# Personal Health Insurance & Health Coverage Choice

## ADVISOR GUIDE

### What's inside

- Product comparison
- Product information
- Underwriting
- Administration

**ADVISOR USE ONLY**

Sun Life Financial

# TABLE OF CONTENTS

## WHY OFFER PERSONAL HEALTH INSURANCE FROM SUN LIFE FINANCIAL?

**When clients don't have health benefits through an employer, health care expenses can add up. That's why personal health insurance is a healthy financial decision, especially for those without group benefits coverage.**

Offer peace of mind to clients. If clients have personal health insurance and need certain prescription drugs, health care or dental services, they won't be burdened with the entire cost.

Although the government provides provincial health plans to cover basic health expenses for residents, there are many expenses that are not covered. Many Canadians turn to group health and dental benefit plans to have these expenses covered, but those who are self-employed or working on contract, for example, do not always have access to group benefit coverage. There are also those who retire or change jobs and have to leave their group coverage behind.

Sun Life Financial's leading suite of personal health insurance plans is an excellent choice to offer clients. Talk to clients today about one of our two types of personal health insurance: Personal Health Insurance (PHI) or Health Coverage Choice (HCC).

## HOW DO I DETERMINE WHETHER MY CLIENTS NEED PERSONAL HEALTH INSURANCE OR HEALTH COVERAGE CHOICE?

| **Personal Health Insurance (PHI)** | **Health Coverage Choice (HCC)** |
|---|---|
| May or may not have group benefits<br>• young individuals/couples/families self employed, small business owners<br>• contract positions<br>• small business<br>• close to retirement | Eligible if applied for within 60 days of leaving any group benefits plan<br>• employment is ending<br>• retirement |
| Medically underwritten | Not medically underwritten |

## PRODUCT COMPARISON – PRODUCT AT A GLANCE

| | PHI | HCC |
|---|---|---|
| **Types of plans available** | • Basic plan<br>• Standard plan<br>• Enhanced plan | • Health and dental choice A<br>• Health choice B<br>• Health choice C |
| **Coverage options available** | • Single person coverage for individuals<br>• Multi-person coverage for couples or families<br>• Joint ownership not allowed<br>• Optional benefits available<br>• Plans cannot be customized | • Single person coverage for individuals<br>• Multi-person coverage for couples or families<br>• Joint ownership not allowed<br>• Optional benefits available<br>• Plans cannot be customized |
| **Issue ages** | • 69 or younger on the PHI application date<br>• Renewable for clients age 70 and over | • 74 or younger on the HCC application date<br>• Renewable for clients age 75 and over |
| **Eligibility requirements** | • Resident of Canada<br>• Covered under provincial health insurance<br>• Quebec residents must have the health and drug insurance through RAMQ or through group benefits<br>• Must be the policy owner or related to the policy owner<br>(see complete details on page 10) | • Resident of Canada<br>• Covered under provincial health insurance<br>• Quebec residents must have the health and drug insurance through RAMQ or through group benefits<br>• Have been covered under a group plan within 60 days prior to the HCC application date<br>• Must be the policy owner or related to the policy owner<br>(see complete details on page 27) |
| **Renewability, expiry, convertibility** | • Standalone, guaranteed renewable plans<br>• Renewable every year<br>• Non-convertible<br>• Emergency travel medical benefit on Standard and Enhanced plans expires on the insured person's 80th birthday. | • Standalone, guaranteed renewable plans<br>• Renewable every year<br>• Non-convertible<br>• Available for group conversions if application is received within 60 days from the date when a client's coverage ends<br>• Emergency travel medical benefit on Health choices B and C expires on the insured's 80th birthday. |
| **Risk classes** | • Age<br>• Plan type<br>• Province of residence | • Age<br>• Plan type<br>• Province of residence |

## PRODUCT COMPARISON continued

| | | |
|---|---|---|
| **Underwriting decisions** | The costs of medications, the disease process and any pre-existing conditions are taken into consideration.<br>**Decisions:**<br>• Standard issue<br>• Exclusions — applicants who have pre-existing conditions may have exclusions within their policy<br>• Ratings — build is the only condition that is charged an extra premium. If rated, the premium will be two times standard<br>• Postponed — the application will be postponed if client is pending surgery, has outstanding test results or is currently seeing a doctor for symptoms and we are unable to assess eligibility<br>• Declined — coverage will be declined if the client is currently on disability, receiving disability benefits from any source, or has had any of the illnesses or conditions outlined in the underwriting guidelines | • Customers must apply within 60 days of ending their group benefits<br>• No medical evidence is required<br>• If optional dental is chosen, clients must also have had dental coverage through their group plan |
| **Administration / policy fee** | • None | • None |

# SECTION A: Personal Health Insurance (PHI) – Series 7.0

Here's a convenient summary of the current product features for PHI. Keep it handy for easy reference.

## PLAN DETAILS

### PRESCRIPTION DRUGS

| Basic plan | Standard plan | Enhanced plan |
|---|---|---|
| • 60% reimbursement<br>• $750 annual maximum<br>• Excludes oral contraceptives<br>• Up to $5.00 paid towards dispensing fee on prescriptions | • 70% reimbursement on first $7,000 of annual eligible expenses ($4,900 paid expenses)<br>• 100% reimbursement on next $93,000 of annual eligible expenses<br>• Excludes oral contraceptives<br>• Full coverage of reasonable and customary dispensing fees | • 80% reimbursement on first $5,000 of annual eligible expenses ($4,000 paid expenses)<br>• 100% reimbursement on next $95,000 of annual eligible expenses<br>• Includes oral contraceptives<br>• Full coverage of reasonable and customary dispensing fees |

All three plans include:

- Pay Direct drug card for residents outside of Quebec (In Quebec, this card is not available)
- No deductible
- Smoking cessation medication ($250 lifetime maximum)

### SUPPLEMENTAL HEALTH CARE

| | Basic plan | Standard plan | Enhanced plan |
|---|---|---|---|
| | • 60% reimbursement[1]<br>• No deductible | • 100% reimbursement[1]<br>• No deductible | • 100% reimbursement[1]<br>• No deductible |
| **Hearing aids** | • $400 maximum every five years | • $400 maximum every five years | • $500 maximum every five years |
| **Accidental dental** | • $2,000 per fracture or injury | | |
| **Ambulance** | • Ground or air ambulance services | | |
| **In-home nursing**[2] | • $2,500 annual maximum and a $20,000 lifetime maximum combined with medical equipment and services | • $5,000 annual maximum and a $25,000 lifetime maximum | • $10,000 annual maximum and a $30,000 lifetime maximum |

1 See maximums listed in chart.
2 In-home nursing includes services of RNs, RPNs or RNAs.

## PLAN DETAILS continued

### SUPPLEMENTAL HEALTH CARE continued

| | Basic plan | Standard plan | Enhanced plan |
|---|---|---|---|
| **Medical equipment and services** | The following items have a $2,500 annual maximum and a $20,000 lifetime maximum combined with in-home nursing | The following items have a $5,000 annual maximum | The following items have a $5,000 annual maximum |
| **Quebec only: Medically necessary MRI, ultrasounds, CAT and CT scans** | • $750 combined annual maximum | • Up to reasonable and customary | • Up to reasonable and customary |
| **Orthopedic shoes** | • $150 annual maximum | • $200 annual maximum | |
| **Blood glucose monitor** | • $150 every five years | • $300 every five years | |
| **Medically necessary wigs and hair pieces** | • $100 annual maximum | • $500 lifetime maximum | |
| **Wheelchairs, walkers and traction kits** | • $1,000 lifetime maximum | • $4,000 lifetime maximum | |
| **Hospital bed, oxygen** | • Up to reasonable and customary | • $1,500 lifetime maximum for hospital beds | |
| **Casts, crutches** | | • $500 annual maximum | |
| **Prosthetic appliances (e.g. artificial limbs)** | • Up to reasonable and customary | | |
| | | • Breast prosthesis: $200 annual maximum applies to Standard and Enhanced plans | |

