Group Benefits Solutions
from Health Association Nova Scotia

June 2015

Your Vision Benefit

The Health Association Nova Scotia vision care benefit is an enhanced vision care plan and very unique in the market today. People who require stronger lenses or whose visual acuity changes more frequently may be eligible to receive a much better benefit than what they would receive through a traditional vision Benefit.

Effective January 1, 2015, Health Plan members are covered under Manulife for the following eligible vision care expenses:

Eye Exams: Eye exams are reimbursed at Manulife's reasonable and customary (R&C) level. The total maximum eye exam (including retinal imaging) is once every two consecutive calendar years for you and your spouse, and once every consecutive calendar year for your dependents under age 21.

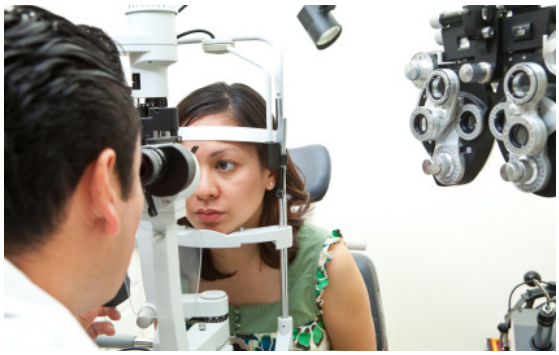
NEW.

- Vision Provider can submit Eye Exam electronically

- New Vision Claim Form

- Assignment of Benefits

More information on page 2…



Lenses and Frames: The Plan covers the R&C charges for prescribed lenses or contact lenses plus $150 for frames once every four consecutive calendar years for adults, or once every two consecutive calendar years for eligible dependent children under age 21. Prescribed lenses or contact lenses are covered more often if there is a *significant prescription change. If there is a significant change in prescription, during the four years (two years for dependents) coverage period, you cannot switch your claim between glasses and contact lenses. We recommend you discuss with your vision care provider.

Visual Training: Visual training services are covered as required for the treatment of ocular muscle imbalance, or other medical conditions(s) as approved by Manulife, to a lifetime maximum of $200 per person. These services are reimbursed at 100% of the eligible expense, as established and approved in advance by Manulife.

Laser Eye Surgery: Laser eye surgery is covered to a lifetime maximum of $200 per person.

** A significant prescription change is defined as meeting one or more of the following criteria:*

For Spectacles Lenses – 0.50 diopter in the sphere or cylinder; at least 10 degrees in the axis when cylinder is 2 diopters or less; at least 5 degrees in the axis when the cylinder is greater then 2 diopters; 1 diopter of horizontal prism (base in/out); 0.50 diopter of vertical prism (base up/down); 0.50 diopter in the ADD power.

For Contact Lenses – 0.50 diopter in the sphere or cylinder; at least 10 degrees in the axis when cylinder is 2 diopters or less; at least 5 degrees in the axis when the cylinder is greater then 2 diopters; 0.50 diopter in the ADD power.

