

An aerial photograph of Pittsburgh, Pennsylvania, showing the Allegheny River, several yellow steel arch bridges, and the city skyline with various skyscrapers. In the foreground, a red trolley is visible on a track, surrounded by lush green trees.

# The Steelworkers Health & Welfare Fund ArcelorMittal HRA Presentation

# As a Blue member:



Nearly **1 in 3**  
Americans carry a  
**Blue ID Card**



**96%** of all hospitals  
and **92%** of all  
physicians are in  
**Blue networks**

# What's a PPO plan?



= Savings



= More \$

## NETWORK PROVIDERS

Doctors, hospitals and other health care professionals that agree to accept the amount that the health plan will pay for covered care

## OUTSIDE THE NETWORK

You pay more.

# PPO Blue Benefits

BENEFIT CATEGORY	IN-NETWORK	OUT-OF-NETWORK
Deductible (Individual/Family)	\$200 / \$400	\$500 / \$1,000
Coinsurance	90%	70%
Out-of-Pocket Limit (Individual/Family)	\$1,500 / \$3,000	\$2,000 / \$4,000
Hospital Services Inpatient and Outpatient	90% after deductible	70% after deductible
Primary Care Office Visit	100% after \$20 copay	70% after deductible
Specialist Office Visit	100% after \$20 copay	70% after deductible
Preventive Care	100% (deductible does not apply)	70% after deductible
Urgent Care	100% after \$30 copay	
Emergency Room Services	100% after \$50 copay (waived if admitted)	
Spinal Manipulations	100% after \$20 copay	70% after deductible
	Limit: 18 visits/ calendar year	

# Pay Medical Expenses with an Employer-Funded **HRA**



# Incentive HRA Plan

The incentive HRA plan provides funding for those members that successfully completed the Health Awareness Initiative.



# The Value of a Health Reimbursement Arrangement

Your employer pays for the cost of qualified medical expenses in your HRA.

You don't pay income tax on the money your employer contributed

Free money to help limit your out-of-pocket health care costs



# How Expenses Are Paid from Your HRA



# Every Health Plan Has Out-of-Pocket Responsibilities that Vary by Plan Option

## Costs covered by your health plan



**Preventive & Well-visits**



**Coinsurance** (plan share)



**Post-deductible Expenses**

## Costs covered by your HRA



**Medical Deductibles**



**Coinsurance**  
(your share)



**Prescriptions**



**Dental & Vision**

**Retiree Premium Payments can also be reimbursed**



# What is eligible under the HRA?

## Deductible & Coinsurance

- Claims for Deductible and Coinsurance will Auto Pay To Provider.  
No member action needs taken

## Dental, Vision, Medical Copays, Prescription Copays & other Non-Covered Services

- Manual Submit
  - via the Highmarkbcbs.com website
  - the Mobile App
  - HRA Paper claim form
  - Email to: [SpendingAccountProcessing\\_Receipts@alegeus.com](mailto:SpendingAccountProcessing_Receipts@alegeus.com)

# Simple Online and Mobile App Access

Access Accounts

Track Account Activity

Manage Expenses

Receive Notifications



Visit [www.highmarkbcbs.com](http://www.highmarkbcbs.com)

Select Language ▾

AA ▾

 Need Help ▾



Log In or **Register**



PAY PREMIUM

DISCOVER

SHOP

FIND A DOCTOR OR RX

MEDICARE

# WELCOME

## WE'RE HERE FOR YOU

Meet your Highmark health care team.



# REGISTER

1 Member ID

## CREATE YOUR ONLINE ACCOUNT

Enter your information exactly as it appears on your member ID card.

Member ID/SSN

---

First name

---

Last name

---

Date of birth

---



### Wait, I don't have my ID card!

If you're the main policyholder, you can use your SSN to register. If your insurance is through another family member, you'll need their SSN to register.

CANCEL

NEXT

To access your HRA click on the Claims & Spending Tab. Then select Access Spending Account.



