Claims and Reimbursements

In this section, you'll find the basics on claim filing, including information about the Explanation of Benefits (EOB) statement and the Coordination of Benefits (COB) process. The information that follows is an overview; for more details, refer to the Membership Agreement, or other Plan document for your plan.

Receipt and Processing

We need to receive claims within 180 days from the date services or supplies were received; otherwise we will not provide reimbursement.

Care Received from Participating Providers

In general, members should not receive bills from participating providers. This is because participating providers bill ConnectiCare directly for their services, which eliminates paperwork for our members. If a member does receive a bill from a participating provider, it probably means more information is needed. The member should call the provider immediately to find out what is required. The participating provider will then bill us directly and remove the member's name from the billing system if the member has no financial responsibility.

If the member receives a second billing notice, he or she should call Member Services at **(860) 674-5757** or **1-800-251-7722**. For members covered under self-funded plans, call **(860) 674-2075 or 1-800-846-8578**. You can also visit our website at **www.connecticare.com**.

Care Received from Nonparticipating Providers

Members may receive care from nonparticipating providers if:

- They are members of a Point-of-Service plan.
- They need emergency care (as defined under the Emergency Care section.)

These claims must be submitted to us within 180 days at the following address:

Massachusetts:
ConnectiCare of Massachusetts, Inc. & Affiliates
175 Scott Swamp Road
P.O. Box 522
Farmington, CT 06034-0522

Connecticut:
ConnectiCare, Inc & Affiliates
175 Scott Swamp Road
P.O. Box 546
Farmington, CT 06034-0546

Information Required
The claim should include:

- The subscriber's name.
- The name and ConnectiCare ID number of the person who received the care.
- A complete, itemized bill that describes the services provided and the diagnosis. Note that charge card receipts and "balance due" statements are not acceptable.
- A copy of the written pre-authorization letter issued by us or our Behavioral Health Program. If the care did not require pre-authorization, an explanation of why care was sought from a nonparticipating provider (i.e., that the care was emergency or urgent care received 30 miles outside the ConnectiCare service area) should be provided.

Foreign Claims

If the claim is for emergency or urgent care received outside the United States, the member will need to ensure:

If the care received was provided in another country the following measures must be taken:

- The itemized bill is written or translated in English, and
- It shows the amount paid in U.S. dollars.

It also can be helpful for the member to provide a charge receipt with the itemized bill.

Coordination of Benefits

If a member is eligible to receive benefits under another plan — including group HMOs, Medicare, Workers' Compensation and employer-sponsored medical plans — Coordination of Benefits will apply. A member's ConnectiCare benefits will be coordinated with the other plan's benefits.

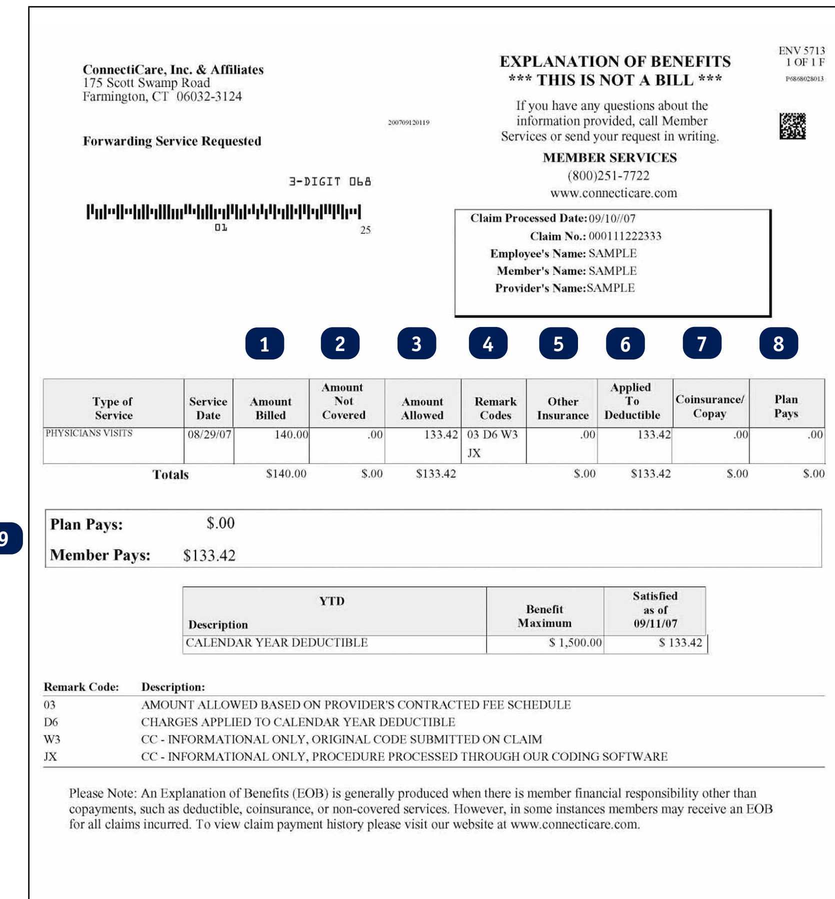
When ConnectiCare is the secondary plan, the member must send us a copy of the Explanation of Benefits (EOB) statement received from the primary plan, along with the claim form. If we receive a claim without an EOB from the primary plan, we will deny the claim. It is the member's responsibility to ensure that the claim is processed with the primary plan. If we are the secondary carrier, the member has 180 days from the date the primary plan processed the claim to submit the claim to us. The rules and guidelines for Coordination of Benefits are described in the Membership Agreement, or other Plan document for your plan.

