limited period of time as specified in your master policy(ies) to submit outstanding claims to your previous underwriter(s) or claims processors.

Please ensure your employees/members receive written instruction of this fact in the event of a change in underwriter(s).

## Invoice Payment Options

There are two invoice payment options available to all our clients. They are as follows:

### ***Option #1- Electronic Funds Transfer (EFT)***

Drug invoice payments ( issued twice a month) may be deposited to either of the following banks:

Toronto Dominion Bank  
Commercial Banking Centre  
43 Elm Street  
Sudbury, Ontario  
Bank Transit                    37122  
Account Number 0438-0300033

The Royal Bank of Canada  
Main Branch  
72 Durham Street  
Sudbury, Ontario  
Bank Transit                    04982  
Account Number 1007905

The banks will require guaranteed funds prior to accepting the request for transfer. When making payment in this fashion, we request that clients fax payment details to the Accounting Dept. at (705) 673-6286 to ensure proper allocation of payment.

### **Option #2 - Mail or Courier**

Payment may be mailed directly to ClaimSecure Ltd. at the following address:

ClaimSecure Inc.  
P.O. Box 6500, Station "A"  
Sudbury, Ontario  
P3A 5N5

OR

ClaimSecure Inc.  
43 Elm Street, Suite 200  
Sudbury, Ontario  
P3C 1S4