

Health Navigator benefit navigation guidance

Your guide to simplified healthcare

Navigating the complexities of health insurance can be challenging. That's why Sun Life's Heath Navigator offers benefit navigation guidance, designed to empower you with the knowledge and tools needed to confidently manage your insurance plan and make informed healthcare decisions.

Key features of our benefit navigation guidance

Plan understanding: We help you decipher the differences between various plan types (HMO, PPO, POS, EPO) and explain key concepts like copays, coinsurance, and deductibles.

Provider network assistance: Our team assists you in finding in-network providers, including specialists and imaging centers, to maximize your benefits and minimize out-of-pocket costs.

Coverage clarification: We provide guidance on what services are covered, including preventive care, prescriptions, and specialized treatments like therapy sessions or home health care.

Cost estimation: Get a clearer picture of potential expenses for visits, tests, and procedures based on your specific plan details.

Claims support: If you encounter a denied claim, we'll guide you through the appeal process step-by-step.

Personalized guidance: Our Health Navigator Care Advisors are available to address your unique questions and concerns.

For personalized support, connect with a Care Advisor:

Call: 888-352-4969
Monday - Friday, 8:00 a.m. - 6:00 p.m. ET
Visit: sunlife.com/healthnav

Sun Life is committed to simplifying your healthcare journey, ensuring you can focus on what matters most – your health and well-being.

Remember, while this guidance offers valuable guidance, always refer to your plan documents or contact your insurance provider for details about your individual coverage. The Health Navigator team is here to provide personalized assistance and help you make the most of your health benefits.



Benefit Navigation Service Overview

Understanding your health plan

What is the difference between HMO, PPO, POS, and EPO plans?

- HMO (Health Maintenance Organization): In-network providers only, often require PCP referrals for specialists
- PPO (Preferred Provider Organization): Allows in- and out-of-network providers, no referrals needed
- POS (Point of Service): Hybrid of HMO and PPO; requires referrals but allows some out-of-network coverage
- EPO (Exclusive Provider Organization): Similar to PPO but typically doesn't cover out-of-network providers except for emergencies

What is a copay and coinsurance?

- Copay: Fixed amount paid for specific services (e.g., $25 for a doctor visit)
- Coinsurance: Percentage of total cost paid after meeting deductible (e.g., you pay 20%, insurance covers 80%)

What is a plan deductible?

The amount you pay out-of-pocket for covered services before insurance begins to pay. Some services, like preventive care, may be covered before reaching your deductible.

What are the trade-offs between high-deductible and low-deductible plans?

High-Deductible Plans: Lower monthly premiums, higher out-of-pocket costs initially. Often paired with Health Savings Accounts (HSAs)

Low-Deductible Plans: Higher monthly premiums, lower out-of-pocket costs. Better for frequent care needs

How can I acquire a copy of my plan documents?

Access plan documents by:

- Logging into your insurance portal
- Navigating to "Plan Documents" or "Summary of Benefits" section
- Calling customer service to request a copy

Key plan documents include:

- Plan Summary/Member Handbook
- Schedule of Benefits
- Summary Plan Description (SPD)
- Formulary / Drug List



Finding care

How can I find an in-network provider?

- Use the "Find a Doctor" or "Find Care" tool in your insurance portal
- Call the customer service number on your insurance card

Can you help me find an imaging center that takes my insurance?

To find in-network imaging centers and providers:

- Log into your insurance portal and use the "Find a Doctor" or "Find Care" tool
- Search on your insurance carrier's website for providers within your plan's network
- Call the member services number on your insurance card for assistance

What is the difference between in-network and out-of-network providers?

- In-Network: Contracted with your insurance, providing services at negotiated rates (lower costs)
- Out-of-Network: Not contracted, potentially leading to higher out-of-pocket costs and balance billing

What is a specialist?

A healthcare provider focusing on a specific area of medicine. Some plans require a referral from your primary care provider (PCP) to see a specialist.

Coverage and costs

Does my insurance cover this type of imaging?

