Recognizing fraud and abuse

Pay the "out-of-pocket" portion of your benefits claims

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Many group benefits plans require you to pay a portion of your health or dental claims.

These out-of-pocket payments encourage you to:

- seek good value in the medical services you pay for and the medical supplies you buy, and
- only claim for services and supplies that you truly need.

They also help your employer keep your group benefits plan affordable by sharing some of the health costs. Employers can structure these out-of-pocket payments in several ways:

- **Co-insurance payment.** This is when you pay a fixed percentage of the claim cost. For example, you might pay 20% of the cost, and through the benefits plan, your employer pays 80%.
- **Deductible.** Your benefits plan reimburses you for amounts above a certain deductible amount. The deductible is the amount of money that you must contribute to your health costs before we pay your claim.
- **"Per visit" maximum.** This is when your employer pays 100% of the cost up to a certain dollar amount. You pay any amount above this maximum. For example, your employer might pay the first $40 of any treatment. And you cover the rest (if there is any).

Any cost sharing within the benefits plan is part of the benefits plan agreement between the insurer and the plan sponsor. Health-care providers do not have a role in this.

Out-of-pocket payments and benefits fraud and abuse

Benefits fraud or abuse occurs when a plan member doesn't actually pay the out-of-pocket portion of their health expense. Here's an example of how this can happen.

Let's say you receive a $100 physiotherapy or massage therapy treatment. Your plan reimburses at 80%, leaving you to pay 20% of any treatment cost. Be aware of health care providers who offer any of the following arrangements.

Mismatched receipt	Cash back	Waive the amount owing
The provider collects $80 from you and issues you a false receipt in the amount of $100. In this way, you will not be out of pocket when you receive reimbursement from your benefits plan.	The provider issues you a receipt in the amount of $100 and you pay $100 (perhaps by credit card). The provider then gives you $20 back in cash. This ensures you will not be out of pocket when you receive reimbursement from your benefits plan.	The provider submits the $100 expense to Sun Life electronically (and receives $80 directly from Sun Life). But they waive the $20 amount that you are supposed to pay.

In each of these cases, the benefits plan (and your employer) are a victim of fraud. That's because the amount charged and claimed has been misrepresented. In all the cases above, the "true" cost of the service is $80, not $100. That means the benefits plan is overpaying for the services you received.

Why fraud matters

These examples of benefits fraud and abuse increase costs to your benefit plans. This can result in future cuts to benefits coverage due to these higher plan costs. In addition, such actions can have employment consequences. We notify plan sponsors if we find plan members who are participating in these types of schemes.

There are consequences to health care service providers as well. We may delist those who promote these schemes. This means that we reject any future claims involving these providers.

The problem with incentives

Another example of plan abuse is the use of inappropriate incentives by health care vendors and providers.

Some providers and vendors of medical equipment will promote incentives to encourage purchases. An example of an inappropriate incentive is giving free merchandise (like a pair of shoes, clothing, or handbags). It may also include things like gift cards or cash back.

Some providers inflate the cost of the medical supply or service to cover the cost of providing the incentive. In other cases, providers will issue a receipt that does not accurately represent the service or product provided. This is done to cover the cost of the incentive. The patient receives an inferior product in order for the benefits plan to pay for the incentive. This can be fraud through misrepresenting the product and its value.

Inappropriate incentives can lure plan members into purchasing medical products and services that may not be medically necessary. Plan members who take advantage of such "deals" do so at the expense of their benefits plan.

How to protect yourself and your benefits plan

Here are four simple steps that can help protect both you and your benefits plan from fraud or abuse.

Tip 1: Check your coverage to understand what amounts you must pay that aren't reimbursed under your benefits plan.

Tip 2: Choose vendors that do not offer inappropriate incentives.

Tip 3: Report service providers and vendors who offer to waive amounts not covered by your benefits plan.

Tip 4: Check your explanation of benefits to confirm the services and products you received are accurate.

Benefits fraud and abuse is everyone's business. Do your part to help protect your plan and your future coverage. Learn more about group benefits fraud, visit **fraudisfraud.ca** and **sunlife.ca/fraudmanagement**.

Report suspected fraud

If you are suspicious of any activity regarding your benefits plan – please contact Sun Life's Fraud Tip Line. Call toll free at **1-888-882-2221** or email at **clues@sunlife.com**.

Sun Life's role in fighting fraud

Sun Life has a comprehensive fraud prevention, detection and investigation program and a zero tolerance policy for fraud. We continue to invest in anti-fraud technologies and resources to help protect you, your employer and your benefits plan.

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