### PARAMEDICAL PRACTITIONERS

| Basic plan | Standard plan | Enhanced plan |
|---|---|---|
| • 60% reimbursement<br>• $25 maximum per visit<br>• Up to $250 per year, per practitioner | • 100% reimbursement<br>• No per visit maximum<br>• Up to $300 per year, per practitioner | • 100% reimbursement<br>• No per visit maximum<br>• Up to $400 per year, per practitioner |

Paramedical practitioners include:

- Chiropractors, including one x-ray examination per calendar year
- Registered massage therapists
- Naturopaths and acupuncturists
- Osteopaths, including one x-ray examination per calendar year
- Physiotherapists
- Podiatrists or chiropodists, including one x-ray examination per calendar year
- Speech language pathologists
- Psychologist

Note: Clients must apply to their province of residence first as 1st payor; the unpaid portion should be submitted for coverage. All annual or lifetime maximums are per person and are based on a calendar year.

*If a client chooses to add dental coverage to their Enhanced plan, preventive, restorative and orthodontic coverage will all be added. Preventive dental coverage, for example, cannot be added on its own.*

## PLAN DETAILS continued

| | Basic plan | Standard plan | Enhanced plan |
|---|---|---|---|
| **DENTAL** | | | |
| **Preventive** | • 60% reimbursement<br>• $500 annual maximum | • Optional benefit<br>• 70% reimbursement<br>• $750 annual maximum | • Optional benefit<br>• 80% reimbursement<br>• $750 annual maximum |
| | All three plans include:<br>• Exams, diagnosis, tests, x-rays, lab exams<br>• Space maintainers for children under 12 years of age<br>• Pit and fissure sealant for children under 19 years of age<br>• A three month waiting period before coverage begins<br>• White fillings<br>• Scaling, minor extractions<br>• Nine month recall visits | | |
| **Restorative** | • No coverage | • No coverage | • Optional benefit<br>• 50% reimbursement<br>• $500 annual maximum<br>• One year waiting period before coverage begins<br>• Includes endodontics, periodontics, oral surgery, crowns, onlays, bridges, dentures (and repairs) |
| **Orthodontics** | • No coverage | • No coverage | • Optional benefit<br>• 60% reimbursement<br>• $1,500 lifetime maximum<br>• Two year waiting period before coverage begins |
| **VISION CARE** | | | |
| | • No coverage | • 100% reimbursement<br>• $150 maximum every two years ($200 maximum every two years for Enhanced), including $50 maximum per eye exam<br>• One year waiting period before coverage begins<br>• Prescription eye glasses, contact lenses, sunglasses, laser eye surgery | • 100% reimbursement |
| **EMERGENCY TRAVEL MEDICAL** | | | |
| | • No coverage | • 100% reimbursement<br>• $1 million lifetime maximum<br>• Coverage provided for the first 60 days of a trip<br>• Covers travel outside of the client's province and outside of Canada<br>• Multiple trips allowed<br>• Coverage ends on the insured person's 80th birthday.<br>• If the client has a pre-existing medical condition where symptoms have appeared or required medical attention, hospitalization or treatment (this includes changes in medication or dosage), and existed during the nine months prior to their trip, expenses related to this condition are not included | |

| PLAN DETAILS continued | | | |
|---|---|---|---|
| | **Basic plan** | **Standard plan** | **Enhanced plan** |
| **SEMI-PRIVATE HOSPITAL ROOM** | | | |
| Consider adding the optional benefit of a semi-private hospital room to any of the three plans. This will provide you with:<br>• 85% reimbursement<br>• Coverage up to $200 daily and $5,000 annually<br>• Convalescent hospital: $20 per day up to 180 days per incident | | | |

Rates may change from year to year. If they are going to change, you'll receive written notice 45 days prior to the change.

## Series 7.0

You can see a summary of Series 7.0 enhancements in the chart below:

Note: These enhancements are for Series 7.0 plans effective September 2009, and does not apply to previous series.

| | |
|---|---|
| **Prescription drugs** | Available for Standard and Enhanced plans:<br>• Increased coverage<br>• Removed dispensing fee cap of $5.00 |
| **Supplemental health care** | Available for Standard and Enhanced plans:<br>• Increased medical equipment as well as in-home nursing maximums<br>• Increased reimbursement level<br>• Updated annual and lifetime maximums<br>• Removed per visit maximum for paramedical practitioners |
| **Semi-private hospital** | • Increased reimbursement level and per day maximum<br>• Added coverage for convalescent hospital |
| **Vision** | • Increased coverage for Enhanced plan |

## Eligibility and issue ages – PHI

**To become eligible and to continue to be eligible for insurance, the client must be:**

- a resident of Canada,
- covered under the provincial health plan in the client's province of residence,
- 69 years of age or younger on the PHI application date (renewable for clients age 70 and over), and
- the policy owner, or related to the policy owner in one of the following ways:

  a. legally married to the policy owner or in a civil union,

  b. living with the policy owner in a conjugal relationship and represented as a spouse or partner, or

  c. an unmarried natural, adopted, or step child who is entirely dependent for maintenance and support and who is:

  - under 21 years of age,
  - under 25 years of age and attending a college or university full time, or
  - physically or mentally incapable and became incapable while entirely dependent on the policy owner for maintenance and support while eligible under a) or b) above.

**Other requirements**

- Quebec residents must have and continue to have the health and drug insurance through the Régie de l'assurance maladie du Québec (RAMQ) or through a group benefits plan.
- No backdating allowed.
- PHI plans can be established one business day after underwriting approves it, or on a specific day requested by the client.

## Renewability, expiry, convertibility – PHI

- As long as premiums are paid and up-to-date, the plan does not expire. The only exceptions are if the policy owner cancels the plan or upon death of the policy owner.
- Emergency travel medical benefit on Standard and Enhanced plans expires on the insured person's 80th birthday.
- These plans are not convertible.

## Optional benefits – PHI

*Couples and families must choose the same plan type and optional benefits to cover all insured persons.*

**Dental coverage**

- Optional for Standard and Enhanced plans only.
- This option can only be selected at time of application.
- This benefit ends when the base plan ends.
- Premiums and banding are determined the same way as the base plan.

**Semi-private hospital room**

- Available on all three plan types.
- This benefit expires when the base plan expires.
- Premiums and banding are determined the same way as the base plan.

# Best Doctors® Services – PHI

With Personal Health Insurance from Sun Life Financial, clients can get access to Best Doctors, an international medical referral network that can help them find the best medical care and can help confirm:

- if the diagnosis is correct,
- what will happen to the client,
- the best treatment available.

