Understanding your travel benefit

A medical emergency while travelling can be a frightening and costly experience. But with your Sun Life Financial group benefits plan you'll have the protection you need and you'll have access to the expertise of our emergency travel assistance partner – Worldwide Assistance Services Inc. (Worldwide Assistance) 24 hours a day if you suffer an illness or injury while away from home.

When you travel

Before you leave, be sure to print a copy of your Travel Card. You can do so quickly and easily by logging on to our Plan Member Services website at www.sunlife.ca/member. All contact information is printed on your card.

At the time of a medical emergency, you or someone with you **must contact** Worldwide Assistance before receiving medical care. Any invasive and investigative procedures (e.g. surgery, angiogram MRI) must be pre-authorized by Worldwide Assistance, except in extreme circumstances. **Note**: If Worldwide Assistance is not contacted, your claim may be denied or payments limited for all expenses related to those emergency services.

What's the definition of 'emergency'?

Emergency means an acute illness or accidental injury that requires immediate, medically necessary treatment prescribed by a doctor. An emergency ends when you are medically stable to return to the province where you live.

What's the definition of 'emergency services'?

Emergency services mean any reasonable medical services or supplies including advice, treatment, medical procedures or surgery required as a result of an emergency.

When appropriate, WA staff will:

- refer you to a medical facility or physician,
- confirm your coverage and benefits,
- facilitate payments to a hospital or medical provider whenever possible.

Chronic pre-existing conditions

There are some emergency services you aren't covered for, or there may be limits and conditions that apply. Please ensure you read your employee booklet or visit our Plan Member Services website to understand your coverage. **Note:** When you or a family member has a chronic pre-existing condition, emergency services do not include treatment provided as part of an established management program for a chronic condition that existed before you left your province of residence.

Here are some examples of when emergency services would, and would not be covered:

1. A member has a chronic asthma condition that they manage with medication. While traveling abroad, they suffer an unexpected asthma attack and require emergency medical treatment. This treatment ***would*** be covered because it is an illness that requires immediate medical attention that can't wait until the member returns home to Canada.
2. A member with kidney disease requires regular dialysis treatments to manage their chronic condition. While traveling abroad, they are unable to access their regular treatment. In this case, any dialysis treatment or any medical emergency resulting from the absence of such treatment would ***not*** be covered. It is expected that the member would make arrangements for continued dialysis, as required, during their trip.

3. A member with a heart condition needs to take blood thinner medication and has to be monitored regularly to ensure that the clotting time of their blood is within the desired range (PT/INR monitoring). While traveling abroad, these monitoring visits would ***not*** be covered if they decide to go to a doctor's office to have their blood levels checked, as they are not considered to be an emergency service. However, if the patient ran into complications (i.e. develops a blot clot causing a stroke or embolism) and needed emergency care, the emergency services ***would*** be covered.

HealthTalk

Nine factors identify risk of heart attack

A major Canadian-led global study has found that the vast majority of heart attacks may be predicted by nine easily measurable factors and that these factors are the same in virtually every region and ethnic group worldwide.

The INTERHEART study looked at more than 29,000 people in 52 countries and from all inhabited continents of the world. The study was presented at the European Society of Cardiology (ESC) conference in Munich, Germany in August.

Nine risk factors - no matter where you live

The INTERHEART study found that nine risk factors account for 90% of the world's cardiovascular disease. This means that regardless of where you live in the world, or to which ethnic or cultural group you belong, the exact same factors predict your likelihood of developing cardiovascular disease. They are:

1. Smoking
2. Bad cholesterol (abnormal lipids)
3. High blood pressure (hypertension)
4. Diabetes
5. Size of your waistline (abdominal obesity)
6. Psychosocial factors (e.g. depression and stress)
7. Lack of fruits and vegetables
8. Lack of physical exercise
9. Level of alcohol consumption

“These risk factors appear to predict the majority of the risk in virtually every region, every ethnic group, in men and women and in the old and the young,” said Dr. Salim Yusuf, a professor of medicine at the Michael G. DeGroote School of Medicine at McMaster University. “This suggests that the message of preventing cardiovascular disease can be quite simple and, generally, similar across the world, after taking into account economic and cultural differences.

