HEALTH REIMBURSEMENT ACCOUNT

How Your HRA Works

Prepared for County of Washington

Your employer has agreed to pay a portion of your in-network deductible through a health reimbursement account.

How Your HRA Works

When you receive health care services such as lab work, X-rays, hospital care or other medical procedures, show your medical insurance card.

- Your provider will send your claim to your health plan for processing.
- These claims are automatically submitted to your HRA and paid to you/your in-network provider.
- Your HRA pays for deductible expenses only, not copays.

Looking at Your Account

You can check your account balance and payments at your member website, **highmarkbcbs.com**.

- Go to the **Claims** tab to view your claims.
- Click the arrow in the claim to see details and download your Plan Activity Statement.
- This statement lists the claims paid from your HRA and your current balance.

Community Blue/PPO and Your HRA

	In-Network		Out-of-Network	
Benefit Level	**Individual**	Family	**Individual**	Family
Medical Plan Deductible (Plan begins paying when claims total this amount.)	$1,250	$2,500	$2,500	$5,000
	Order of Payment			
Member Pays First (Before HRA begins paying)	$500	$1,000	n/a	n/a
HRA Pays Remaining	$750	$1,500	n/a	n/a

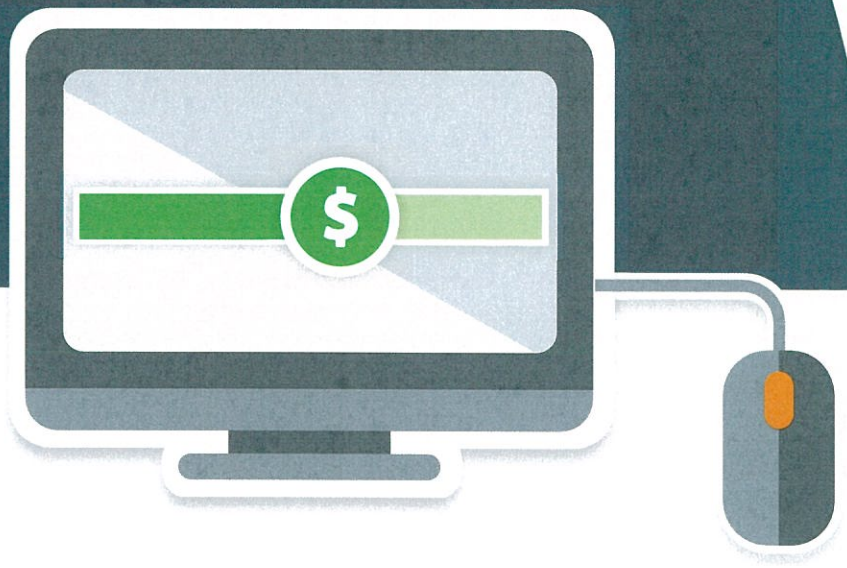
Notes on Family Coverage:

- An individual within a family has an amount he or she must pay first, before the HRA begins paying.
  1. Once an individual family member pays $500 the HRA will begin to pay their claims.
  2. Once an individual's payment, plus the HRA payments, total the Medical Plan individual deductible, $1,250 the Medical Plan will begin paying for that person.
  3. The HRA will pay the rest of the HRA money – to a total of $1,500 – for other family members until the combined total reaches the Medical Plan family deductible of $2,500.
  4. The HRA doesn't pay for out-of-network expenses; if you use in-network providers, you will pay far less out of pocket.

If you have any questions about your HRA plan, please call the Member Service phone number listed on the back of your medical insurance card.

SPENDING ACCOUNT

Plan Activity Statement



The Plan Activity Statement makes it easy for you to find the information and answers you need — and it's right on your member website, **highmarkbcbs.com**.

Claims and Spending Details in One Statement

The Plan Activity Statement shows both claims information and spending account activity in a single user-friendly statement. This applies if you're enrolled in both medical coverage and a health spending account, including:

- Health Savings Accounts (HSAs)
- Health Reimbursement Accounts (HRAs)
- Medical Flexible Spending Accounts (FSAs)

Find Your Statements Online

Log in to your member website to download your Plan Activity Statement.

- Click the **Claims** tab.
- Find the expense you want to review.
- Click the **arrow** to display details.
- Click on the **link** to download the Plan Activity Statement.

Follow these steps to request email notification when a Plan Activity Statement is available:

- Click on **Your Account** in the upper right of the home page.
- Choose **Account Settings** from the dropdown menu.
- Click on **Contact Preferences** to select your communications preferences.

Easy to Read and Understand

The Plan Activity Statement gives you a clear, all-in-one view of what services have been performed, what they cost, what has been paid and the amount you may owe.

The Plan Activity Statement information includes:

- **Medical Claims** that have been submitted, reviewed and paid, and what you may still owe for medical services
- **Expenses** that have been submitted, processed and paid from a spending account
- **Year-to-date progress** toward your deductible and out-of-pocket maximums, both in-network and out-of-network

Learn more about it

View the Plan Activity Statement video.
Go to the **Spending** tab and click the link to **Educational Materials**.

HOW TO READ YOUR
EXPLANATION OF BENEFITS (EOB) STATEMENT

An EOB is not a bill. Instead, it explains how your benefits have been applied. It shows what you may owe after your health insurance claim has been processed. You should review it to make sure you received the services that are being billed.