Best Doctors offers ongoing support and guidance so the client and their physician can make informed decisions about the client's health care. While insured, Best Doctors gives clients access to expert medical information and connects them and their treating physician with world-renowned specialists, through these unique services:

- Interconsultation™
- FindBestDoc™
- FindBestCare®
- Best Doctors 360°™

Detailed information about these unique services is available in the Best Doctors client brochure (810-3314), on the advisor website. This brochure is a valuable resource for PHI clients to keep, in order to reference the services available to them.

## Family use of Best Doctors services

Unlimited access to Best Doctors is available at no charge for the insured, their spouse and dependent children for as long as their coverage is in place. They don't need to have a diagnosis or make a claim to access these valuable services – help is available if they suspect they have a serious medical condition.[1]

Best Doctors contact information is provided along with the policy in the client's welcome package. The insured person will simply need to contact Best Doctors at 1-877-419-BEST (2378) and provide their policy number.

[1] Excludes mental, nervous and chronic pain conditions (e.g. fibromyalgia).

# Premium details – PHI

## Premium rates

**The premium is determined according to the age of each insured person and the province where they live.** A rating may apply to PHI but build is the only condition that is charged an extra premium. If rated, the premium will be two times the standard rate.
Sun Life Financial has the right to change the premium as long as we provide 45 days written notice to the policy owner.

- Rates are not guaranteed.
- When the insured moves into the next age band, the premiums will increase on their next policy anniversary.
- Sun Life Financial will review pricing annually. Changes in overall claims experience or major shifts in health care expenses could cause an increase in a client's premiums.
- If we need to increase rates, the client's premiums will increase at their next policy anniversary.
- Couple rates are charged on a per person basis – for example, if a man is over 65 and his spouse is under 65, they are charged the couple rate for their individual age bands. Couple rates are only available when both adults have chosen the same plan type.
- Discounts are not available for multiple sales.

### DID YOU KNOW

Clients can pay their premiums by:

- Pre-authorized chequing withdrawals (PAC) monthly.
- Cheque annually (for paper applications only).
- Credit card (monthly payment or annual payment).

## Grace period

**The grace period is 30 days for the payment of premiums and is allowed for each premium except the first.** During the grace period, insurance remains in force and premiums continue to be payable. The policy will be terminated when payment has not been made before the end of the grace period.

### TIP

**Here's how to calculate the premium* for PHI plans:**

**Monthly premium =** premium rate for appropriate age band, province and plan type, times any rating (200%)

**Annual premium =** multiply the monthly premium by 12

To find a client's premium rate, use the online illustration tool at www.sunlife.ca/personalhealth.

* Actual premiums are not guaranteed. They are subject to underwriting criteria and rates are subject to change.

The age bands are the same for each province. They are:

| ISSUE AGE BANDS | RENEWAL AGE BANDS |
|---|---|
| Under 30 years of age | Ages 70 – 74 |
| Ages 30 – 44 | Ages 75 – 79 |
| Ages 45 – 54 | Ages 80 – 84 |
| Ages 55 – 59 | 85 years of age or older |
| Ages 60 – 64 | |
| Ages 65 – 69 | |

# Applications – PHI

Clients can apply for PHI by completing an application form online, either on their own or in person with you. Clients can also apply by paper application in person, with you.

## Web application

**To apply online, clients simply need to visit www.sunlife.ca/personalhealth.** This brings them to the main personal health insurance page where they'll find all the necessary information about Sun Life Financial's personal health insurance.

From there, they can choose "How do I buy it?" which leads to the "buy online" option when they're ready to apply. Before completing the online application form, clients will be asked to have the following items ready:

- The birth date of their spouse and any dependant children who will be included in the application.
- The name and dosage of any prescription drugs for all persons included in the application.
- The name and address of their family doctor.
- The name and address of the family doctor for each family member included in the application, if different from their own.
- If they had group health or dental coverage with Sun Life Assurance Company of Canada in the last two years, they'll need the group plan number and group certificate number. This information is also required for a spouse, if he or she is included in the application.
- Either their chequing account information if having premiums withdrawn from their bank account, or a credit card number and expiry date if they want to pay for premiums using their credit card (Visa and MasterCard are accepted).
- If the client chooses to pay by PAC complete form #E4392 Personal Health Insurance – Pre-Authorized chequing (PAC) authorization for Web applications.

Once the client has decided which plan suits their needs best, and has collected the information above, they'll be ready to complete their application online.

### DID YOU KNOW

You'll receive an additional 2% first year commission (FYC) if a client completes their application online! Take the opportunity to encourage clients to complete the web application while supporting their questions and providing any help they may need.

### Paper application

For clients to apply for PHI with the paper application, you'll need to complete form #E3494 called "Personal Health Insurance application form."

Once completed, you or the client will need to mail this form along with a cheque marked "VOID" for monthly payments, or a cheque made payable for the annual premium, to:

Sun Life Assurance Company of Canada
Personal Health Insurance
227 King Street South
P.O. Box 1601 Stn Waterloo
Waterloo ON N2J 4C5

Note: If paying by Visa or MasterCard, the client should fill out the necessary information on the application and send to the above address. After we approve the application, we will contact them to obtain the credit card information.

**THINGS TO REMEMBER**

- You need to provide clients with the most up-to-date application forms to ensure they receive the most recent series of coverage. If you don't use the most recent application forms available, you may be asked to complete and re-submit an up-to-date application form.
- If a client chooses a PAC date that is different from the effective date of the policy, two full premium withdrawals will be processed in the first 30 days.
- Please advise the client to read their contract carefully. There are waiting periods on some benefits.

## Underwriting – PHI

PHI follows different underwriting guidelines than life insurance. Most of the time, an underwriting decision can be made based on the information requested on the application. It is important that the application is completed in full, including all information that is relevant to a client's overall health.

PHI medical underwriting takes the costs of medications, the disease process and any pre-existing conditions into consideration.

PHI does not cover pre-existing conditions/treatments and they will be excluded from coverage. A pre-existing condition or treatment is any injury, illness, disease or sickness of which there are symptoms, or for which medical treatment, care, advice or diagnosis was recommended or received before the date the application was signed.

**Underwriting decisions:**

- Standard issue.
- Exclusions — Applicants who have pre-existing conditions may have exclusions within their policy.
- Ratings — For PHI, build is the only condition that is charged an extra premium. If rated, the premium will be up to two times standard.
- Postponed — If the client is pending surgery, has outstanding test results, or is currently seeing a doctor for symptoms and we are unable to assess eligibility, underwriting will be postponed.
- Declined – Coverage isn't available if the client:
  a. is currently on disability,
  b. is receiving disability benefits from any source,
  c. not able to work full time, or
  d. has had any of the following illnesses or conditions, listed in the chart below:

## PRE-EXISTING ILLNESSES OR CONDITIONS THAT WILL BE DECLINED

This is a partial list of common conditions that result in uninsurability and there may be others that may also be uninsurable. Please do not submit an application for coverage if the client has one of the following conditions:

- AIDS or tested positive for HIV
- Alzheimer's disease
- aneurism (abdominal or aortic)
- angina
- angioplasty
- anorexia nervosa / bulimia within the past five years
- aortic valve replacement
- arterior sclerotic heart disease
- asthma (severe)
- cancer within the past ten years
- cerebral palsy
- chronic pain disorder
- cirrhosis
- coronary artery bypass grafting
- cystic fibrosis
- Down's syndrome
- drug / alcohol abuse within the past five years
- Guillain – Barré syndrome
- heart attack
- hepatitis B, C, D
- Huntington's chorea
- hydrocephalus
- Insulin-dependent diabetes
- kidney disorders / disease
- liver disease (chronic)
- lung disease (chronic)
- lupus systemic / erythematosus
- major depression / psychosis (eg. schizophrenia)
- major heart irregularities
- major organ transplant
- multiple sclerosis
- muscular dystrophy / muscular disorder
- pacemaker
- Parkinson's disease
- permanent paralysis
- rheumatoid arthritis
- spina bifida
- stroke (cerebral vascular accident)
- treatment with coumadin
- treatment with lithium
- treatment with prednisone
- treatment with methotrexate

## General exclusions – PHI

**The following expenses will not be covered under any of the three types of plans:**

- expenses incurred, directly or indirectly due to civil disorder or war, whether declared or not; or service in the naval, military or air force of any country, combination of countries or international organization at war, whether war is declared or not;
- expenses that Sun Life Financial is not legally allowed to pay;
- services or items that are considered cosmetic or experimental;
- delivery, transportation and administration charges;
- services and products that are self-prescribed or are rendered or prescribed by a person who is ordinarily a resident in the insured person's home or who is related to the insured person by blood or marriage;
- services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program unless explicitly listed as covered under this benefit;
- services or supplies that are not approved by Health Canada or any other government regulatory body for the general public;
- services or supplies that are not generally recognized by the Canadian medical profession as effective, appropriate and required in the treatment of an illness in accordance with Canadian medical standards;
- services or supplies that do not qualify as medical expenses under the Income Tax Act (Canada);
- elective (non-emergency) medical treatment or surgery which is received or performed out of province; and
- Services received out of country for a pre-existing condition, where symptoms have appeared or required medical attention, hospitalization or treatment (this includes changes in medication or dosage), and existed during nine months prior to the trip, expenses related to this condition are not included.

Sun Life Financial will also not pay for intentionally self-inflicted injuries, while sane or insane.

## Making a claim – PHI

When the insured has incurred an eligible expense that is covered under the policy, the policy owner can either:

- submit a claim through their mobile device,
- submit a claim through web services at mySunLife.ca, or
- complete the appropriate form listed and send it to the address as per the details below.

**Eligible claims must be completed as follows:**

- While the policy is in effect, we must receive claims within 12 months of the date that the eligible expense was incurred.
- After the policy ends, we must receive claims within three months of the date the policy ended.

A few copies of the necessary claim forms will be provided in the client's welcome package.

## Mobile app

Before gaining access to submit a claim through the my Sun Life Mobile app, clients must register through www.mySunLife.ca.

With the mobile app, clients can use their smartphone to:

- submit claims (vision, paramedical, and dental claims, if applicable) for automatic processing and receive payment into their bank accounts within 48 hours,
- view information about recently submitted or processed claims,
- access their drug and travel cards (if applicable), and
- access interactive financial planning tools.

## Web services

Clients can manage their PHI plan online at www.mySunLife.ca to receive fast and efficient services, as well as:

- submit claims online (vision, paramedical and dental if applicable),
- get claim payments deposited into their bank account,
- print their claims form[1], and
- view their coverage details and claims history.

Clients who have registered for web services cannot change their address online, but can contact the PHI administration team if the address shown needs to be corrected.

Please note access to web services will be available to clients only.

## How clients can register

Clients can register online at: www.mySunLife.ca or by phone at 1-877-SUN-LIFE (1-877-786-5433). They will need to know their policy number (037000) and their ID number.

Please note that clients will be using the Group Benefits website to view their coverage. Although they may see Group Benefits verbiage that doesn't apply to PHI, the coverage details are correct.

Clients do not need to register if they already have Customer Access.

[1] For forms which require changes (such as a termination form), clients must contact the PHI administration team at 1-877-SUN-LIFE (1-877-786-5433) Changes to the plan such as an address change, adding or removing a dependant or adding or removing a benefit cannot be done on the website.

### Questions?

If clients have administrative or technical questions with registering or needs to reset a password, please have them call 1-877-SUN-LIFE (1-877-786-5433) .

## Dental and supplemental health claims

**To make a dental claim,** clients must use form #4137-E called "Dental claim form for personal health insurance."

**To make a health claim,** clients must use form #4136-E called "Extended health care claim form for personal health insurance."

You or the client can print the appropriate form directly from www.sunlife.ca/personalhealth – How do I make a claim?

Once completed, clients need to mail their form along with original receipts to:

Sun Life Financial
Health and Dental Claims
PO Box 3417 Stn D
Ottawa ON K1P 1G1

You should remind clients to keep a copy of the receipts for their records.

## Prescription drug claims

For prescription drug claims in all provinces except Quebec, clients simply need to use their Pay Direct drug card when purchasing their prescriptions. When a client presents their card to the pharmacist, the portion of their bill that is covered by their policy will be paid automatically.

If a client does not use his/her Pay Direct drug card at the pharmacy, the client will need to pay the full cost of the prescription and then submit a health claim form for reimbursement.

If a client lives in Quebec, their claims can be filed using form #4136-E called "Extended health claim form for personal health insurance."

Once completed, Quebec clients need to mail their form along with original receipts to:

Sun Life Financial
Health and Dental Claims
PO Box 3417 Stn D
Ottawa ON K1P 1G1

## Emergency travel medical claims

**To ensure payment of these expenses, clients should take the following steps:**

1. Call the 24-hour helpline listed on the emergency travel medical card or have someone call on their behalf immediately when an emergency occurs. Europ Assistance USA, Inc. will verify the client's health coverage and provincial health care coverage so payments can be arranged on behalf of the insured person, their insured spouse or their insured dependant.
2. An authorization form will need to be signed, allowing Europ Assistance USA, Inc. to recover any amount payable to the provincial health care plan.
3. The insured person is responsible for expenses incurred that are not covered under their plan or their provincial health care plan. Clients will need to reimburse Europ Assistance USA, Inc. for any excess amount paid on their behalf.
4. If subsequent bills are received for these expenses, they need to be forwarded to Europ Assistance USA, Inc. and payments will be coordinated by Europ Assistance USA, Inc. with the provincial health care plan and Sun Life Financial.
5. To ensure travel dates are within the eligible 60 day period Europ Assitance USA, may request proof of travel (i.e. plane ticket, gas receipts, car rental receipt). In the case where proof is not provided, a claim may be denied.

# Benefit payments – PHI

## Payment of benefits

- The payment amount is determined by applying the reimbursement percentage and then applying the maximums.
- Clients can manage their claim payments directly into their bank accounts by registering at www.mySunLife.ca.
- Clients will be reimbursed for eligible expenses within approximately two weeks of Sun Life Financial receiving the client's claim form.

**How we calculate the amount of benefits that will be paid:**

1. We confirm all of the expenses that have been submitted are eligible for reimbursement.
2. We determine if there are any limitations which are described in the applicable provisions. If any of the expenses aren't eligible, we subtract that expense from the total amount claimed.
3. For each eligible expense, we compare:

- the amount being claimed,
- the customary charge for the expense, and
- the maximum amount the client can claim as described on the plan summary page.

The client's reimbursement is based on the lowest of these three amounts.