“Since these risk factors may all be modified, this is remarkable and will change the way we look at heart attack prevention. It means we should be able to prevent the majority of premature heart attacks in the world.”

Dr. Anthony Graham, cardiologist and spokesperson for the Heart and Stroke Foundation, said: “The Heart and Stroke Foundation recently reported that eight out of 10 Canadians have at least one risk factor for developing heart disease or stroke. Developing a better understanding of these risks and the root causes of heart disease and stroke through research, and sharing that information with the public is a priority for the Foundation.”

Dr. Alan Bernstein, president of the Canadian Institutes of Health Research said, “This is a landmark study. It suggests that a combination of lifestyle changes including stopping smoking, eating a healthier diet and exercising could lead to an 80 per cent reduction in the risk of heart attacks," he said. "The INTERHEART study provides the health research evidence needed to build national and international programs for the prevention and control of one of the leading causes of death in Canada and world-wide."

The World Health Organization, the World Heart Federation, and the International Clinical Epidemiology Network endorsed the INTERHEART study.

Based on a McMaster University Health Sciences press release. For more information go to

http://www.canadian-health-network.ca/servlet/ContentServer?cid=1099486425150&pagename=CHN-RCS/CHNResource/CHNResourcePageTemplate&c=CHNResource

Are you covered by more than one benefit plan?

Many people have coverage under more than one benefit plan – for example, their own plan plus their spouse's plan or a plan offered through their professional association. If this is your situation, you can use both plans when claiming expenses. This is called *coordinating your benefits*, and it's a great way to cover more of your costs.

The rules

The insurance industry has guidelines for how to coordinate benefits, to ensure claims are charged to the right benefit plan. Please note you can never receive **more** than the actual cost of a product or service (i.e. you can't claim the full amount of the expense under both plans. You can only claim under the second plan the portion that the first plan did not cover.)

Each time you submit a claim, simply check the 'yes' box on your claim form to show that you have other coverage. Remember to make copies of your receipts before you submit a claim.

If you are submitting an expense for yourself, you need to send it to your own benefit plan first then to your spouse's plan. Your spouse should submit their claims to their benefits plan first then to your benefit plan if there is any unpaid amount.

If you have children, the parent whose birthday falls earliest in the year sends the child(ren)'s claims to their plan first. For children whose parents have the same birthday, claims should be sent first to the plan of the parent whose first name begins with the earlier letter in the alphabet.

Important notes

Be sure to let your benefits administrator know about any changes to your covered dependents (e.g. if you get married, or have a child, or if your spouse gains or loses their own benefits plan).

If you have a drug card, remember to give your pharmacist the details of both your benefit plans so they can send claims to the right plan. If both you and your spouse have drug cards under your plans, the pharmacist can coordinate your benefits right at the pharmacy counter.

Examples of how benefits are coordinated

Jane and John get 100% of their expense	**Mark and Mary get less than 100% of their expense**	**Teresa and Tom get less than 100% of their expense**
Jane receives a therapeutic massage and is charged $37.50. Her benefit plan covers $20 per visit to a yearly maximum of $200. Jane's husband John also has a plan that covers the same service for the same amount. Both have already satisfied their annual deductibles and neither of them has reached their yearly maximums. In this case, Jane sends a claim form and the original receipts to her plan, and receives a $20 claim payment and a claim statement. John then submits a claim for the balance to his benefit plan. He sends a copy of Jane's claim statement and the expense receipt. His plan pays him the remaining $17.50.	Mark buys a pair of glasses for $500. His benefit maximum is $150. He submits a claim to his plan and receives a claim payment of $150. Mark's wife, Mary, then claims the remaining $350 from her plan. Her benefit maximum is $200. Therefore Mark and Mary are responsible for the remaining $150.	Tom submits expenses for $40, and $60 for a total of $100. His plan covers him at 50%. He submits a claim to his plan and receives a payment of $50. Tom's wife, Teresa then submits the claims to her plan. Her plan covers her at 80%. However, the $40 expense is not eligible under Teresa's plan so her plan will only coordinate benefits for the $60 eligible expense. Teresa's plan therefore covers $30 (which is the unpaid 50% of the $60 eligible expense). Note: While Teresa's plan covers her own claims at 80% she can only claim the remainder of Tom's eligible expenses up to a combined total of 100%.