COVERAGE

CLAIMS & SPENDING

FIND A DOCTOR

PRESCRIPTIONS

WELLNESS

## CLAIMS & SPENDING

### REVIEW YOUR PLAN ACTIVITY

View Your Claims, check account balances and see your progress towards your deductible

#### Spending Accounts

Claims History

Covered Expenses

Forms Library

Cost-Saving Tools

Messages

Statement Archive

Educational Material



### SPENDING ACCOUNTS MADE EASIER

We've created a smart, simple and flexible solution for managing your spending accounts, paying claims and getting reimbursements.

#### CURRENT CLAIMS & SPENDING ACCOUNT

\$

\$554.92

Opened 01/01/2019

Access your current plan year to pay claims, submit reimbursements and more.

[ACCESS SPENDING ACCOUNT](#)

#### PRIOR YEAR SPENDING ACCOUNT

Add claim for immediate reimbursement

### Your Accounts

Plan years to show:  Previous  Current  Future

#### Wellness Account

\$500.00

● Available \$325.00
● Spent \$175.00

### Recent Transactions

(\$25.00)	Wellness Account	Approved	Claim Feb 4, 2019
(\$25.00)	Wellness Account	Approved	Claim Feb 4, 2019
(\$125.00)	Wellness Account	Partially Paid	Claim Feb 1, 2019

[See All](#)

### Alerts

Right now you're only receiving email alerts. Click below to maximize the value of your account. Link your mobile phone and get real-time balance updates!

[Sign Up](#)

---

Feb 1, 2019    [Account Balance](#)    [Spending Account Balance](#)

### Get Reimbursed Faster

Add your bank account for direct deposit reimbursement [+](#) ADD

---

Download our free **Highmark Blue Shield Spending** mobile app for on-the-go account access from your smart phone or tablet.

**To register you'll need:**

## Claim Activity

Which claims do you want to see? Select here ▾

- Action Needed
- Approved/Paid/Submitted
- Denied

 Submit Claim

 Export To Excel

 [SEARCH FOR CLAIMS](#)

### Action Needed

\$35.<sup>00</sup>

**Eligible For Reimbursement**  
MEDICAL  
ADVACARE HOME SERVICES, INC

**Manual Claim**  
MEDICAL  
ADVACARE HOME SERVICES, INC  
#123456123458  
Date of Service:  
Jan 6, 2019  
Date of Transaction:  
Jan 16, 2019



[Request Reimbursement](#)

CLAIM DETAILS

DOCUMENTATION

CONFIRMATION

[Claim Form Instructions](#)

Please fill out the fields below and make sure to attach the proper documentation. When finished, accept the terms and click submit.



Get your reimbursement as quickly and securely as possible by changing your reimbursement method to Direct Deposit.

[Click Here to change your settings](#)

\* - Required Field

Service Start Date *	Jan 6, 2019
Service End Date	Jan 6, 2019
Claimant	Bob Awesome
Reimbursement Method	Check
Service Type *	MEDICAL
Claim Amount *	\$ 35.00



Whom shall we pay?\*

<input checked="" type="checkbox"/> Pay Provider	<input checked="" type="checkbox"/> Pay Me
--	--

Provider Name

Comments

Good news. You do not need to attach a receipt since this claim was loaded by your carrier.

## Claim Details

Claim Line	Service	Your Total Responsibility	Amount you paid out-of-pocket ?	Your Benefit Accounts Paid	Remaining Responsibility
1	MEDICAL	\$35.00	\$0.00	\$0.00	\$35.00
	<b>Total Claim</b>	<b>\$35.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$35.00</b>



Next



Cancel



CLAIM DETAILS DOCUMENTATION CONFIRMATION



Your submission is complete. Should you have any questions or concerns, please feel free to contact us at the number on the back of your Member ID card. If you did not attach a receipt when submitting the claim, you may do so now by clicking "open claim list" button below or by clicking on Claims and then Claim Activity in the top navigation.

