Frequently asked questions: CLAIM PROCESSING

Understanding plan benefits and claim processing issues can sometimes seem confusing and frustrating. We hope you find the answers to these frequently asked questions helpful and informative.

Q: Who do I call with questions about the plan and my claim for benefits?

A: Call our customer service department using the telephone number on the back of your ID card. Customer First Representatives are available Monday through Friday between the hours of 8 a.m. and 5 p.m. in your geographic area. UMR is also available 24/7 for customer service through our chat feature found on the member portal at **umr.com**.

Q: What if I have special language needs?

A: If English is not your primary language, we can assist you or your family members with questions about your health benefits. To find out about our translation services, please contact our customer service department.

Q: How long does it take to process a claim?

A: A complete claim is typically processed within 30 days of the receipt of the claim.

Q: What is meant by a complete claim?

A: A complete claim means that the plan has all the information that is necessary to process the claim. From time to time, we may contact you with requests for additional information to complete your claim for benefits.

Q: Why did I receive an explanation of benefits (EOB) stating my claim for benefits was denied because other insurance coverage information is needed?

A: We periodically need to know if you have other insurance coverage. This information assists us in coordinating your benefits (see "What is coordination of benefits?").

Other insurance information is updated on a yearly basis. You can update this information by visiting **umr.com** and logging into the member portal. You can also call our customer service department to let us know if you have other coverage. A representative will take your information over the phone and reprocess any denied claims.

Group health plans do not coordinate benefits with insurance coverage that has been obtained on an individual basis. (This includes Champus, CHIP and Medicaid.) Refer to your summary plan description's coordination of benefits provision for details.

Q: What is coordination of benefits?

A: Coordination of benefits (COB) applies whenever you have insurance coverage (group medical or dental) under more than one plan. For example, you have health insurance coverage through Medicare and your employer.

Coordination of benefits ensures the proper plan (the primary plan) pays first on a claim for benefits. The secondary plan may then pay an additional amount. The purpose of coordinating benefits is to help you pay for covered expenses, but not to result in total benefits that are greater than the covered expenses incurred.

Q: Why did I receive an explanation of benefits (EOB) stating my claim for benefits was denied because accident information is needed?

A: The claim for benefits most likely contained information indicating that the claim may be accident related. When these types of claims are identified, a questionnaire is generated asking if you have received treatment for an injury or illness that may be accident related.

You must complete and return the questionnaire for us to know if your claim(s) are accident related. If you indicate that your claim was for an illness or injury that was not caused by another person or party, we will reprocess your claim for benefits. If you indicate your claim was for an illness or injury that was caused by another person or party, and you have signed the reimbursement agreement (if required by your plan), we will reprocess your claim(s) for benefits and pursue the plan's right of reimbursement of the medical bills paid by the plan.

Q: What is subrogation?

A: If you incur charges as a result of an accident, illness or injury caused by an act or omission of another person or party, the plan has a right to recover benefits paid from the person or party responsible for the accident, illness or injury. By accepting benefits from the plan, you agree to cooperate fully with the plan and its right to recover the benefits paid.

The plan's subrogation/reimbursement provision helps to reduce the cost to your employer of sponsoring a group health plan. It also reduces the amount of benefits applied to any plan maximums (if applicable) and conserves benefits for future covered expenses.

Q: What can I do if I have a problem or complaint?

A: We hope you will be completely satisfied with your group benefit plan and our administration of your plan's benefits. However, if you are not and have a complaint or problem or wish to dispute a coverage decision, please call our customer service department. If we cannot resolve the issue to your satisfaction, you have access to the plan's appeal procedure, or other options may be available to you. The appeals procedure is described in your plan's summary plan description.

Q: Will my health care information be kept private?

A: Absolutely. UMR is fully committed to protecting the privacy of your health information, known under federal law as protected health information (PHI). We encourage you to consult your summary plan description to review our policies or call our customer service department if you have any questions about our privacy practices.

Q: How do I provide the information being requested from me?

- Log onto our website **umr.com** or email us by clicking the "Contact us" button (after logging in to the member portal);
- Use our interactive voice response (IVR) telephone system; or
- Call our customer service department using the phone number on the back of your ID card

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