# How direct deposit of claims payment works

Direct deposit of claims is only available to clients who have registered for web services. The following provides additional information on how direct deposit of claims will work:

- If each spouse has a separate policy, they will each need to register for web services.
- If a claim is submitted on a paper claim form and the client is registered for web services, payment will be deposited into the bank account[3].
- Changes to the banking information used to deposit a claims payment can only be made on the website. If the same bank account is used to pay premiums, Personal Health Insurance – Pre-authorized chequing (PAC) or Credit card authorization form # E4360 is required to change the bank account information where premiums are withdrawn.
- Clients who pay their premiums by cheque or credit card can have direct deposit. Clients just need to register and provide bank account details.
- A client cannot have direct deposit for one benefit and not the other (if the plan has both health and dental, direct deposit will apply to both benefits).

[3] When the payment is deposited, an email is sent to the owner informing them the claim has been processed and the owner can sign in to see the claims payment details.

*To add dental coverage within the first 30 days, or to add semi-private hospital room coverage, use form #E327 called "Personal Health Insurance – Add optional benefit."*
*To remove dental or semi-private hospital room coverage, use form #E118 called "Personal Health Insurance – terminating coverage."*

# Post issue changes – PHI

## Changing a plan type:

Clients can change to an existing Basic, Standard or Enhanced plan, or any other plan type we offer at the time when the client applies for the change. For example, if the client had a Series 1.0 Basic Drug plan and would like to switch to Standard, subject to underwriting approval, they'll be changed to a Series 7.0 Standard plan.

A new application must be completed, including medical information for every person to be insured under the new policy, and submitted for underwriting. Upon approval, coverage will be established under the new policy and the old policy will be terminated.

### THINGS TO REMEMBER

- Maximums and any unsatisfied waiting periods will start over.
- Current rates will apply to the new policy.
- The new policy is effective the later of when the application is approved or when the paid coverage period for the old policy ends.

**Adding or removing the dental option on PHI Series 7.0 Standard and Enhanced plans:**
The dental option can be removed at any time, but can only be added to a Standard or Enhanced plan when the client applies for coverage. If the client wants to add optional dental after the first 30 days, this is considered a plan change and a new application must be completed along with medical information for each insured person. The removal of this benefit will begin the next coverage month after the request has been approved.

**Adding or removing the semi-private hospital room coverage on all PHI plans:**
The semi-private hospital room coverage can be added or removed at any time, subject to underwriting approval.

Additional medical information is required for each insured person. The addition or removal of this benefit will begin the next coverage month after the request has been approved.

**Adding a spouse and/or dependants:**
Family members can be added as long as they meet eligibility requirements and provide satisfactory evidence of insurability by completing form #E323 called "Personal Health Insurance – Add family member". The added dependant's coverage will be effective with the next coverage period.

**Adding children, including legally adopted and step children:**
These specific types of family members may be added as long as they are entirely dependent on the policy owner for maintenance and support and are:

a. Under 21 years of age, or

b. Under 25 and attending college or university full time, or

c. Physically or mentally incapable and became incapable while entirely dependent on the policy owner for maintenance and support while eligible under a) or b) above.

**Adding newborn children:**
A newborn child can be added to the plan if they request that their child be added within 30 days of when the child is born. Form #E323 called "Personal Health Insurance – Add family member" must be completed and the added child's coverage will be effective with the next coverage period.

**Right to cancel a policy:**
The client may cancel a policy at any time by sending a written request to Sun Life Financial's Waterloo office. 10 days' notice is required before cancellation to avoid paying an additional month's premium.

## SUMMARY OF POLICY FEATURES – PHI

| Feature | Availability |
|---|---|
| Policy fee | None |
| Policy loans | Cash policy loans or automatic policy loans are not available |
| Withdrawal premium fund (WPF) | Not available |
| Non-withdrawal premium fund (NWPF) | Not available |
| Non-forfeiture option | Not available |
| Participating or non-participating | Non-participating |
| Cash values | None |

# SECTION B: Health Coverage Choice (HCC) – Series 7.0

Here's a convenient summary of the current product features for HCC. Keep it handy for easy reference.

## PLAN DETAILS

### PRESCRIPTION DRUGS

| Health and dental choice A | Health choice B | Health choice C |
|---|---|---|
| • 80% reimbursement<br>• $400 annual maximum<br>• Up to $5.00 paid towards dispensing fee on prescriptions | • 80% reimbursement<br>• $1,000 annual maximum<br>• Full coverage of reasonable and customary dispensing fees | • 80% reimbursement<br>• $2,000 annual maximum<br>• Full coverage of reasonable and customary dispensing fees |

All three plans include:

- Pay Direct drug card for residents outside of Quebec (In Quebec, this card is not available)
- No deductible
- Smoking cessation medication ($250 lifetime maximum)

### Supplemental health CARE

| | Health and dental choice A | Health choice B | Health choice C |
|---|---|---|---|
| | • 80% reimbursement[1] | • 100% reimbursement[1] | • 100% reimbursement[1] |
| **Hearing aids** | • $300 maximum every five years | • $350 maximum every five years | • $500 maximum every five years |
| **Accidental dental** | • $2,000 per fracture or injury | • $5,000 lifetime maximum | |
| **Ambulance** | • Ground ambulance service | | |
| | • No coverage for air ambulance | | • Air ambulance $5,000 maximum per incident |
| **In-home nursing**[2] | • $2,500 annual maximum and a $20,000 lifetime maximum combined with medical equipment and services | • $5,000 annual maximum and a $25,000 lifetime maximum | |

1 See maximums listed in chart.
2 In-home nursing includes services of RNs, RPNs or RNAs.

## PLAN DETAILS continued

### SUPPLEMENTAL HEALTH CARE continued

| | Health and dental choice A | Health choice B | Health choice C |
|---|---|---|---|
| **Medical equipment and services** | The following items have a $2,500 annual maximum and a $20,000 lifetime maximum combined with in-home nursing | The following items have a combined $2,500 annual maximum | The following items have a combined $5,000 annual maximum |
| **Quebec only: Medically necessary MRI, ultrasounds, CAT and CT scans** | • No coverage | • Up to reasonable and customary | • Up to reasonable and customary |
| **Orthopedic shoes** | • $150 annual maximum | • $200 annual maximum | |
| **Blood glucose monitor** | • $150 every five years | • $250 every five years | • $300 every five years |
| **Medically necessary wigs and hair pieces** | • $100 annual maximum | • $350 lifetime maximum | • $500 lifetime maximum |
| **Wheelchairs, walkers and traction kits** | • $1,000 lifetime maximum | • $4,000 lifetime maximum | |
| **Hospital bed, oxygen** | • Up to reasonable and customary | • $1,500 lifetime maximum for hospital beds | |
| **Casts, crutches** | | • $300 annual maximum | • $500 annual maximum |
| **Prosthetic appliances (eg. artificial limbs)** | • Up to reasonable and customary | | |
| | | • Breast prosthesis: $200 annual maximum applies to Health choice B and C | |

### PARAMEDICAL PRACTITIONERS

| Health and dental choice A | Health choice B | Health choice C |
|---|---|---|
| • 80% reimbursement<br>• $25 maximum per visit<br>• Up to $250 annually per practitioner, except psychologists<br>• Psychologist: $50 per visit maximum up to $250 annually | • 100% reimbursement<br>• No per visit maximum<br>• $300 per year for each practitioner and combined maximum up to $500 per calendar year<br>• Psychologist: $60 per visit up to seven visits per year | • 100% reimbursement<br>• No per visit maximum<br>• $300 per year for each practitioner and combined maximum up to $650 per calendar year<br>• Psychologist: $60 per visit up to 10 visits per year |

**Paramedical practitioners include:**

- Chiropractors, including one x-ray examination per calendar year
- Registered massage therapists
- Naturopaths and acupuncturists
- Osteopaths, including one x-ray examination per calendar year
- Physiotherapists
- Podiatrists or chiropodists, including one x-ray examination per calendar year
- Speech language pathologists

Rates may change from year to year. If they are going to change, you'll receive written notice 45 days prior to the change.