Claim Details

Amount: **\$35.<sup>00</sup>**

Type: Check

Claimant: Bob Awesome

Tracking #: 123456123458

Service Type: MEDICAL

Service Start Date: Jan 6, 2019

Service End Date: Jan 6, 2019

Comments:

Provider: ADVACARE HOME SERVICES, INC

*For questions regarding the processing of your payment request, please contact the Member Advocate Team at the number located on the back of your Member ID Card or your plan administrator, if applicable.*



The above is a true and accurate statement of all expenses incurred by my eligible dependents or me on the date(s) indicated, and I will not seek reimbursement from any other health plan or spending account including a Health Savings Account (HSA). I understand that I cannot claim any reimbursed expenses on my income tax return, and that I may be liable for payment of all related taxes including Federal, State, or City income tax and any associated penalties on the amounts paid for an expense improperly claimed under the provisions of this plan.

By choosing Submit, you agree to the conditions for reimbursement 

 Submit  Cancel



Thank you!

Your submission is complete. Should you have any questions or concerns, please feel free to contact us at the number on the back of your Member ID card. If you did not attach a receipt when submitting the claim, you may do so now by clicking "open claim list" button below or by clicking on Claims and then Claim Activity in the top navigation.

---

What do you want to do next?



Submit Another Claim



Open Claims List

**If you chose to use Direct Deposit for reimbursement you will see a credit in your Bank Account from either PNC or MBI.**

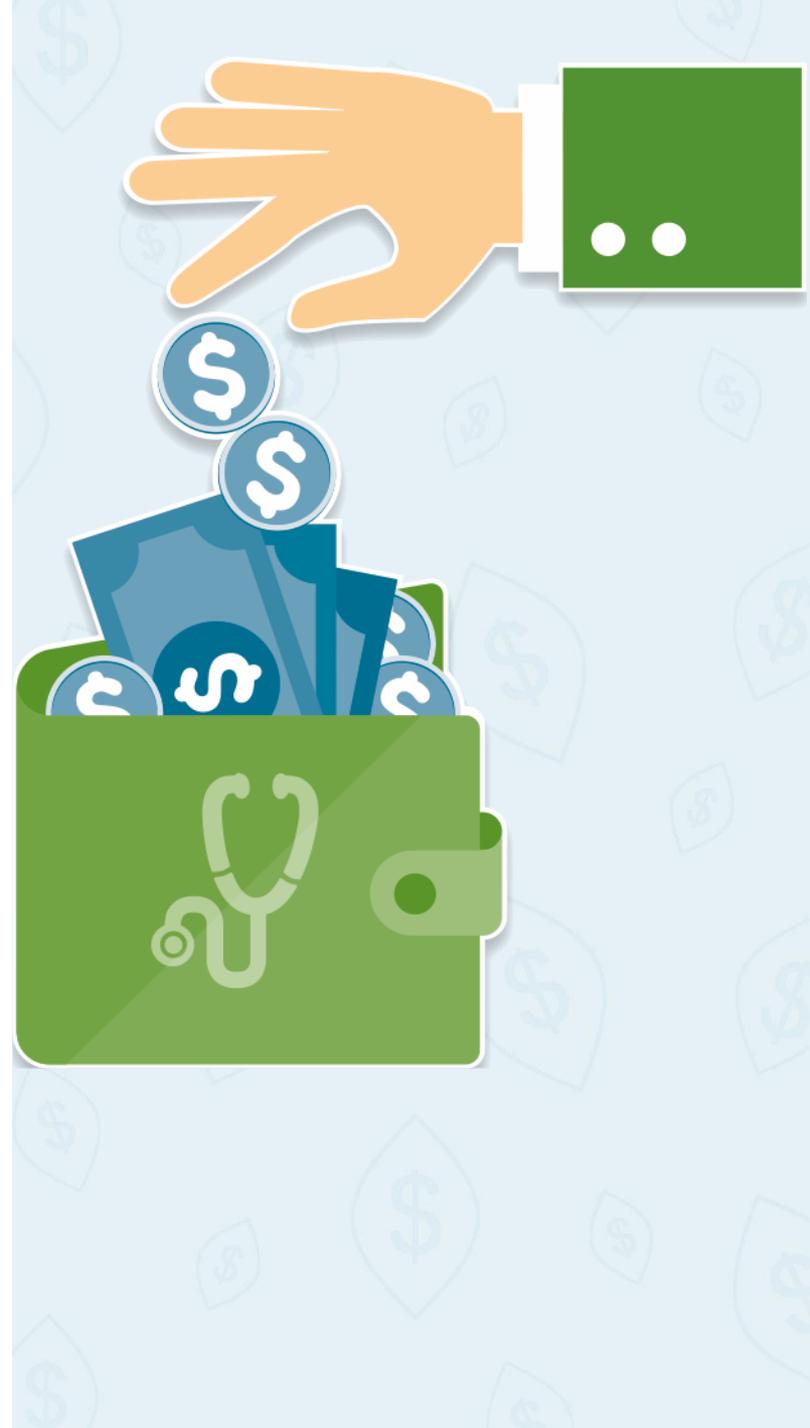
ACH CREDIT 9113 HSA PNCCUSTODIAN  
HSADISTRIB

