Equitable™

Protecting your plan

Benefits fraud and abuse

By providing group benefits coverage, you're investing in the health of your employees and their families. Unfortunately, some people – healthcare providers or even plan members – may try to abuse or even defraud your plan. This can lead to increased premiums or result in reduced or lost benefits coverage for plan members.

Together, advisors, plan members, employers and Equitable® share in the responsibility of protecting health benefits plans from fraud and abuse.

What we're doing to protect your health benefits plan

Equitable is responding to health benefits fraud and abuse and protecting both you and your plan members through detection, investigation and action.

Detection

We value reports of suspected fraud, but we're also continually enhancing our systems and technologies to proactively identify fraudulent or suspicious behaviour. We identify these outliers by scouring our plan member, provider and claims data to find questionable patterns that raise red flags.

In addition to our highly skilled analysts, we use Artificial Intelligence to identify plan members and providers with suspicious or abnormal claiming patterns.

Investigation

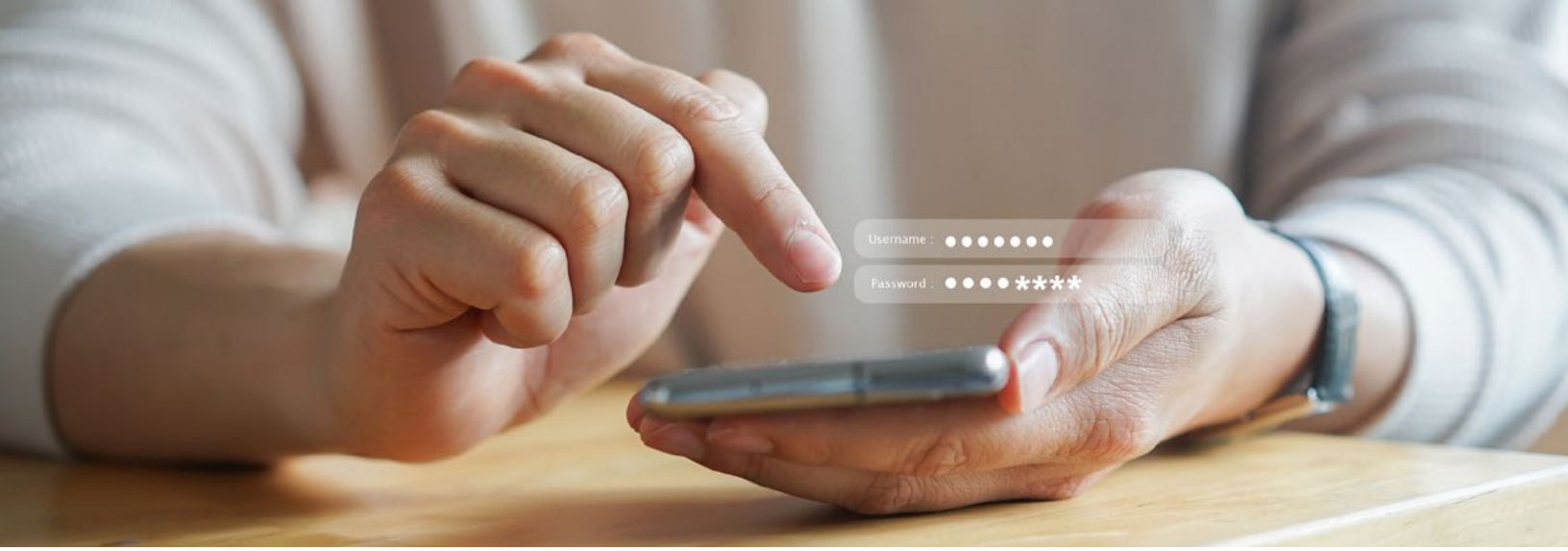
Our Investigative Claims Unit (ICU) continues to grow with the addition of skilled consultants including former police officers and investigators with extensive health and dental claims experience. These experts are responsible for:

- Conducting frequent claims audits; and
- Investigating suspicious billing patterns or claims activity. This may include research, surveillance, interviews, audits and even undercover operations.

What does health benefits fraud and abuse look like?

Health benefits fraud and abuse can be carried out in a number of ways:

- A healthcare provider overbills for a service, or charges for a treatment or service they didn't provide.
- A plan member submits a claim for a service they didn't receive or claims more for the service than they were billed.
- A plan member and their healthcare provider work together to falsify claims for products or services that would not be covered under the health benefits plan or that the plan member did not receive.



Action

The Investigative Claims Unit takes action against healthcare providers abusing benefits plans or with unsatisfactory billing and administrative practices by delisting these providers and pursuing recovery of money obtained improperly. They also file college complaints against providers and file police reports when appropriate.

Products and services from delisted providers become ineligible for reimbursement through all of Equitable group benefits plans.

We also take action against plan members abusing their health benefits. This may include terminating benefits coverage and recovering money obtained improperly.

How you can protect against health benefits fraud:

Your plan members should:

- Keep their health benefit information, including passwords and coverage details, private;
- Validate the credentials of a healthcare provider and check our delisted practitioners list before seeking treatment; and
- Check their receipts and claim forms for accuracy following treatment.

Plan administrators can:

- Understand the allure of benefits fraud, and the risks it poses to your group health benefits plan and company;
- Build an anti-benefits-fraud culture in your workplace. Our online resources can help you educate plan members and encourage them to do their part to protect their group health benefits plan; and
- Let employees know they may lose their group benefit coverage and their job if they commit group benefits fraud.

Report suspected fraud

Benefits fraud affects everyone, and it's our shared responsibility to report it when we see it. You can support us by reporting suspicious activity and cooperating with investigations.

Reports can be made to your service representative, or anonymously to Equitable's Investigative Claims Unit at 1.800.265.8899 or email investigations@equitable.ca.

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