HIGHMARK.
An Independent Licensee of the Blue Cross and Blue Shield Association

Explanation of Benefits
THIS IS NOT A BILL

1 Contract Holder Name: SAMUEL SAMPLE
2 Member ID: 012345678910
Group Name: ABC CORP.
Group ID: 123456 789
3 Claim Activity For: SAMUEL SAMPLE
4 Claim Number: 12345678910

EXPLANATION AT A GLANCE

5 Date of Service: 01/28/14

6 We Sent Payment To:
PATHOLOGY PRACTICE
A Network Provider

Claim Payment Amount: $ 90.00

7 Provider May Bill You
(If Not Already Paid) : $ 7.00

Member Responsibility

Provider Date of Service Type of Service Service Code (Number of Services)	Provider's Charge	Non-Billable To Member	Plan Allowance (Covered Charges)	Your Deductible	Health Plan Pays	Amount You Owe Provider
8 PATHOLOGY PRACTICE 01/28/14 SURGICAL PATHOLOGY TEST 88305 (2)	284.00	187.00 J4047	97.00	7.00	90.00	7.00
TOTALS	9 284.00	10 187.00	11 97.00	12 7.00	90.00	13 7.00

14 **Explanation of Remark Codes**

J4047 - This is the difference between the provider's charge and our allowance. Since the provider is in-network, you are not responsible for this amount.

X5018 - The allowance for this service has been applied to the dollar deductible amount required under the patient's coverage.

15 **PATIENT BENEFIT SUMMARY**

Patient: SAMUEL SAMPLE
Group Number: 123456-789
Benefit Period: 12/01/13 - 11/30/14
$500.00 has been applied to your $1,000.00 individual in network total maximum out-of-pocket amount.
$500.00 has been applied to your $1,000.00 individual in network out-of-pocket limit.
You have satisfied $500.00 of your $500.00 individual in network deductible.

Please refer to your benefit booklet or agreement for further information. Amount(s) shown may include totals from claims which are still being processed and for which you have not been notified.

16 **PROGRAM BENEFIT SUMMARY**

Benefit Period: 12/01/13 - 11/30/14
Group Number: 123456-789
$500.00 has been applied to your $2,000.00 program in network total maximum out-of-pocket amount.
$1,350.00 has been applied to your $2,000.00 program in network out-of-pocket limit.
You have satisfied $1,000.00 of your $1,000.00 program in network deductible.

Please refer to your benefit booklet or agreement for further information. Amount(s) shown may include totals from claims which are still being processed and for which you have not been notified.

Please turn this page over for definitions of health insurance terms.

To better understand your EOB and how charges are calculated, here are definitions for terminology used in the statement.

1. **CONTRACT HOLDER NAME** – the health care coverage is listed under this person's name.
2. **MEMBER ID** – contract holder's member identification number.
3. **CLAIM ACTIVITY FOR** – the person who received the services, either the contract holder, a spouse or dependent.
4. **CLAIM NUMBER** – the system assigns each claim a number for identification purposes.
5. **DATES OF SERVICE** – the day or days when services were performed.
6. **WE SENT PAYMENT TO** – health care provider that received payment for services.
7. **PROVIDER MAY BILL YOU** – what you may owe the provider.
8. **PROVIDER** – facility or professional providing medical service, such as a hospital or a doctor.
   A. DATE OF SERVICE – the day or days when services were performed.
   B. TYPE OF SERVICE – surgery, office visit or test, for example.
   C. SERVICE CODE – medical billing code to identify what services were performed.
   D. NUMBER OF SERVICES – total number of services performed.
9. **PROVIDER CHARGES** – the amount the provider charged for the services.
10. **NON-BILLABLE TO MEMBER** – amount that the provider discounts for being in-network and does not charge you.
11. **PLAN ALLOWANCE (COVERED CHARGES)** – the amount your plan allows as payment. This is the discounted rate you receive.
12. **DEDUCTIBLE** – the amount that has been applied towards meeting your deductible.
13. **AMOUNT YOU OWE PROVIDER (TOTAL OF SHADED COLUMNS)** – the total amount you owe, including any deductible, coinsurance or copayment amounts.
14. **EXPLANATION OF REMARK CODES** – these codes explain why payments are approved or denied.
15. **PATIENT BENEFIT SUMMARY** – summarizes a single patient's coverage within a benefit period.
    A. INDIVIDUAL IN-NETWORK TOTAL MAXIMUM OUT-OF-POCKET AMOUNT – the most you pay during a benefit period ***including*** deductibles, copayments and coinsurance. Once this amount is reached, the health plan pays 100% of the allowed amount for covered services.
    B. INDIVIDUAL IN-NETWORK OUT-OF-POCKET LIMIT – the most you pay during a benefit period, ***excluding*** copayments and deductibles. This amount generally includes only coinsurance. Once this amount is reached, the health plan pays 100% of the allowed amount for covered services. You may still be responsible for copayments or to fulfill the deductible.
    C. INDIVIDUAL IN-NETWORK DEDUCTIBLE – the amount you pay during a benefit period before your health plan begins to pay anything.
16. **PROGRAM BENEFIT SUMMARY** – similar to the Patient Benefit Summary (#15), these amounts are added together to summarize all family members' coverage within a benefit period.
    A. INDIVIDUAL IN-NETWORK TOTAL MAXIMUM OUT-OF-POCKET AMOUNT – the most you pay during a benefit period ***including*** deductibles, copayments and coinsurance. Once this amount is reached, the health plan pays 100% of the allowed amount for covered services.
    B. INDIVIDUAL IN-NETWORK OUT-OF-POCKET LIMIT – the most you pay during a benefit period, ***excluding*** copayments and deductibles. This amount generally includes only coinsurance. Once this amount is reached, the health plan pays 100% of the allowed amount for covered services. You may still be responsible for copayments or to fulfill the deductible.
    C. INDIVIDUAL IN-NETWORK DEDUCTIBLE – the amount you pay during a benefit period before your health plan begins to pay anything.

If you suspect fraud or abuse involving your health insurance, please call the toll-free fraud or abuse hotline at 1-800-438-2478.