The Explanation of Benefits (EOB) Statement

Members will receive an Explanation of Benefits (EOB) statement according to the following guidelines:

1. For claims from in-network providers, an EOB is issued whenever the member has financial responsibility other than a fixed cost (e.g., coinsurance, deductibles, etc.)
2. All claims from nonparticipating providers will generate an EOB.

Sample Explaination of Benefits Form



ConnectiCare, Inc. & Affiliates
175 Scott Swamp Road
Farmington, CT 06032-3124

Forwarding Service Requested

200709120119

3-DIGIT 068

01 25

EXPLANATION OF BENEFITS
***** THIS IS NOT A BILL *****

ENV 5713
1 OF 1 F
P6868028013

If you have any questions about the information provided, call Member Services or send your request in writing.

MEMBER SERVICES
(800)251-7722
www.connecticare.com

Claim Processed Date: 09/10//07
Claim No.: 000111222333
Employee's Name: SAMPLE
Member's Name: SAMPLE
Provider's Name: SAMPLE

Type of Service	Service Date	Amount Billed (1)	Amount Not Covered (2)	Amount Allowed (3)	Remark Codes (4)	Other Insurance (5)	Applied To Deductible (6)	Coinsurance/ Copay (7)	Plan Pays (8)
PHYSICIANS VISITS	08/29/07	140.00	.00	133.42	03 D6 W3 JX	.00	133.42	.00	.00
Totals		$140.00	$.00	$133.42		$.00	$133.42	$.00	$.00

(9)
Plan Pays: $.00
Member Pays: $133.42

YTD Description	Benefit Maximum	Satisfied as of 09/11/07
CALENDAR YEAR DEDUCTIBLE	$ 1,500.00	$ 133.42

Remark Code:	Description:
03	AMOUNT ALLOWED BASED ON PROVIDER'S CONTRACTED FEE SCHEDULE
D6	CHARGES APPLIED TO CALENDAR YEAR DEDUCTIBLE
W3	CC - INFORMATIONAL ONLY, ORIGINAL CODE SUBMITTED ON CLAIM
JX	CC - INFORMATIONAL ONLY, PROCEDURE PROCESSED THROUGH OUR CODING SOFTWARE

Please Note: An Explanation of Benefits (EOB) is generally produced when there is member financial responsibility other than copayments, such as deductible, coinsurance, or non-covered services. However, in some instances members may receive an EOB for all claims incurred. To view claim payment history please visit our website at www.connecticare.com.

The numbers below correspond to those on the sample EOB statement shown.

1. The actual amount billed by the provider of service.

2. The portion of the claim that has been denied or the portion that exceeds the "Amount Allowed." See "Member's Responsibility" for the amount the member must pay, if any.

3. The amount the provider agreed to accept as payment in full. The member is not responsible for the difference between the "Amount Billed" and the "Amount Allowed."

   If the member used a nonparticipating provider: The maximum allowable amount, as defined by ConnectiCare, the member may be responsible for is the difference between the "Amount Billed" and the "Amount Allowed."

4. Further explanation of how the claim was processed.

5. If covered by more than one insurance plan, the amount paid by that other plan.

6. If the benefit plan has a deductible requirement, this will reflect the amount applied to the deductible.

7. The portion of the "Amount Allowed" that the member is responsible for, not including the deductible.

8. The amount the plan is responsible for paying the member or the provider of service. This amount includes any provider and health plan risk share amount under their contract.

9. The amount the member owes (or has already paid) to the provider. It includes the "Amount Not Covered" (if applicable); the amount "Applied to Deductible" and "Coinsurance/Copay" amounts.

Questions, Grievances and Appeals

The information that follows is an overview. For more details, refer to the Membership Agreement, or other Plan document for your plan.

Questions and Complaints

Most questions or complaints can be resolved informally. If a member has a question or complaint, his/her first step should be to call our Member Services Department at **(860) 674-5757** or **1-800-251-7722**. For members covered under self-funded plans, call **(860) 674-2075** or **1-800-846-8578**. You can also visit our website at **www.connecticare.com**.

Or you can write to us at:
ConnectiCare, Inc.
Member and Provider Services
175 Scott Swamp Road
P.O. Box 4050
Farmington, CT 06034-4050

Representatives are available Monday through Friday during regular business hours.

The Appeals Process

If the question or complaint can't be resolved informally, the member may use the appeals process. This process is available to members who disagree with a decision we've made regarding:

- covered health services,
- benefits,
- pre-authorization or pre-certification, or
- claims processing.

Details regarding the appeals process are provided within the Membership Agreement, Evidence of Coverage, or other Plan documents.Representatives are available Monday through Friday during regular business hours.