MBI SETL

# Itemized Receipt Requirements for Manually Submitted Claims

The receipts that are uploaded or sent along with the claim form must include specific details:

- Name of person who received services (or RX number for Prescriptions)
- Name of Doctor or Provider
- Date and Type of Service
- Amount Charged



Patton Pharmacy V&S Variety

PATIENT IRS STATEMENT  
Period 06/01/18 to 12/15/18  
Sat Dec 15, 2018

Page 1

PID: [REDACTED]

NPI: [REDACTED]

Patton, PA 16668

EMAIL: [REDACTED]

[REDACTED] JAMES

Rx Nbr	Rf	Date	Drug	Pat Paid	Doctor
[REDACTED]	01	06/14/18	BUPROPION HCL XL 150 MG TAB	\$0.00	SABO, [REDACTED]
[REDACTED]	00	06/15/18	CARISOPRODOL 350 MG TABLET	\$0.00	SABO, [REDACTED]
[REDACTED]	00	06/16/18	OXYCODONE-ACETAMINOPHEN 10-	\$0.00	SABO, [REDACTED]
[REDACTED]	02	09/07/18	BUPROPION HCL XL 150 MG TAB	\$30.98	SABO, [REDACTED]
[REDACTED]	00	09/20/18	BUPRENORPHINE 8 MG TAB SL	\$14.90	SABO, [REDACTED]
[REDACTED]	00	09/24/18	BUPRENORPHINE 8 MG TAB SL	\$48.00	SABO, [REDACTED]
[REDACTED]	01	09/26/18	BUPRENORPHINE 8 MG TAB SL	\$70.99	SABO, [REDACTED]
[REDACTED]	02	10/04/18	BUPRENORPHINE 8 MG TAB SL	\$159.00	SABO, [REDACTED]
[REDACTED]	03	10/12/18	BUPROPION HCL XL 150 MG TAB	\$30.98	SABO, [REDACTED]
[REDACTED]	00	10/22/18	BUPRENORPHINE 8 MG TAB SL	\$236.50	SABO, [REDACTED]
[REDACTED]	00	11/19/18	BUPRENORPHINE 8 MG TAB SL	\$236.50	SABO, [REDACTED]

No. Rx's = 11 Total Patient Paid \$827.85

RPh Signature: \_\_\_\_\_

*[Handwritten Signature]*



<b>Options</b>	<b>HBS Spending App</b>	<b>Highmark Plan App</b>
<b>View ID Cards</b>		<b>X</b>
<b>View Medical Plan Coverage</b>		<b>X</b>
<b>Access Provider Directory</b>		<b>X</b>
<b>View Spending Account Balances</b>	<b>X</b>	<b>X</b>
<b>View Spending Account Claims and Details</b>	<b>X</b>	<b>X</b>
<b>Submit/Upload Manual Claims</b>	<b>X</b>	
<b>Virtual Spending Account Assistant “Ask Emma”</b>	<b>X</b>	
<b>Upload photos of receipts from SmartPhone</b>	<b>X</b>	

**Visit your App Store on your Smart Phone to Download**



# Highmark Plan App

1. **Users can register on the App, or login with their previously registered member website username and password from the desktop website.**
2. **Users can login with their new user name and password if they choose to create something different than what the user for the desktop website.**
3. **Users can set up for biometric finger print Touch ID or Face ID, depending on if their mobile device is enabled for that type of login technology.**



Keep track of your health care events and costs.