How do I make a Claim?	Provider Submit/eClaims	Paper Claims
Eye Exam	**NEW**. Yes. Your vision care provider can submit electronically. ▪ You must be registered on the Manulife Plan member Website and signed up for direct deposit and electronic claims. Your provider must be registered with Telus Health. ▪ Your provider submits your eye exam electronically. Note: Lenses (glasses) or contacts cannot be submitted with the eye exam. If submitted electronically with your eye exam, your claim will not be processed, it will be returned to you to mail a paper claim and delay your reimbursement.	Yes. You mail the paper claim to the address on the claim form. ▪ If your provider is not registered for eClaims, you must submit a paper claim. ▪ If you require additional eye exams resulting from approved medical conditions you must submit a paper claim. ▪ You and your provider must complete the HANS customized vision care claim form and provide proof of purchase. ▪ The completed form and proof of purchase is mailed to the address on the claim form.
Lenses (glasses), or Contact Lenses We suggest you bring a Vision Claim Form with you when you visit your provider.	No. At this time, lenses or contact lenses cannot be submitted electronically by the provider or the plan member. If submitted electronically with your eye exam, your claim will not be processed, it will be returned to you to mail a paper claim and delay your reimbursement.	Yes. You mail the paper claim to the address on the claim form. ▪ You and your provider must complete the HANS customized vision care claim form and provide proof of purchase. ▪ The completed form and proof of purchase is mailed to the address on the claim form.
Assignment of Benefits	**NEW**. If your vision care provider agrees to wait for payment, you can assign reimbursement directly to them (section 3 of the vision claim form). You understand that the full fee might not be covered and costs may exceed plan benefits. You are financially responsible to the provider for the entire cost.	
Pre-Determination for Lenses and Frames	Pre-determination is not required. However, if you wish to know coverage and eligibility before purchase, you can request a pre-determination. Have your prescription available when you contact the Manulife Customer Service Centre toll-free at 1-855-626-4267.	
Online Purchases	For online purchases, the relevant prescription section of the vision claim form must be completed by the "prescriber" (i.e. optometrist or ophthalmologist) who would have the details of the current and any prior prescription. Prescription information and lenses must be submitted together, or, if lenses are not being ordered, a note from the prescriber advising the prescription lenses will be placed in the frames is required.	

If you have not already registered on the Manulife Plan Member site and set-up direct deposit, please go to www.manulife.ca/planmember and follow the instructions to register. If your provider is not registered please direct them to Manulife for details on setting up with the Telus network.

Claim forms are available on the Manulife Plan Member Secure Website www.manulife.ca/planmember or the Health Association Nova Scotia website, www.healthassociation.ns.ca/benefits/forms (copy attached to this bulletin).

If you have questions regarding your coverage or claims, please contact the Manulife Customer Service Centre toll-free at 1-855-626-4267.

If you have questions about your benefits, please call Health Association Nova Scotia at 1-866-886-7246.

This information is also available from our website. Visit www.healthassociation.ns.ca/benefits

HEALTH ASSOCIATION NOVA SCOTIA

Manulife

Group Benefits
Vision Claim

To make a claim, original receipts (not photocopies) must accompany this claim form.
Please keep a copy of your receipt(s) for your records, originals will not be returned.

1 Plan member information

To be completed by the plan member.

Plan contract number	Plan sponsor	Plan member certificate number
1472	Health Association Nova Scotia	

Plan member name (first, middle initial, last)	Date of birth (dd/mmm/yyyy)

Plan member address (number, street and apt.)	City or town	Province	Postal code

Are you, your spouse or dependants covered under any other plan for the expenses being claimed?

◯ Yes ◯ No If *yes*, please retain photocopies of all receipts submitted with this claim for submission to your secondary carrier. If this is your first claim, or if information has changed, please provide the following:

Spouse's date of birth (dd/mmm/yyyy)	Name of spouse's insurance company	Spouse's plan contract number	Spouse's plan member certificate number

Sign up for direct deposit and electronic claim statements

Receive your claim payments up to 70% faster with direct deposit and enjoy the convenience of seeing your claim statements online.

- Go to **www.manulife.ca/groupbenefits** and register for the plan member secure site
- Once you've registered, or if you're already registered, log into the secure site and select **Direct deposit for claims** from the menu to the left of the screen
- Enter your banking information

2 Provider statement

To be completed by provider.

Provider name	Provider number	Registration number

Company name	Licence number	Date of order (dd/mmm/yyyy)

Address (number, street and suite)	City	Province	Postal code

Telephone number	Fax number
( )	( )

Total charges billed to insurer	Patient name	Date of birth (dd/mmm/yyyy)
$		

For partial or subsequent eye exams exceeding the regular benefit, is the eye exam required due to a medical condition/disease? ◯ Yes ◯ No
If *yes*, state condition/disease.

