MDM INSURANCE SERVICES INC.

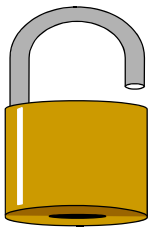
THE GUARDIAN

BENEFIT NEWS & VIEWS MAY 2002

Welcome to the 4th edition of The Guardian. This newsletter is designed to inform you of current topics and trends relevant to your employee benefit plan. The newsletter contains sections for both claims and administration issues. Please share this newsletter with others in your company (owner, benefits administrator, human resources managers, etc.).

The Protection of Personal Information

What does it mean to insurers?



Comprehensive federal legislation to protect personal information throughout the private sector has been in place since January 1, 2001. This legislation, the Personal Information Protection and Electronic Documents Act (PIPEDA), formerly known as Bill C-6 comes into effect for life and health insurers on January 1, 2004. Although this date is nearly two years away, insurers have already begun the huge undertaking of ensuring their businesses comply with the Act.

Personal information is the raw material which life and health insurers use to deliver their products and services. Protection of that information has always been of key importance to insurers as evidenced by the fact that the Canadian Life and Health Insurance Association (CLHIA) has had its own privacy guidelines in place for over twenty years. To a significant degree the principles contained in the PIPEDA legislation are the same as those underlying CLHIA's Right to Privacy Guidelines.

Legislation to protect personal information is also emerging at the provincial level. Quebec has had legislation in place since 1994. The Ontario legislature is expected to table privacy legislation in February of 2002. Insurers and other private sector businesses are hopeful that provincial legislation will mirror federal legislation (PIPEDA).

What information is personal?

Under PIPEDA, all information about an identifiable individual is personal, including name, age, sex, social insurance number, health status, health history, financial information and insurance claims data. This includes information which identifies the individual, and also information which can be matched with other information which could identify an individual.

What does the legislation mean to insurers?

Organizations covered by PIPEDA must obtain an individual's consent when they collect, use or disclose the individual's personal information. The individual has the right to access personal information held by an organization and to challenge its accuracy. Personal information can only be used for the purposes for which it was collected. If an organization is going to use it for another purpose, consent must be obtained again. Individuals must also be assured that their information will be protected by specific safeguards, including measures such as locked cabinets, computer passwords or encryption.

Since personal information is used in the core functions of insurance including claims, administration and underwriting, insurers must ensure processes are in place to properly collect, use, disclose, retain and dispose of personal information. The rules apply to information collected prior to the effective date of the legislation therefore insurers plan to be compliant in advance of January 2004.

What changes will plan sponsors notice as insurers prepare to comply with the legislation?

As we review and change our processes to comply with PIPEDA, you can expect to see:

- A Privacy Statement added to communications such as employee benefit booklets and our website.
- Forms updated to include a more detailed consent from the individual providing personal information.
- Changes in the way we collect personal information related to administration and claims. For example, we are reviewing our process in the circumstances where the plan sponsor verifies eligibility for claims.
- Changes in the way we disclose personal information related to reporting to the plan sponsor or advisor. We will examine all reports and notify our clients and their advisors if there are changes necessary to comply with the federal legislation.
- Regular updates from us about what needs to be done to comply with the legislation. We will keep you informed.

The Privacy Commissioner of Canada has published an information guide for organizations about their responsibilities under the federal legislation (PIPEDA) available on their website at http://www.privcom.gc.ca/.

Claims Issues

Changes to the Ontario Dental Fee Guide

Important changes occurred to the Ontario Dental Association (ODA) Fee Guide January 1, 2002. The changes, which will be phased in over the next five years, will affect your dental plan.

The two significant changes to the ODA Fee Guide are:

< Package codes have been eliminated and have been replaced with individual codes. Package codes were priced according to whether the teeth were baby teeth, permanent or mixed. Depending on how dentists choose to bill for these services, this could have a significant impact on dental claims.

< The method for setting fees has changed. Rather than an across the board increase, each dental procedure will be adjusted separately. There will be significant differences in fees geographically (i.e. higher in Toronto than North Bay). According to the ODA, the new Fee Guide reflects both the cost of dental care and the value that patients place on that care.

Ontario dental plans using a "current" Fee Guide will have claims reimbursed according to the 2002 ODA Fee Guide.

The degree to which the ODA Fee Guide reform will affect Ontario dental plans is not yet known. We will keep you informed of the impact on dental plans.

As always, you have choices. You may wish to consider other plan design features to control claims costs. Please discuss this with your insurance advisor.

Totally Disabled

For consideration of benefits for the purposes of Weekly Indemnity benefits, along with other eligibility requirements, an employee *must be unable to perform the ususal and customary duties of the their occupation.*

The Detailed Job Description (Form #5 of a disability claim application) is an essential component of a claim application for total disability. Although it may seem irrelevant at times based on the diagnosis of the claimant, it is part of the application for disability benefits and must be completed.

In determining whether or not an employee is eligible for disability benefits, we must determine if they are in fact totally disabled as defined by the group policy. This includes being unable to perform the usual and customary duties of their occupation.

Upon review of a claim application, we must know what duties an employee is mentally/physically required to perform during a regular work day. If an employee's job varies from day to day, we must be aware of all potential demands of the job. For example, if an employee is normally required to manipulate weights up to 10 lbs. but could potentially be required to maneuver weights up 30 lbs., we must also be aware of that possibility.

By having a complete knowledge of what an employee is normally required to perform during a routine work day, we can then determine if an employee is in fact totally disabled from their job. This decision includes the examination of all information submitted, medical information provided and our review of other eligibility requirements.

Often the medical information provided will indicate specific restrictions related to diagnosis and symptoms. After review of the Detailed Job Description, it is often determined that the employee could be at work, on modified duties (if available), simply acknowledging the specific restrictions/limitations outlined by the physician.

Having a complete understanding of the requirements to perform a job allows the adjudicator to;

1. Determine if a claimant is disabled from performing the duties of their job.

2. Co-ordinate, with the employer, a return to work on modified/light duties (if available).

3. Allow an employee to return to work in a safe and timely manner, avoiding unreasonably lengthy absences from the workplace.

When completing the Detailed Job Description (Form #5) please ensure you are providing a clear interpretation of the functional requirements that your employee is expected to and/or may be required to perform during a regular work day. Attaching a preprinted job description and/or Physical Demands Analysis is extremely useful in our evaluation of the Detailed Job Description.

Doctors' Recommendations for Treatment

Most plans require a patient to obtain a doctor's recommendation for massage therapy treatment. It is unreasonable to presume that a doctor's recommendation for massage should be considered a blanket endorsement for unlimited treatments. In most situations 12 treatments from a massage therapist should be enough to deal adequately with most conditions.

A doctor's recommendation for treatment is recognized as **valid for one year** from the date of the prescription. If an employee is claiming massage therapy expenses regularly, he/she will receive a warning approximately 4 months prior to the expiration of his recommendation. This should give him/her adequate time to obtain and submit a new recommendation for treatment should one be required.

Massage therapy expenses incurred either prior to the date a doctor recommends treatment, or after the date it expires, cannot be considered for reimbursement.