[SET UP](#) or [LOGIN](#)

Forgot [username](#) or [password](#)?

We'll protect your information.  
[Check out our legal terms.](#)



## Set up your account

Enter your information exactly as it appears on your member ID card.

Member ID/SSN\*

First Name\*

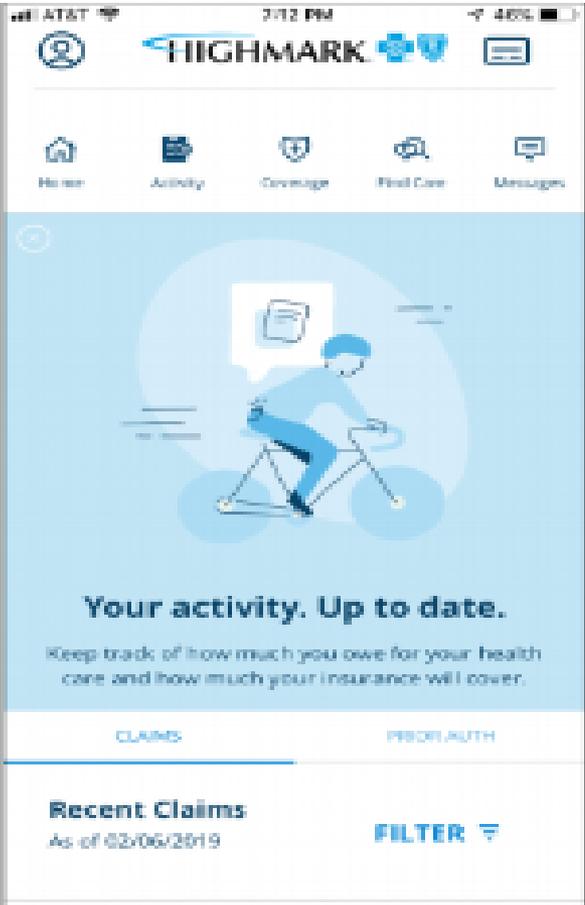
Last Name\*

Date of Birth\*

\* Required fields

← BACK

NEXT →





Home



Activity



Coverage



Find Care



Messages

### Spending Account Balance

You have a spending account, and you can use this money to help pay for eligible expenses.



Plan Year: 01/01/2019 - 12/31/2019

Available Balance

**\$1,675.46**

[Details >](#)

### Health Care Services Status

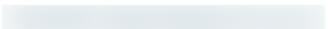
Keep track of how much you owe for your health care and how much your insurance will cover.

**We'll Pay Our Part**

-  Home
-  Activity
-  Coverage
-  Find Care
-  Messages

[← Back to Home](#)

