

Claim Filing Procedures

(Accident and Sickness claims only)
especially created for

Please submit clear copies or originals of all required paperwork.

Although the claims process is simple, it **requires YOUR PARTICIPATION**. Please follow the instructions below so that we may process your claim on a timely basis.

An ID card is included with your certificate – please carry it with your major medical ID card. When visiting a provider, present both cards. Providers can then verify both your major medical and supplement coverages, and know where to submit claims for processing. Although every provider has their own procedures for deductible expenses, presenting the card should alert them to the fact that you have a supplemental plan designed to alleviate you having to pay this expense up front. Encourage your provider to contact our customer service department if they have questions as to how the plan works and we will be happy to assist.

For covered Physician visits, In Patient Hospital Confinements, and Out Patient Services, **SIS will need the following in order to process your claim:**

1. A completed claim form. A form is not required for every physician visit, however, we will need at least one in your file annually. Remember to include a completed claim form with your first submission for each year. Be sure to complete the Statement of Insured on the claim form, sign and date the authorization section, and sign and date the claim form for your dependent children (if covered and submitting a claim on their behalf).
2. A copy of the original itemized bill. If your provider has not submitted this directly to us, it is up to you to obtain a copy and submit it for claims processing. The itemized bill must show the diagnosis for your visit, date of service, itemized charges, and the name/address/tax ID of the provider. **A balance due statement is not sufficient.**
3. A copy of the explanation of benefits from your major medical carrier that corresponds to each itemized bill. This is the statement from the primary carrier that tells what charges they are paying, denying, or applying to deductibles, etc. If you participate in an HMO, you will most likely not receive an explanation of benefits. In this case, please be sure the itemized bill you submit includes any HMO payment amount, discounts, write offs, or copays that were paid to the provider.

You may fax or mail these items to:

ATTN: Claims Department
Special Insurance Services, Inc.
P O Box 250349
Plano, TX 75024-0349
Fax: (972) 960-0377 or (214) 291-1301

SIS Customer Service: (800) 767-6811 or (972) 788-0699

IMPORTANT!! The Out Patient benefit is a per person, per sickness or injury benefit subject to a maximum of four (4) occurrences* per person/per family per calendar year. If you have dependents enrolled, all of you together are only entitled to four (4) out-patient benefits per calendar year. Please remember this and contact SIS if you have questions. For more information on how to use your out-patient benefit to your best advantage, please see the reverse side of this form.

*An occurrence is the treatment of, or series of treatments for a specific medical condition, illness, or injury. If, however, you are treatment-free for any specific medical condition, illness or injury, for more than 90 days, you may qualify for another out-patient "occurrence" under the policy.

ITEMS NOT COVERED: *Certain items may not be covered under this plan, including, but not limited to: wellness expenses (physicals, pap smears, mammograms, prostate exams, etc.), unless wellness coverage was purchased, prescription drugs, durable medical equipment, vision expenses, and dental expenses. Please refer to your individual certificate for details.*

USING YOUR OUT-PATIENT BENEFITS WISELY

The out-patient benefit will pay, up to maximum benefit elected, for covered expenses applied to your major medical deductible (including co-pays) or coinsurance percentage. This benefit is a “per occurrence” benefit with a calendar year limit of 4 occurrences per family unit. If you, or your covered dependent have an out-patient lab procedure that, in the absence of this benefit, would cause you to be out of pocket a fairly small amount, you might want to consider not having the provider bill us, and pay the provider yourself. This way, you will not use all of your occurrences or events up early in the calendar year for small items, then realize you do not have anything left to help offset that large item you need it for at the end of the year. If you do not have any large items come up, you can always file for reimbursement of your previous items at the end of the calendar year.

The following illustration, which is based on an out-patient benefit of \$1,000, may help you understand this benefit better:

In January - you go in to doctor for the flu. You have \$100 in x-ray charges assessed, all of which are applied to your deductible.

In March – you go to the doctor for strep throat. You have \$80 in lab charges assessed, all of which are applied to your deductible.

In July – You go into the hospital for surgery. You meet deductible at this point.

In August – you go to doctor because you have an eye irritation. The doctor runs a lab culture to rule out pink-eye. Your 20% coinsurance amount is \$10 for this service.

In October – You go to the doctor because you are feeling tired, and the doctor runs blood work. Your 20% coinsurance for this service is \$20.

If at this point, either you, or your provider, file for reimbursement of the January, March, August and October events, as they occur, you will have used all four of your occurrences for the calendar year.

If you then injure your knee in December and have an MRI and subsequent arthroscopy, totaling \$5,000, of which your 20% share would be \$1,000, you would have no further out-patient benefit to assist you with the large bill. Had you waited on filing the original four items, you would have had \$1,000 of this expense paid by this plan, and you could have then filed three of the other events at your choosing. See the following table.

Events filed as they occur:			Events filed at end of year after Dec event		
<u>EE Portion</u>	<u>Pd by this Plan</u>	<u>EE Balance</u>	<u>EE Portion</u>	<u>Pd by this Plan</u>	<u>EE Balance</u>
\$100	\$100	\$0	\$1,000	\$1,000	\$0
\$80	\$80	\$0	\$100	\$100	\$0
\$10	\$10	\$0	\$80	\$80	\$0
\$20	\$20	\$0	\$20	\$20	\$0
\$1,000	\$0	\$1,000	\$10	\$0	\$10
\$1,210	\$210	\$1,000	\$1,210	\$1,200	\$10

In the above example, your wise use of your benefit would have meant the difference between being out of pocket \$1,000 or \$10.

It is important to note, that if you present your ID card to a provider and execute an “assignment of benefits”, the carrier is obligated to honor that assignment of benefit and must pay the provider, whether or not you pay the provider at the time of service. By taking an active role in your healthcare usage, and choosing when and when not to use your assignment of benefits option, as well as when and when not to file for benefits in accordance with your own financial needs, you can maximize your out-patient benefits to the fullest.