*Preventive and major restorative dental coverage are optional benefits you can offer clients to add to Health choice B or C.*

## PLAN DETAILS continued

### PREVENTIVE DENTAL

| Health and dental choice A | Health choice B and C |
|---|---|
| • 80% reimbursement<br>• $700 annual maximum<br>• Coverage automatically included<br>Eligible expenses:<br>• Examinations and diagnosis<br>• Tests, x-rays and lab exams<br>• White fillings<br>• Scaling and extractions | • Optional dental benefit available<br>(See optional benefit section for details)<br>• Space maintainers for children under 12 years of age<br>• Pit and fissure sealant for children under 19 years of age<br>• Recall visits every nine months<br>• Minor emergency treatments |

### VISION CARE

All three plans include:

- 100% reimbursement
- $150 maximum every two years ($200 maximum every two years for Health choice C), including $50 maximum per eye exam
- Coverage of prescription eyewear, contact lenses, prescription sunglasses and laser eye surgery

### EMERGENCY TRAVEL MEDICAL

| Health and dental choice A | Health choice B and C |
|---|---|
| • No coverage | • 100% reimbursement<br>• $1 million lifetime maximum<br>• Coverage provided for the first 60 days of a trip<br>• Covers travel outside of the client's province and outside of Canada<br>• Multiple trips allowed<br>• Coverage ends on the insured person's 80th birthday.<br>• If a client has a pre-existing medical condition where symptoms have appeared or required medical attention, hospitalization or treatment (this includes changes in medication or dosage), and existed during the nine months prior to their trip, expenses related to this condition are not included |

### SEMI-PRIVATE HOSPITAL ROOM

| Health and dental choice A | Health choice B | Health choice C |
|---|---|---|
| • 50% reimbursement<br>• $5,000 annual maximum | • $175 daily maximum | • $200 daily maximum |
| | • 85% reimbursement<br>• $5,000 annual maximum<br>• Convalescent hospital: $20 per day up to 180 days per incident | |

### ELIGIBLE EXPENSE LIMITS

| | |
|---|---|
| • $250,000 lifetime maximum[3] | • $300,000 lifetime maximum[3] |

3 Lifetime maximum applies to drug, supplemental health care, vision and semi-private hospital room.

## OPTIONAL BENEFIT – Health choice B or C

Based on their needs, consider the following optional benefits when a client is purchasing a plan:

**Additional dental coverage**

Preventive and major restorative dental coverage is an optional benefit you may add to Health choice B or C. The optional coverage includes the same features for both plans, as follows, however annual maximums differ:

- 80% reimbursement on preventive services
- 50% reimbursement on major restorative services after a one year waiting period (The waiting period is the amount of time that needs to pass before the dental coverage is available. This period starts from the day that the client's Health Coverage Choice plan coverage begins.)
- $700 combined annual maximum for preventive and major restorative combined (Health choice B)
- $750 combined annual maximum in the first calendar year for preventive and major restorative combined; $1,000 annual maximum in subsequent calendar years (Health choice C)

**Preventive services include:**

- Examinations and diagnosis
- Tests, x-rays and lab exams
- White fillings
- Scaling and extractions
- Space maintainers for children under 12 years of age
- Pit and fissure sealant for children under 19 years of age
- Recall visits every nine months
- Minor emergency treatments

**Major restorative services include:**

- Endodontics
- Periodontics
- Oral surgery
- Crowns
- Onlays
- Bridges
- Dentures (and repairs)

Note: The client must also apply to their province of residence as 1st payor; the unpaid portion should be submitted for coverage. All annual or lifetime maximums are per person and are based on a calendar year.

## Series 7.0

You can see a summary of the Series 7.0 enhancements in the chart below:

Note: These enhancements are for Series 7.0 effective September 2009, plans and does not apply to previous series.

| | |
|---|---|
| **Prescription drugs** | Available for Health choice B and C:<br>• Increased annual maximum<br>• Removed dispensing fee cap of $5.00 |
| **Supplemental health care** | Available for Health choice B and C:<br>• Increased medical equipment as well as in-home nursing maximums<br>• Increased reimbursement level<br>• Updated annual and lifetime maximums |
| **Dental** | • Increased coverage for Health choice C with dental |
| **Semi-private hospital** | Available for Health choice B and C:<br>• Increased reimbursement level and added per day maximum<br>• Added coverage for convalescent hospital |
| **Vision** | • Increased coverage on Health choice C |
| **Eligible expense limits** | • Added overall plan maximum for Health choice A, B, and C |

## Eligibility and issue ages – HCC

To become eligible and to continue to be eligible for insurance, a client must:

- be a resident of Canada,
- be covered under the provincial health plan in the client's province of residence,
- be 74 years of age or younger on the HCC application date (renewable for clients age 75 and over),
- have been covered under a group plan within the 60 days prior to the HCC application date, and
- be the policy owner, or related to the policy owner in one of the following ways:
  a. legally married to the policy owner or in a civil union,
  b. living with the policy owner in a conjugal relationship and represented as a spouse or partner, or
  c. an unmarried natural, adopted, or step child who is entirely dependent on for maintenance and support and who is:
    - under 21 years of age,
    - under 25 years of age and attending a college or university full time, or
    - physically or mentally incapable and became incapable while entirely dependent for maintenance and support while eligible under a) or b) above.

Other requirements

- If applying for supplemental health care and dental coverage, the client must have had supplemental health care and dental coverage through their group plan.
- Quebec residents must have drug and health coverage through the Régie de l'assurance maladie du Québec (RAMQ).
- No backdating allowed.

### DID YOU KNOW

**Health Coverage Choice** goes into effect either one day after group benefits end, or one business day after the application has been received and approved.

Here's an example to illustrate:

- If group benefits end November 30 and the client's application is received November 15, then coverage would be effective December 1.
- If group benefits end October 31 and the client's application is received November 15, then coverage would be effective November 16.

## Renewability, expiry, convertibility – HCC

- As long as premiums are paid and up-to-date, the plan does not expire. The only exceptions are if the policy owner cancels the plan or upon death of the policy owner.
- Emergency travel medical benefit on Health choices B and C expires on the insured person's 80th birthday.
- These plans are not convertible.

# Optional Benefit – HCC

**Dental coverage**

- Optional for Health choice plans B and C.
- This option can only be selected when the client applies or within 60 days of applying for HCC.
- This benefit ends when the base plan ends.
- Premiums and banding are determined the same way as the base plan.
- Couples and families must choose the same plan type and optional benefits to cover all insured persons.

**Semi-private hospital room**

- Available on all three plan types.
- This benefit expires when the base plan expires.
- Premiums and banding are determined the same way as the base plan.

# Best Doctors® Services – HCC

With Health Coverage Choice from Sun Life Financial, clients can get access to Best Doctors an international medical referral network that can help them find the best medical care and can help confirm:

- if the diagnosis is correct,
- what will happen to the client,
- the best treatment available.