Are specialty lenses required due to a medical condition/disease? ◯ Yes ◯ No
If *yes*, state condition/disease and provide a description of the specialty lens design required.

Benefit description			Date of service* (dd/mmm/yyyy)	Charge**
Eye Examination Specify type:				
Frame				
Lens	Right	Left		
Tinting				
UV Coating				
Anti-reflection Coating				
Plano Sunglasses				
Contact Lens	Right	Left		
Laser eye surgery Details:				
Other Description:				
			TOTAL	$

***Indicate the date goods paid in full.**

****The charge must be broken down by benefit description.**

2 Provider statement *(continued)*

Details of this prescription

	SPHERE	CYLINDER	AXIS	PRISM	BASE
Right					
Left					
ADD R					
ADD L					

Bifocal type ◯ Round ◯ ST

Type of **right** lens

◯ Single ◯ Bifocal
◯ Trifocal ◯ Hi index
◯ Aspherical ◯ Progressive

If changed, details of last prescription

Note: this information is not required if this is a new patient.

	SPHERE	CYLINDER	AXIS	PRISM	BASE
Right					
Left					
ADD R					
ADD L					

Bifocal type ◯ Round ◯ ST

Type of **left** lens

◯ Single ◯ Bifocal
◯ Trifocal ◯ Hi index
◯ Aspherical ◯ Progressive

Was a change in prescription required? ◯ Yes ◯ No

I hereby certify that the information on this form as well as on the documents attached, is true, accurate and complete.

Signature of provider | Date signed (dd/mmm/yyyy)

3 Assignment of benefits

I hereby assign my benefits payable from this claim to the named provider and authorize payment directly to him/her.

Signature of plan member | Date signed (dd/mmm/yyyy)

I understand that the fees listed in this claim may not be covered by or may exceed my plan benefits. **I understand** that I am financially responsible to my provider for the entire treatment. **I acknowledge** that the total fee of $_____ is accurate and has been charged to me for services rendered. **I authorize** release of this information contained in this claim form to my insuring company/plan administrator.

Signature of patient (Parent/Guardian) | Date signed (dd/mmm/yyyy)

4 Claims confirmation

NOTE - ORIGINAL RECEIPTS must be attached for all expenses.

Total amount of ALL receipts submitted $

I certify that I, my spouse and/or my dependants of minor or major age ("Dependants"), have received all goods or services claimed and that the information provided for this claim is true and complete. **I authorize** Manulife Financial ("Manulife") to collect, use, maintain and disclose personal information relevant to this claim ("Information") for the purposes of Group Benefits plan administration, audit and the assessment, investigation and management of this claim ("Purposes"). **I am authorized** by my Dependants to disclose and receive their Information, for the Purposes. **I authorize** any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with Manulife, its reinsurers and/or its service providers, for the Purposes. **I authorize** the use of my Social Insurance Number ("SIN") for the purposes of identification and administration, if my SIN is used as my plan member certificate number. **I agree** a photocopy or electronic version of this authorization is valid. **I understand** that Manulife's Privacy Policy and Privacy Information Package are available at **www.manulife.ca/planmember**, or from my Plan Sponsor.

Please sign here

Signature of plan member | Date signed (dd/mmm/yyyy)

Any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a Group Benefits health file. Access to your Information will be limited to:

- Manulife employees, representatives, reinsurers, and service providers in the performance of their jobs;
- persons to whom you have granted access; and
- persons authorized by law.

You have the right to request access to the personal information in your file, and, where appropriate, to have any inaccurate information corrected.

5 Mailing instructions

Please mail your completed claim form and receipts to the appropriate address.

If you live outside Quebec:
Manulife Financial Group Benefits
Group Claims Department
PO BOX 1653
WATERLOO ON N2J 4W1

If you live in Quebec:
Manulife Financial Group Benefits
Group Claims Department
PO BOX 2580 STN B
MONTREAL QC H3B 5C6