Your drug card – making it work

Drug cards offer great advantages and convenience. There are no claim forms to complete and you don't have to wait for a cheque in the mail. To ensure your experience continues to be a positive one here are some ways you can make your drug card work for you and your family.

- Always carry your drug card with you and present it to the pharmacist when you drop off your prescription. Also, if you get a new drug card or there are changes to your benefit plan, be sure to let your pharmacist know. The pharmacist keeps a separate computer file for each individual patient, so ask him or her to update the files for all your family members at the same time.

- If you are the member whose benefit plan has issued the drug card (the **cardholder)**, it's important to register all eligible members of your family and let your plan administrator know of any life event changes (i.e. marriage, new child) so they can keep your records up to date.

- One of the most common problems is incorrect birthdates. It's vital that birthdates for you and your family are correct both at your pharmacy and in your benefit records. This

information acts like the PIN number on your bank card, linking all information together to process your claim, so if a date is incorrect it could result in not having your claim processed.

- Remember to include dependent children attending a post secondary school who still need to be covered. If their names are not on file, claims for their prescriptions will be declined. If you're not the cardholder, be sure to let your pharmacist know who the cardholder is, and what your relationship is to the cardholder.

My claim was declined
Having a drug card doesn't mean all drug claims are covered or that they will be covered at 100%. Be sure to review your benefit plan booklet so you understand how your drug card works and what is covered by your plan. Here are some examples as to why a claim may be declined.

- Your drug plan does not cover all prescription drugs on the market. It covers a defined list of drugs that have been selected by qualified pharmacists by Sun Life Financial's drug card provider. If the drug your doctor has prescribed isn't on the list for your plan, it won't be covered. You may want to discuss another option with your doctor before filling this prescription.
- Your pharmacist plays an important role in helping to manage drug care. If your pharmacist believes that your prescription may pose a health risk based on your health history or other medications you may be taking, they won't fill your prescription. For example, the drug prescribed may be a duplicate prescription or may have a negative interaction with another drug you're taking. When the pharmacist processes your drug claim, he or she will get an immediate message from our Pharmacy Benefit Manager letting them know if there is such a risk. They will then discuss the risk with you, and can suggest an alternate medication or consult with your doctor.

Remember drug plans have a lot of great benefits, however it's important that you work together with your benefits administrator and your pharmacist to ensure the plan works the best it can for you. Keep everyone updated on a regular basis and you won't be disappointed whenever you go to fill a prescription using your drug card.

Did you know?

You may have heard about "phishing," when companies identify themselves as reputable financial institutions and send unsolicited e-mail, or "spam", requesting personal information, banking information and/or credit card PIN and passwords.

We would never request your banking and/or credit card PIN and password information via e-mail. As your service provider, we take great care to protect your privacy, while making it easy for you to access information about your Sun Life Financial plans and accounts.

If you are suspicious of any e-mail, call the Sun Life Financial Customer Care Centre at 1-800-361-6212 and a representative will help you determine the authenticity of the e-mail.

What does *that* mean?

Dependent child

Your children and your spouse's children (other than foster children) are eligible dependents if they are not married or in any other formal union recognized by law and are under your plan's age limit (e.g. under age 22). Eligible children include stepchildren who live with you in a parent-child relationship as well as your natural children and legally adopted children.

An eligible child, who is over your plans' lower age limit and in school, could also qualify as a dependent until they reach the extended age limit (e.g. age 25). Students do not have to live with you or even attend a school in your province to maintain dependent status. However, they must be covered under a provincial medicare plan or federal government plan that provides similar benefits and must be unmarried and dependent upon you for support. Keep in mind that if your child is going to be attending school out of your home province, you have to apply to your provincial health care plan for extension of coverage.