Most imaging services, including advanced imaging (CT, MRI, etc.), are typically covered if deemed medically necessary. Note:

- Many plans require prior authorization before scheduling
- In-network imaging centers usually handle the authorization process
- For emergencies, the treatment facility will work with your insurance provider for approval

Do you know how much my co-pay will be for this visit or testing?

Find your deductible, co-pay, and coinsurance details in your plan documents under the summary of benefits section in your insurance portal. Remember, if your deductible hasn't been met, you may have higher out-of-pocket costs.

How many therapy (PT, OT, ST, etc.) sessions are covered in my plan?

Coverage for physical therapy (PT), occupational therapy (OT), and speech therapy (ST) varies by plan. Many plans have:

- Annual visit limits
- Referral requirements
- Prior authorization needs

Review your plan documents or contact member services for specific coverage details.

Is home health, skilled nursing, or rehabilitation covered by my insurance?
Most plans provide some coverage for these services, but it depends on:

- Medical necessity
- Prior authorization
- Network restrictions

Check your plan documents or contact your insurance provider for details on coverage limits, co-pays, and pre-approval requirements.

Helpful questions to ask your insurance company:

- How many days/visits are covered per year?
- Is pre-approval required?
- What co-pays can I expect?

Is this prescription covered by my insurance?
Prescription coverage varies by plan and drug formulary. To check coverage:

- Log into your insurance portal and review the plan's formulary
- Use the "Find a Drug" tool on your insurance provider's website
- Call member services for assistance

The "Formulary" lists all covered medications for the plan. If a prescription isn't listed, it may be "non-formulary," requiring prior authorization.

Common medication coverage terms:

- **PA (Prior Authorization):** Pre-approval required
- **QL (Quantity Limit):** Limits on dispensed amount
- **ST (Step Therapy):** May require trying a lower-cost medication first
- **PE (Plan Exclusion):** Not covered

Note: When prior authorization is needed, the pharmacy will notify the prescriber's office to submit necessary documentation.

What is included in preventive care?
Typically, it includes routine screenings, vaccinations, annual physicals, and certain tests at no cost when provided by in-network providers. Check your plan's guidelines for specifics.



Dealing with coverage issues

Can you help me get my insurance to cover ___?
Coverage depends on medical necessity, plan benefits, and network participation. If seeking coverage:

- Verify if prior authorization is required
- Check if it falls under your benefits
- If denied, you may have appeal rights
- Your provider's office may assist with authorization requests or appeals

For in-network provider denials, the provider often appeals proactively. For out-of-network providers, you may need to file the appeal yourself.

My insurance denied my procedure/treatment, but I think this should be covered. What can I do?
If your claim is denied:

- Check the denial reason on your Explanation of Benefits (EOB)
- Contact your insurance provider for details
- For in-network services, the facility may appeal on your behalf
- If unsuccessful, you may have additional appeal rights
- Contact your insurance provider to learn about options, including submitting medical documentation or requesting an external review

What are the steps for appealing a denied claim?

We can guide you through the appeal process. Here are the general steps:

- **Step 1: Review the Denial Notice**
  - Check your Explanation of Benefits (EOB) or denial letter
  - Identify the reason for denial
  - Note appeal deadlines (usually 30-180 days from denial date)
- **Step 2: Gather Supporting Documents**
  - Get a detailed bill from your provider
  - Request a letter of medical necessity from your doctor
  - Include relevant medical records and test results
  - Review your insurance policy to verify benefits
- **Step 3: Contact the Insurance Company**
  - Call customer service to discuss the denial and confirm the appeal process
  - Ask for a supervisor if needed for policy clarification
  - Document all communication
- **Step 4: Submit a Written Appeal**
  - Write a formal appeal letter including policyholder details, reason for appeal, and supporting documents
  - Send via certified mail or fax with confirmation
- **Step 5: Follow Up**
  - Expect a response within 30-60 days
  - Check status periodically
  - Document all communication
- **Step 6: Request a Second-Level Appeal (If needed)**
  - If the first appeal is denied, request a higher-level review
  - Some plans allow multiple appeal levels
- **Step 7: External Review (Final Step)**
  - If internal appeals fail, request an external review through appropriate channels
  - This decision is typically legally binding on the insurer

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