**This Year**



Plan Year: 01/01/2019 - 12/31/2019

Managed by ALEGEUS

Available Balance

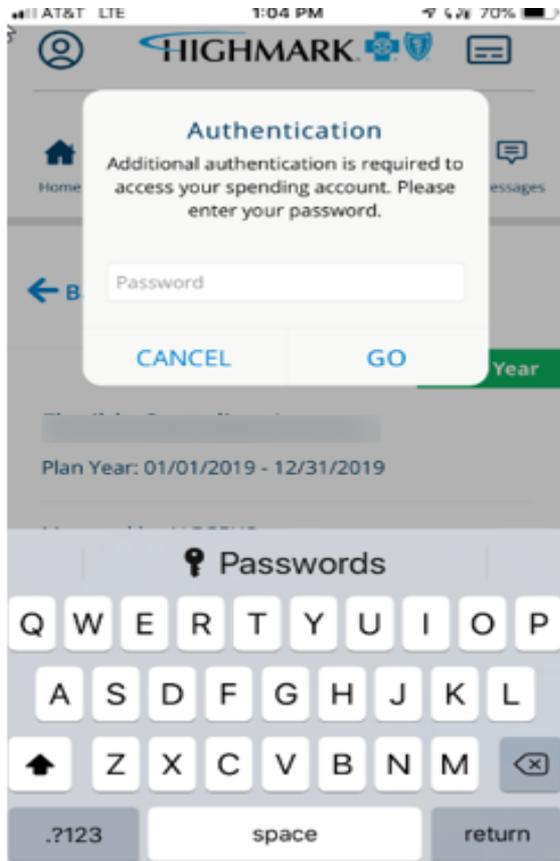
**\$1,675.46**

[MANAGE](#) 

**Prior Year**

Prior Year Medical Reimbursement Account

Plan Year: 01/01/2018 - 12/31/2018



documentation is required.

[See All](#)

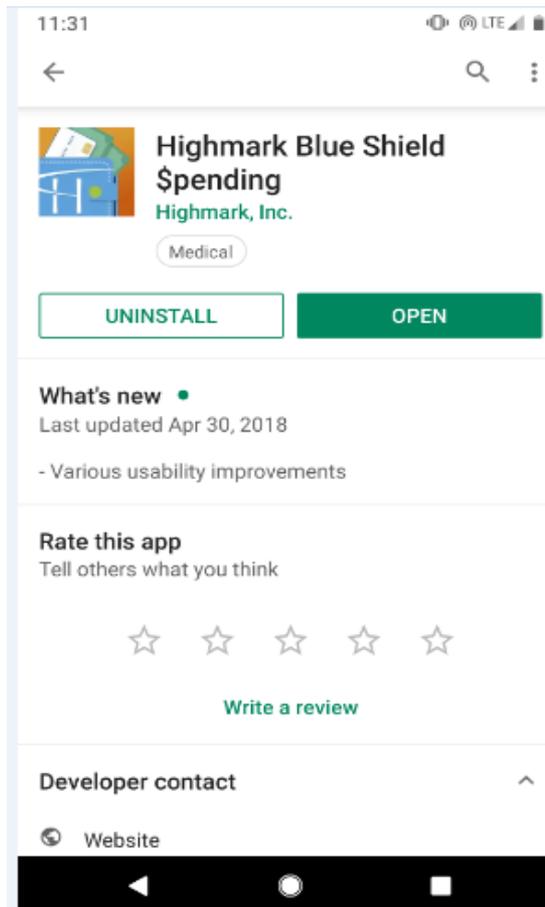
### Recent Transactions

(\$40.00)	Approved	Card Feb 23, 2019
(\$40.00)	Approved	Card Feb 23, 2019
(\$72.54)	Pending	Card Feb 22, 2019
\$76.92	Approved	Deposit Feb 22, 2019
(\$72.00)	Approved	Card Feb 18, 2019
(\$30.00)	Eligible For Reimbursement	Claim Feb 17, 2019
(\$85.37)	Eligible For Reimbursement	Claim Feb 17, 2019
(\$40.00)	Eligible For Reimbursement	Claim Feb 17, 2019
\$76.92	Approved	Deposit Feb 8, 2019
(\$40.00)	Approved	Card Feb 5, 2019

[See All](#)

# How to Download Highmark Blue Shield Spending mobile App





**Visit your App Store on your Smart Phone. Once downloaded, you must register!**

SIGN IN

Username

Save this Username

SIGN IN

[Forgot Username?](#)

REGISTER

*i* If you don't have an online account, you can create one by registering below

REGISTER

Login Problems Contacts

**\*\*New Users Must Register\*\***

**Tap the register button on the landing screen to Register.**

**\*\*The Highmark Plan App and Member Website User Name and Password will not work with this App, You must Register with this App.\*\***

Register

User Name

Password

A password must contain 3 of the following types of characters:

- AN UPPER CASE LETTER
- lower case letter
- Special Character (% , ! , @ , etc.)
- A number

Confirm Password

First Name

Login Problems    Contacts

Register

Employee ID

00003

Employee ID was assigned by your Administrator and could be your Health Plan Member Number, Social Security Number, an ID provided by your Employer or an alternate ID created by your Administrator.

