Pewaukee School District
Section 105 Health Reimbursement Arrangement
Employee Instruction Sheet

Pewaukee School District provides a Section 105 Health Reimbursement Arrangement (HRA) to help provide better health care to employees and their families. HRAs are being implemented by many employers to help manage increasing health care costs and to provide employees with an incentive to be better consumers of health care. Pewaukee School District's HRA is administered by Diversified Benefit Services, Inc. (DBS). The program works as follows:

- You and/or your family members utilize your health plan as you normally would. The insurance company will process your claim and send an Explanation of Benefits form (EOB) to you. The EOB form shows the date of service, service provided, cost of the service, amount insurance paid on the claim, and the portion of the claim you are responsible for paying.
- When you receive an EOB statement, affix a completed 105-HRA claim form to the EOB statement and send a **copy** of the documents to DBS. The forms may also be faxed to DBS at 262-367-5938 or submitted online for processing.
- The DBS Claims Department reviews the claim. Eligible expenses are reimbursed directly to you based on the schedule below.
- If you provide DBS your email address, email notifications will be sent to inform you of claims received, reimbursements issued or requests for additional information needed to process your claims.
- Requests received by Friday (9:00 a.m. CST) will be processed the following Friday.

HRA Reimbursement Schedule

Plan Year:	01/01 – 12/31
In-Network Deductible Level:	$1,500 (maximum 2 per family)

In-Network Reimbursement Levels for the Plan Year:

First $500 per in-network deductible:	Employee Responsibility
Next $1,000 per in-network deductible:	Reimbursed by the HRA

Out-of-Network Deductible Level:	$3,000 (maximum 2 per family)

Out-of-Network Reimbursement Levels for the Plan Year:

First $500 per out-of-network deductible:	Employee Responsibility
Next $2,500 per out-of-network deductible:	Reimbursed by the HRA

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Additional Information:

- You are responsible for paying the doctor and/or hospital bills. You will be reimbursed directly after an EOB statement and completed claim form has been submitted.
- You must be an active employee on the Employer's Group Health Plan or on COBRA (under your current Employer's Group Health Plan) to receive payment.
- If you (or your family) have secondary insurance, please submit copies of the EOB forms from both carriers.
- Any portion of the expense reimbursed by the HRA **IS NOT** eligible for reimbursement under any other program or by any other source. This includes, but is not limited to, Insurance Plans and Flexible Spending Accounts. Any portion of an expense reimbursed by the HRA **IS NOT** eligible as a deduction on your income taxes.
- Reimbursements are tax-free to you.
- If another source reimburses you and/or a provider (i.e. doctor, hospital, and clinic) for an expense that the HRA also reimburses you for, you are responsible for paying back the HRA Plan.
- **At the end of each Plan Year you have a 90-day run-out period in which you may submit your claims.** However, if you terminate employment you have a 90-day run-out period in which you may submit your claims.
- Your employer assumes the cost for the Plan's administration.
- Your employer reserves the right to cancel or modify this program at any time.
- This Employee Instruction Sheet is intended only as an overview of the HRA benefits. The HRA plan qualifications and limitations are stated in the Plan Document. The Plan Document determines how the HRA plan benefits will be administered.

If you have questions on the program, please call DBS at 1-800-234-1229.
www.dbsbenefits.com

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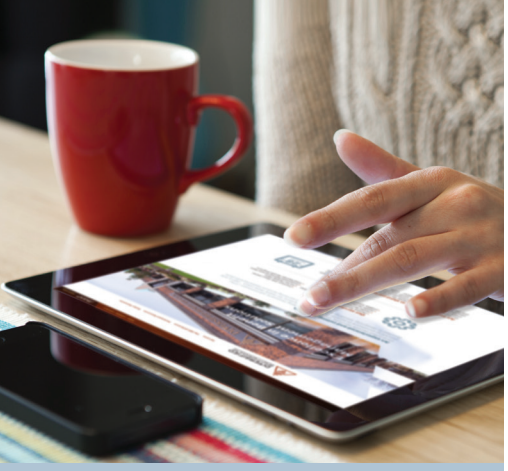

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Claims Filing
Options that meet your needs.

Why file online?

