



CLAIM PROCEDURES

EXTENDED HEALTH CARE

While your health coverage is designed to protect you against unexpected medical expense, you do have a responsibility to use your medical benefits wisely. For example, you can take advantage of pre-admission testing whenever possible to cut down on your hospital stay, get a second opinion before undergoing surgery, and check your bill for any charges you do not understand or think might be incorrect. Determine what the dispensing fee is for your prescriptions by asking your pharmacist. Compare it with other pharmacies and choose one with a lower dispensing fee. In other words, apply the same smart consumer practices to health care that you could to any other purchase. **Remember, how the plan is used will directly affect your future premium rates.**

You may submit claims at any time. However, in order to minimise administrative costs, we strongly recommend that you accumulate receipts for a series of treatments.

If Extended Health Care expenses are incurred, obtain a claim form from the Department of Human Resources. Complete the form and return it, along with any original receipts, to the insurance company. Claim payments will be sent directly to you.

In order to be eligible for payment, health claims must be submitted by the end of the calendar year following the year in which the expense was incurred.

NOTE: Original receipts in support of claims will not be returned, but will be retained by the insurance company.

For all Health Care Benefits, when your insurance terminates for any reason, written proof of claim must be given to the insurance company within 90 days of the date of termination of insurance.

DENTAL

If Dental expenses are incurred, obtain a claim form from the Department of Human Resources; have your dentist complete the form; complete your portion of the form, and return it to the insurance company.

Dental claim payments are made payable to you unless you have previously authorised payment to a person and/or corporation which has rendered services, treatments or supplies. In this case, claim payments for benefits which are assigned will be sent directly to the assignee.

Please note that some dentists charge above the Alberta Dental Association Fee Guide, and that excess expense will be the employee's responsibility.

In order to be eligible for payment, dental claims must be submitted by the end of the calendar year following the year in which the expense was incurred.

NOTE: Original receipts in support of claims will not be returned, but will be retained by the insurance company.

For all Dental Care Benefits, when your insurance terminates for any reason, written proof of claim must be given to the insurance company within 90 days of the date of termination of insurance.

CO-ORDINATION OF BENEFITS

This Plan includes a Co-ordination of Benefits Provision. This provision operates in the event that you, or your spouse, are covered under more than one Group Health or Dental plan, and allows the claimant to receive reimbursement of up to 100% of incurred expenses.

The majority of today's plans include a Co-ordination of Benefits provision however, if a plan does not have such a provision, it is always considered the first to pay for all members of the family.

When both plans include the provision, the order of payment is as follows:

1. Your first payment is from your plan your second payment is from your spouse's plan.
2. Your spouse's first payment is from her/his plan and your plan makes the second payment.
3. For dependent children, the first payment is from the plan of the parent whose birthday is first in the year.

After you have received payment from the first carrier, you may claim the balance not paid from the second carrier. Send a copy of your original claim and a copy of the "Explanation of Benefits" sent to you by the first carrier to the second carrier for payment of the balance, if applicable (i.e., if the procedure is a covered expense under the terms of the second payer's plan).

It is understood that in all cases the employee submits his/her claim to his/her employer's carrier **FIRST**, then to the spouse's plan for the remainder of benefit, if applicable.

ON-LINE CLAIMS SUBMISSION

For the submission of most of your health and dental claims to Sun Life, the online claims submission service from Sun Life is a valuable addition to your group benefits plan and available to you at no additional charge.

How to Self-Register for Plan Member Services:

- Have your policy number 100602 and your member ID number handy. Your member ID is your nine digit employee ID number.
- Access Sun Life Financial's Plan Member Services (www.mysunlife.ca) and select "Don't have an Access ID? Register now"
- Select "Register – benefits plan"
- Simply complete the information requested on the next screen, including your policy number 100602, member ID number and your date of birth.

Once your registration is complete you will receive your online Access ID immediately. A temporary password (PIN) will be sent to your work e-mail. When you receive this temporary PIN you can begin using the Plan Member Services Web Site.