If you do not know your ID or were not provided an ID, please contact your Administrator.

Registration ID

Employer ID

agree with [Terms of Use](#)

REGISTER

Login Problems    Contacts

Tap corner of screen to type.

- Enter User Name: at least six characters long alphanumeric value
- Enter Password & Confirm: Must contain 3 of following types of characters
  - Upper Case Letter, Lower Case Letter, Special Character (&, !, #, \*), or a Number
- Enter First Name and Last Name (as shown on Member ID)
- Enter E-mail Address

**Enter Employee ID : must be your 12 digit UMI plus 0 (i.e. 112223330010)**  
**Enter Employer ID (i.e. SPA031500).**

- Any variation will result in failed registration.
- Check to agree with term of use and click Register

**Employee ID is the Member ID listed here, Numbers Only, Adding a ZERO at the end. Example-1006471450010**



---

MEMBER NAME  
ROBERTCARDTEST  
TESTCARD  
MEMBER ID  
ISM100647145001

---

Group	ISM363	Office Visit	\$20
BC/BS Plan	363/865	Specialist Visit	\$20
		Emergency Room	\$50
		Preventive	\$0

---



**Employer ID-SPA031500, case sensitive.**

Secure Authentication

STEP 1 STEP 2 STEP 3

Please use the following list to choose four questions which are relevant to you and then enter answers to those questions. These questions may be asked during the sign on process to confirm that an authorized individual can access account information online.

Select Question 1

What was the TV series you liked most in the 1990s?

Select Question 2

What was the TV series you liked most in the 1990s?

Select Question 3

Login Problems Contacts

- Select 4 security questions from the drop down.
- Provide the answers to the selected questions and follow the on screen prompts.

Secure Authentication

STEP 1 STEP 2 STEP 3

*i* The email address entered is used for security encryption only. It is not used for solicitation purposes.

First Name: Jon  
Last Name: Smith

my@email.com

CONTINUE

[Login Problems](#) [Contacts](#)

**Verify the First ,Last name, and email address entered  
Select continue.**

Secure Authentication

STEP 1 STEP 2 **STEP 3**

*i* Your setup information has not yet been submitted. Please verify your information below and enter your password before clicking Submit Setup Information. If you need to make a change before submitting, click the appropriate Change Information link.

**Questions and Answers**

- 1 What is the first name of your first crush?  
Highmark
- 2 When is your father's birthday (MM/DD)?  
Highmark
- 3 What was the TV series you liked most in the 1990s?  
Highmark
- 4 What was your boss's first name at your first job?  
Highmark

[CHANGE INFORMATION](#)

**Personal Information**

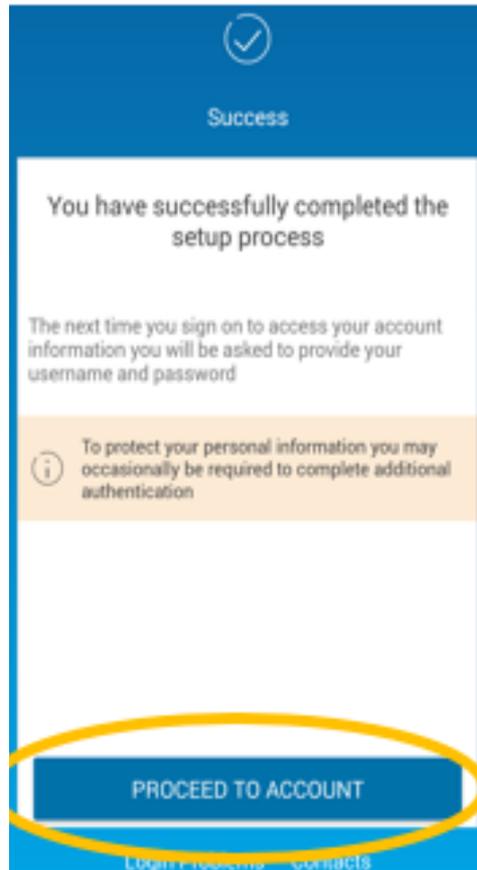
First Name: Jon  
Last Name: Smith  
Email Address: email@email.com

