

Benefit

BULLETIN

Issue #2, 2009

CONSUMER TIPS

What is PVS?

PVS is a network of over 1000 participating vision service providers across the country, offering discounts on prescription eyewear products and laser eye correction surgery. PVS is available to everyone covered under a Sun Life Financial Extended Health Care (EHC) plan. Even if your plan does not include vision care, PVS can help you save on prescription eyewear products and laser eye correction costs.

How does PVS work?

By creating a network of providers, PVS is able to arrange significant discounts for all your vision needs. Up to 20% off the cost of prescription eyewear and 10% off the cost of laser eye surgery!

You have access to discounts and providers by accessing the **PVS website** (www.pvs.ca), where you can search for a provider nearest you or link directly to approved online providers. You can also call 1-800-668-6444. New providers are added all the time, including **ClearlyContacts.ca** and **Lasik MD**.

How do you get the discounts?

As long as you're covered under a Sun Life Financial EHC plan, you are eligible for PVS discounts through the preferred provider network. Make sure you have your Coverage Card or Drug Card at the point of purchase as your proof of coverage. It's that easy!

If you buy eyewear over the internet from **ClearlyContacts.ca**, the discount is already included in the lower price of the eyewear.

If your plan includes vision coverage under your group benefits plan, submit the packing slip from your delivery along with a photocopy of your prescription and we'll pay the claim, up to your vision maximum. (Paper claims only.)

Just remember, all online purchases must be made through approved provider websites. Eyewear purchased through sites like eBay is not eligible for reimbursement. Visit the PVS website (www.pvs.ca) for more details.

Don't have a Coverage Card or Drug Card?

Sign in to the Sun Life Financial Member website using your **Access ID** and **password**. Select my coverage and then **print my coverage card**.



WHAT DOES THAT MEAN?

What does “preventative dental recall date” mean?

Good oral health starts with consistent care. An important part of this care is making sure that you receive routine check-ups from your dentist. The habit of regular check-ups ensures that small problems are caught early, and don't turn into bigger ones later on.

A **preventative dental recall exam** refers to a routine check-up performed by your dentist, and the **preventative dental recall date** is the date that you are next eligible for a routine check-up under your group dental plan. The frequency of these exams can vary depending on your benefits plan, and can range from every 9 to 12 months.

It's important to note that this date may not apply to other procedures like polishing, scaling, fluoride application, or x-rays which are often performed at the same time. Your group plan may have different coverage frequencies for these other procedures. You should refer to your benefits booklet or check with your benefits administrator for details on exactly what your plan covers.

If you'd like to find out when your next preventative dental recall date is, just sign in to our Plan Member Services website (www.sunlife.ca/member) using your access ID and password, and select **Next dental check-up**.

HOW TO

How are claim payments calculated?

Have you ever submitted a claim and wondered how your payment was calculated?

Various factors affect the amount you are reimbursed. The main influence is the design of your benefits plan, which your employer determined when the plan was set up.

Here are some items that affect the amount you are reimbursed for claims:

- **Your plan may have a deductible.**
This is the dollar amount of eligible expenses you are responsible for before your plan begins paying benefits for the year. A new deductible applies at the beginning of each new plan year.
- **Your coverage may include co-insurance.**
Coinsurance is the percentage of eligible expenses that are covered after deductibles. For example, some plans pay 70 per cent of eligible expenses and plan members pay the remaining 30 per cent themselves. The percentages are decided by your employer.
- **Some expenses are limited to a maximum amount.**
Your plan may specify a dollar maximum for some expenses. This is usually the case for eyeglasses and lenses. It helps to keep plan costs within reasonable limits for both members and employers.
- **Your plan is based on “reasonable and customary” rates.**
These are the rates for eligible services and supplies that providers and practitioners typically charge in your province. For example, if a registered massage therapist charges you more for a particular service than another therapist with the same qualifications, your claim payment will be based on the “customary” rate instead of the actual amount charged.
- **Dental payments are based on fee guides.**
Typically, dental plans specify one or more fee guides as the basis for reimbursements, for example, the previous year's provincial dental association fee guide for general practitioners. We pay your claim according to the eligible fee listed for a service in the applicable guide, which may be less than the amount your dentist billed.
- **Your drug plan is based on generic drugs.**
Many plans cover generic equivalent drugs even if brand name drugs are dispensed. In this situation the percentage covered is applied to the cost of the lowest-priced generic equivalent drug
- **Medical equipment is paid for according to need.**
We pay for medically necessary equipment that meets your basic medical needs (assuming your provincial health plan doesn't cover it). For example, if you need a wheelchair and a manual model is appropriate for your medical condition, we would not reimburse the cost of an electric one.

Depending on the length of time you need the equipment, it may be more economical to buy it instead of renting. This will also be considered when your claim payment is calculated.



To become more informed about your claims reimbursements:

- Before you submit a claim, check the Plan Member Services website at www.sunlife.ca/member (if you have access under your plan) to see what your coverage is for a particular expense.
- When you receive a claim statement, review the details. They show how your claim was calculated, including the eligible amount, any deductible amount and the percentage your plan covers. Check for any notes about your claim that give you extra information.

If you still have questions about how your claim was calculated, contact the **Customer Care Centre** at 1-800-361-6212.

FYI

Understanding orthotics and orthopaedic shoe claims

If you've recently purchased orthotics or orthopaedic shoes, you should provide the following when submitting a claim:

- A completed Sun Life Financial claim form
- An original receipt indicating you paid in full and that the orthotics or orthopaedic shoes have been custom made to fit you. (A copy of the receipt is acceptable if a full and detailed explanation of charged expenses is attached.)
- A copy of your current prescription outlining the medical diagnosis from a doctor, podiatrist, or chiropodist. Note: some plans allow other health care practitioners to prescribe. Please refer to your employee booklet for details.

By following this checklist, you can help us accurately process your claim and provide you with timely reimbursement.



KNOW YOUR COVERAGE

Want to make the most of your benefits? Know your coverage.

It's always a good idea to understand your coverage, especially if you recently experienced a life-changing event such as getting married or having a baby.

Here's how:

Visit our Plan Member Services website

Just sign in to our Plan Member Services website using your access ID and password and select 'my coverage' from the home page www.sunlife.ca/member

You'll find:

- Coverage information for you and your dependents, including deductible information, the percentage you're covered for, and more
- Details about prescription drugs, including whether or not you're covered for a particular drug, the percentage you're covered for, conditions the drug treats, possible side effects, how the drug works, and more *
- When you're eligible for your next dental check-up *
- The balance of your Health Spending Account *
- Information about your vision coverage *

* Your plan may or may not include these benefits

Call our automated phone system

Because our automated phone system is available 24 hours a day, you can call whenever it's convenient for you. Just call 1-800-361-6212. With your access ID and password, you can:

- Access our automated phone system 24 hours a day
- Speak to one of our customer care representatives from 8:00 am to 8:00 pm ET on business days

If you still have questions

You can also refer to your employee booklet or contact your benefits administrator.



How to reach us

- Visit our Plan Member Services website at www.sunlife.ca/member
- Call our Customer Care Centre toll-free at **1-800-361-6212**. When prompted, enter your Access ID and password. You can speak directly with one of our customer care representatives between 8 a.m. and 8 p.m. ET, Monday to Friday, excluding holidays.

Articles in Benefit Bulletin are for information purposes only. Not all benefits described may be included in your plan. Visit our Plan Member Services website at www.sunlife.ca/member or refer to your employee booklet to confirm your coverage. Consult your physician or other health care professional before acting on anything you read, and with respect to any symptoms you may experience.