Best Doctors offers ongoing support and guidance so the client and their physician can make informed decisions about the client's health care. While insured, Best Doctors gives clients access to expert medical information and connects them and their treating physician with world-renowned specialists, through these unique services:

- Interconsultation™
- FindBestDoc™
- FindBestCare®
- Best Doctors 360°™

Detailed information about these unique services is available in the Best Doctors client brochure (810-3314), on the advisor website. This brochure is a valuable resource for HCC clients to keep, in order to reference the services available to them.

## Family use of Best Doctors services

Unlimited access to Best Doctors is available at no charge for the insured, their spouse and dependent children for as long as their coverage is in place. They don't need to have a diagnosis or make a claim to access these valuable services – help is available if they suspect they have a serious medical condition.[1]

Best Doctors contact information is provided along with the policy in the client's welcome package. The insured person will simply need to contact Best Doctors at 1-877-419-BEST (2378) and provide their policy number.

[1] Excludes mental, nervous and chronic pain conditions (e.g. fibromyalgia).

# Premium details – HCC

## DID YOU KNOW

Clients can pay their premiums by:

- Pre-authorized chequing withdrawals (PAC) monthly.
- Cheque annually.
- Credit card (monthly payment or annual payment).

## Premium rates

**The premium is determined according to the age of each insured person and the province where they live.** Sun Life Financial has the right to change the premium as long as we provide 45 days written notice to the policy owner.

- Rates are not guaranteed.
- When the insured moves into the next age band, the premiums will increase on their next policy anniversary.
- Sun Life Financial will review pricing annually. Changes in overall claims experience or major shifts in health care expenses could cause an increase in a client's premiums.
- If we need to increase rates, the client's premiums would increase at their next policy anniversary.
- Couple rates are charged on a per person basis – for example, if a man is over 65 and his spouse is under 65, they are charged the couple rate for their individual age bands.
- Rates may change from year to year. If they are going to change, clients must be provided notice within 45 days prior to the change.
- Discounts are not available for multiple sales.

### Grace period

**The grace period is 30 days for the payment of premiums and is allowed for each premium except the first.** During the grace period, insurance remains in force and premiums continue to be payable. The policy will be terminated when payment has not been made before the end of the grace period.

**TIP**

**Here's how to calculate the premium* for HCC plans:**

**Monthly premium =** premium rate for appropriate age band, province and plan type

**Annual premium =** multiply the monthly premium by 12

To find a client's premium rate, use the online illustration tool at www.sunlife.ca/personalhealth.

* Actual premiums are not guaranteed. They are subject to underwriting criteria and rates aresubject to change.

The age bands are the same for each province. They are:

| ISSUE AGE BANDS | RENEWAL AGE BANDS |
|---|---|
| Under 45 years of age | Ages 75 – 79 |
| Ages 45 – 54 | Ages 80 – 84 |
| Ages 55 – 59 | 85 years of age or older |
| Ages 60 – 64 | |
| Ages 65 – 69 | |
| Ages 70 – 74 | |

## Applications – HCC

Clients can apply for HCC by completing an application form online, either on their own or in person with you. Clients can also apply by paper application in person with you.

There are no medical requirements necessary to apply for HCC, except for the pre-existing conditions on the medical travel benefit.

**TIP**

To avoid a gap in coverage, clients can apply before their group coverage ends. Coverage will not be backdated.

## Web application

**To apply online, the clients simply need to visit www.sunlife.ca.** They would choose Products and services – Health insurance – Health Coverage Choice. This brings them to the main product page where they'll find all the necessary information about Sun Life Financial's Health Coverage Choice.

From here, they can choose "How do I buy it?" which leads to the "buy online" option when they're ready to apply. Before completing the online application form, clients will be asked to have the following items ready:

- The name of their group insurance company.
- Their group plan number and certificate number (these are the numbers that clients would have used when sending in a claim).
- The name and phone number of their employer.
- The birth date of their spouse and any dependant children included in the new plan. To be eligible, each person must have been included in the client's group plan.
- Either their chequing account information if having premiums withdrawn from their bank account or a credit card number and expiry date if they want to pay for premiums using their credit card (VISA and MasterCard are accepted).
- If the client chooses to pay by PAC complete form #E4392 Personal Health Insurance – Pre-Authorized chequing (PAC) authorization for Web applications.

Once the client has decided which plan suits their needs best, and has collected the information above, they'll be ready to complete their application online.

## Paper application

**To have clients apply for HCC, you'll need to complete form #E4065 called "Health Coverage Choice application form."**

Once completed, you or the client will need to mail this form along with a cheque marked "VOID" for monthly payments, or a cheque made payable for the annual premium, to:

Sun Life Assurance Company of Canada
Personal Health Insurance
227 King Street South
P.O. Box 1601 Stn Waterloo
Waterloo ON N2J 4C5

Note: If paying by Visa or MasterCard, the client should fill out the necessary information on the application and send to the above address. After we approve the application, we will contact them to obtain the credit card information.

### THINGS TO REMEMBER

- You need to provide the clients with the most up-to-date application forms to ensure they receive the most recent series of coverage. If you don't use the most recent application forms available, you may be asked to complete and re-submit an up-to-date application form.
- If a client chooses a PAC date that is different from the effective date of the policy, two full premium withdrawals will be processed in the first 30 days.
- Please advise the client to read their contract carefully. There are waiting periods on some benefits.

## Underwriting – HCC

- No medical evidence is required.
- Clients must apply within 60 days from the date that their group benefits end.
- Group benefits could have been with another carrier.
- If a client chooses the dental option, he/she must also have had dental coverage through his/her group benefits plan.

## General exclusions – HCC

**The following expenses will not be covered under any of the three types of plans:**

- expenses incurred, directly or indirectly due to civil disorder or war, whether declared or not; or service in the naval, military or air force of any country, combination of countries or international organization at war, whether war is declared or not,
- expenses that Sun Life Financial is not legally allowed to pay,
- services or items that are considered cosmetic or experimental,
- delivery, transportation and administration charges,
- services and products that are self-prescribed or are rendered or prescribed by a person who is ordinarily a resident in the insured person's home or who is related to the insured person by blood or marriage,
- services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program unless explicitly listed as covered under this benefit,
- services or supplies that are not approved by Health Canada or other government regulatory body for the general public,
- services or supplies that are not generally recognized by the Canadian medical profession as effective, appropriate and required in the treatment of an illness in accordance with Canadian medical standards,
- services or supplies that do not qualify as medical expenses under the Income Tax Act (Canada), and
- elective (non-emergency) medical treatment or surgery which is received or performed out of the province, and
- services received out of country for a pre-existing condition, where symptoms have appeared or required medical attention, hospitalization or treatment (this includes changes in medication or dosage), and existed during nine months prior to the trip, expenses related to this condition are not included.

Sun Life Financial will also not pay for intentionally self-inflicted injuries, while sane or insane.

## Making a claim – HCC

When the insured has incurred an eligible expense that is covered under the policy, the policyholder can either:

- submit a claim through their mobile device,
- submit a claim through web services at www.mySunLife.ca, or
- complete the appropriate form listed and send it to the address as per the details below.

**Eligible claims must be completed as follows:**

- While the policy is in effect, we must receive claims within 12 months of the date that the eligible expense was incurred.
- After the policy ends, we must receive claims within three months of the date the policy ended.

