

HOW TO FILE A MEDICAL CLAIM

You will receive a *plan* identification (ID) card. It will show *your* name, group number and the effective date of *your* coverage.

In-*Network* provider bills should be sent to the *Network* address on *your* ID card. **The *claims administrator* does not require special claim forms.** You can mail the bills directly to the *claims administrator* if the provider does not forward them. Mail the bills to:

For Plan A Medical Benefits:
UMR, Inc.
Attention: Claim Department
UMR, Inc.
2700 Midwest Drive
Onalaska, WI 54650-8764

For Plan B Medical Benefits:
Community Health Choice
P.O. Box 301412
Houston, TX 77230-1412

Be sure each bill shows the group number and participant number found on *your* ID card. The *employee's* name and the patient's name should also be included on each bill.

MISCELLANEOUS MEDICAL CHARGES

Bills for medical items *you* purchased yourself should be sent to the *claims administrator* at least once every three months (quarterly). Make sure each receipt includes: the group number, participant number, *employee* name, patient name, name of prescribing *qualified practitioner* and date purchased.

PAYMENT OF CLAIMS

The *plan* will make direct payment to the service provider. If *you* have paid the bill, please indicate on the original bill "paid by *employee*" and payment will be made to *you*. You will receive a written explanation of payment or reason for denial of any portion of a claim. The *plan* reserves the right to request any information required to determine benefits or process a claim. You or the service provider will be contacted if additional information is needed to process *your* claim.

CLAIM FILING LIMITS

You must provide the *plan* with written proof of *your* claim. Proof should be provided within 90 days after the date the claim was incurred. *Your* claim will not be denied if it was not reasonably possible to give such proof. However, unless *you* were legally incapacitated during the period, any claim received by the *plan* more than 15 months after the date the claim was incurred will not be covered under the *plan*.

If the *plan* is terminated, written proof of any claims incurred prior to the termination must be given to the *plan* within 90 days of its termination. Any claim received by the *plan* more than 90 days after it is terminated will not be covered under the *plan*.