- **Fast**
  There's no quicker way to get reimbursed for your FSA or HRA claims.
- **Convenient**
  Day or night, on your favorite device, go online and get account information.
- **Safe**
  You have encrypted Internet access to the site, which is protected and Verisign secured.
- **Comprehensive**
  View account balance and activity.

DBSbenefits.com

Diversified Benefit Services, Inc.
P.O. Box 260
Hartland, WI 53029
(800) 234-1229

File Online—it's fast, convenient and secure

Using your laptop or PC, you can submit your claims online 24/7. DBS's exclusive A.S.A.P.® (Advanced Strategic Administration Program) is a safe and quick way to see claim information and get reimbursed from your Health Care FSA (HCFSA), Dependent Care FSA (DCFSA), Limited Purpose FSA (LPFSA), or Health Reimbursement Arrangement (HRA).

1. Login to your online account at DBSbenefits.com
2. Select the Benefit Plan Type (FSA, HRA)
3. Select "Claims > Online Claim Entry"
4. Complete the required information
5. Attach an image with supporting documentation (.pdf or .jpg)
6. Submit

File on the go—use our Mobile Phone App

Filing using your smartphone or tablet is simple.

1. Login using your A.S.A.P.® name and password, click "File a Claim"
2. Take a picture or use an existing photo, click "Attach Image"
3. Select the Benefit Plan Type
4. Enter dollar amount, answer questions, click "Submit"

Visit your favorite app store to download.

ANDROID APP ON Google play

Available on the App Store

File via mail or fax

More traditional filing is available, too.

1. Download a claim form at DBSbenefits.com
2. Select the "Participant Resources Tab > Forms"
3. Complete the form and attach copies of your documentation
4. Mail to Diversified Benefit Services, P.O. Box 260, Hartland, WI 53029
5. Or fax to 262-367-5938

For assistance, please call DBS at **(800) 234-1229**
or visit **DBSbenefits.com**

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Health Reimbursement Arrangement (HRA) Claim Form

Claim Filing Options

Online: File a claim online by logging into your account at www.dbsbenefits.com

Fax/Mail: Complete form below and mail or fax to: **Diversified Benefit Services, Inc.**
PO Box 260, Hartland, WI 53029
Fax (262)367-5938

For assistance please call (800) 234-1229.

Participant Information

Participant Name (please print): _____

Email: _____ Last 4 Digits of SS#: ☐☐☐☐

Employer Name: _____

Address Change (if applicable): _____

Participant Signature: _____ Date: _____

HRA Qualifying Expense Details

Who incurred the expense? (please select one of the following)

☐ Self ☐ Spouse ☐ Dependent

You must attach proper documentation to this form for reimbursement. Most plans require an Explanation of Benefits (EOB) be submitted with your claim. EOBs can be obtained from your insurance carrier or your carrier's website. If your plan does not require an EOB, documentation must include the following:

1) Date of Service
2) Patient Name
3) Provider of Service
4) Type of Service or Explanation of Service (medical, dental, vision)
5) Your Out-of-Pocket Expense (after insurance has paid, if applicable)

Crossover to FSA

If you are currently enrolled in a Flexible Spending Account (FSA), do you want DBS to automatically apply any out-of-pocket expense to your FSA account?

☐ Yes ☐ No

Claim Authorization - By submitting this form, I certify that the amounts listed are correct and are expenses that represent qualified reimbursable expenses. I will not claim these items on my personal income tax return for medical itemization. I certify that I will not be reimbursed for the expenses listed above from any insurance company or insurance plan or the following: any other Flexible Benefit Plan, Medical Savings Account (MSA), Health Reimbursement Arrangement (HRA), Health Savings Account (HSA), another reimbursement plan or any other source. I also certify that the expenses have been incurred (having dates of service) during the timeframe required by the benefit plan and are for my own expenses, expenses of my spouse and expenses of my dependent children as defined by my employer's Plan. I will provide documentation necessary to support the amounts being requested for reimbursement. In addition, by submitting this document I acknowledge and agree DBS may, in the case of an overpayment (fraudulent, inadvertent or otherwise), offset future expense reimbursements to me to account for such an overpayment. I also agree to immediately inform DBS if I become aware of an overpayment and agree to reimburse the Plan Sponsor to the extent that an offset of future reimbursements is either impossible or inconvenient.