A few copies of the necessary claim forms will be provided in the client's welcome package.

## Mobile App

Before gaining access to submit a claim through the my Sun Life Mobile app, clients must register through www.mySunLife.ca.

With the mobile app, clients can use their smartphone to:

- submit claims (vision, paramedical, and dental claims, if applicable) for automatic processing and receive payment into their bank accounts within 48 hours,
- view information about recently submitted or processed claims,
- access their drug and travel cards (if applicable), and
- access interactive financial planning tools.

## Web services

Clients can manage their HCC plans online at www.mySunLife.ca to receive fast and efficient services, as well as:

- submit claims online (vision, paramedical and dental if applicable),
- get claim payments deposited into their bank account,
- print their claims form[1],
- view their coverage details and claims history, and
- view if a drug is eligible[2].

Clients who have registered for web services cannot change their address online but can contact the PHI administration team if the address shown needs to be corrected.

Please note access to web services will be available to clients only.

## How clients can register

Clients can register online at www.mySunLife.ca or by phone at 1-877-SUN-LIFE (1-877-786-5433). They will need to know their policy number (037000) and their ID number.

Please note that clients will be using the Group Benefits website to view their coverage. Although they may see Group Benefits verbiage that doesn't apply to HCC, the coverage details are correct.

Clients do not need to register if they already have Customer Access.

[1] For forms which require changes (such as a termination form), clients must contact the PHI administration team at 1-877-SUN-LIFE (1-877-786-5433) Changes to the plan such as an address change, adding or removing a dependant or adding or removing a benefit cannot be done on the website.
[2]For PHI clients with medical (non drug) exclusions, they can still see these benefits but there is a disclaimer on the website to indicate the contract will determine the level of coverage they may have.

### Questions?

If clients have administrative or technical questions with registering or needs to reset a password, please have them call 1-877-SUN-LIFE (1-877-786-5433).

## Dental and supplemental health claims

**To make a dental claim,** clients must use form #E4137 called "Dental claim form for personal health insurance."

**To make a health claim,** clients must use form #E4136 called "Extended health care claim form for personal health insurance."

You or the client can print the appropriate form directly from www.sunlife.ca/personalhealth – How do I make a claim?

Once completed, clients need to mail their form along with original receipts to:

Sun Life Financial
Health and Dental Claims
PO Box 3417 Stn D
Ottawa ON K1P 1G1

You should remind clients to keep a copy of the receipts for their records.

## Prescription drug claims

For prescription drug claims in all provinces except Quebec, clients simply need to use their Pay Direct drug card when purchasing their prescriptions. When the client presents their card to the pharmacist, the portion of their bill that is covered by their policy will be paid automatically.

If the client does not use his/her Pay Direct drug card at the pharmacy, the client will need to pay the full cost of the prescription and then submit a health claim form for reimbursement.

If the clients live in Quebec, their claims can be filed using form #E4136 called "Extended health claim form for personal health insurance."

Once completed, Quebec clients need to mail their form along with original receipts to:

Sun Life Financial
Health and Dental Claims
PO Box 3417 Stn D
Ottawa ON K1P 1G1

## Emergency travel medical claims

**To ensure payment of these expenses, clients should take the following steps:**

1. Call the 24-hour helpline listed on the emergency travel medical card or have someone call on their behalf immediately when an emergency occurs. Europ Assistance USA, Inc. will verify the client's health coverage and provincial health care coverage so payments can be arranged on behalf of the insured person, their insured spouse or their insured dependant.
2. An authorization form will need to be signed, allowing Europ Assistance USA, Inc. to recover any amount payable to the provincial health care plan.
3. The insured person is responsible for expenses incurred that are not covered under their plan or their provincial health care plan. The client will need to reimburse Europ Assistance USA, Inc. for any excess amount paid on their behalf.
4. If subsequent bills are received for these expenses, they need to be forwarded to Europ Assistance USA, Inc. and payments will be coordinated by Europ Assistance USA, Inc. with the provincial health care plan and Sun Life Financial.
5. To ensure travel dates are within the eligible 60 day period Europ Assitance USA, may request proof of travel (i.e. plane ticket, gas receipts, car rental receipts). In the case where proof is not provided, a claim may be denied.

# Benefit payments – HCC

## Payment of benefits

- Clients can manage their claim payments directly into their bank accounts by registering at www.mySunLife.ca. The payment amount is determined by applying the reimbursement percentage and then applying the maximums.
- Clients will be reimbursed for eligible expenses within approximately two weeks of Sun Life Financial receiving their claim form.

**How we calculate the amount of benefits that will be paid:**

1. We confirm all of the expenses that have been submitted are eligible for reimbursement.
2. We determine if there are any limitations which are described in the applicable provisions. If any of the expenses aren't eligible, we subtract that expense from the total amount claimed.
3. For each eligible expense, we compare:
   - the amount being claimed,
   - the customary charge for the expense, and
   - the maximum amount the client can claim as described on the plan summary page.

The client's reimbursement is based on the lowest of these three amounts.

# How direct deposit of claims payment works

Direct deposit of claims is only available to clients who have registered for web services. The following provides additional information on how direct deposit of claims will work:

- If each spouse has a separate policy, they will each need to register for web services.
- If a claim is submitted on a paper claim form and the client is registered for web services, payment will be deposited into the bank account[3].
- Changes to the banking information used to deposit a claims payment can only be made on the website. If the same bank account is used to pay premiums, a www.sunlife.ca Credit card authorization form #E4360 is required to change the bank account information where premiums are withdrawn.
- Clients who pay their premiums by cheque or credit card can have direct deposit. Clients just need to register and provide bank account details.
- A client cannot have direct deposit for one benefit and not the other (if the plan has both health and dental, direct deposit will apply to both benefits).

[3] When the payment is deposited, an email is sent to the owner informing them the claim has been processed and the owner can sign in to see the claims payment details.

# Post issue changes – HCC

## The following changes are permitted:

- The dental option can be removed at any time, however cannot be added back again at a later date.
- The dental option can be added within 60 days of group benefits ending.
- Dependants can be added as long as they meet eligibility requirements. A spouse can be added within 60 days of group benefits ending, and a newborn child can be added within 30 days of birth. An 'add family member' form must be completed to add a dependant.
- Changes to plan type are not permitted within HCC.

## DID YOU KNOW

- To add the dental option (within 60 days of group benefits ending), use form #E327 called "Personal Health Insurance – Add optional benefit."
- To remove the dental option, use form #E118 called "Personal Health Insurance – terminating coverage."

### Right to cancel a policy

Clients may cancel a policy at any time by sending a written request to Sun Life Financial's Waterloo office. 10 days' notice is required before cancellation to avoid an additional month's premium.

## TIP

Q: Can a client apply for both PHI and HCC?

**A: Yes,** but the client should indicate that he/she has submitted two applications. If we are not notified that two applications were submitted, it may be possible for HCC to be set up right away, causing the client to be billed before underwriting finishes their decision on the PHI application. We cannot backdate coverage.

## SUMMARY OF POLICY FEATURES – HCC

| Feature | Availability |
|---|---|
| Policy fee | None |
| Policy loans | Cash policy loans or automatic policy loans are not available |
| Withdrawal premium fund (WPF) | Not available |
| Non-withdrawal premium fund (NWPF) | Not available |
| Non-forfeiture option | Not available |
| Participating or non-participating | Non-participating |
| Cash values | None |

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