[CHANGE INFORMATION](#)

**SUBMIT SETUP INFO**

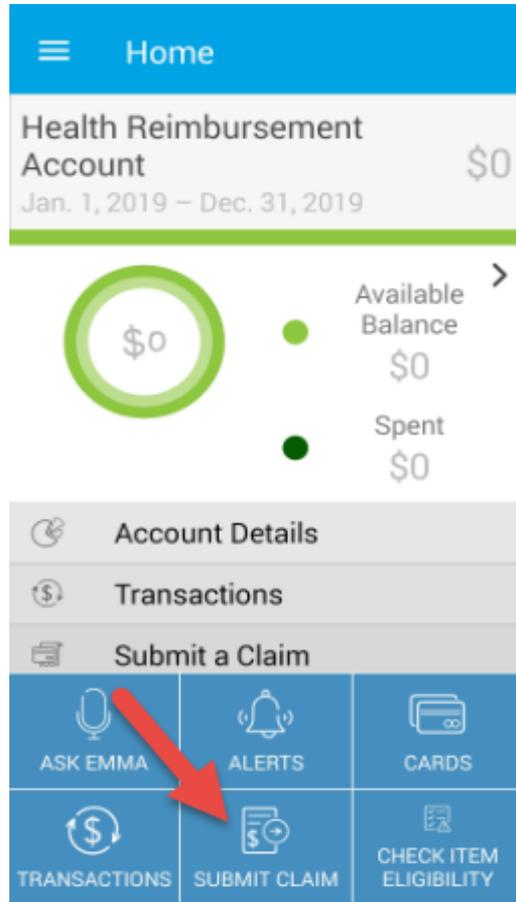
[Log Out](#) [Help](#) [Contact Us](#)

**Verify Security Questions and Answers**  
**Click Submit Setup Info**



**You have successfully completed the setup process**  
**Click proceed to Account**

# How to Submit an HRA Claim on Mobile App



Select Submit a Claim from Home screen

2:34 4G LTE 39%

### Add Claim

📅 Service Start Date Mar. 11, 2019

📅 Service End Date NONE

📄 Reimburse Provider?

✗ No ✓ Yes

👤 Claimant Sophie Demonstration ▾

📄 Reimbursement Method Check ▾

📄 Provider \_\_\_\_\_

📄 Account Number \_\_\_\_\_

📄 \* Service Category Code DENTAL ▾

💰 \* Claim Amount \$ 0.00

☰ ○ <

2:36 4G LTE 38%

### Add Claim

✗ No ✓ Yes

👤 Claimant Sophie Demonstration ▾

📄 Reimbursement Method Check ▾

📄 Provider \_\_\_\_\_

📄 Account Number \_\_\_\_\_

📄 \* Service Category Code MEDICAL ▾

💰 \* Claim Amount \$ 0.00

💬 Comments

📄 \_\_\_\_\_

**NEXT**

☰ ○ <

**Follow the on screen prompts to enter claim details. Use the dropdowns available for Claimant, Reimbursement Method, and Service Category.**

**Tap the Next button at the bottom of the screen to review the details entered.**

**Follow the on screen prompts to Attach a receipt, if applicable.**

 Preview

 Transaction Date  
Mar. 11, 2019

 Service Start Date  
Mar. 11, 2019

 Reimbursement Method  
Check

 Service Category Code  
MEDICAL

 Claimant  
Sophie Demonstration

 Provider  
Test Doctor

By choosing **Submit**, you agree to the conditions for reimbursement 

**SUBMIT**

**Tap Submit to agree to the conditions for reimbursement**

**Certification**

*For questions regarding the processing of your payment request, please contact the Member Advocate Team at the number located on the back of your Member ID Card or your plan administrator, if applicable.*

The above is a true and accurate statement of all expenses incurred by my eligible dependents or me on the date(s) indicated, and I will not seek reimbursement from any other health plan or spending account including a Health Savings Account (HSA). I understand that I cannot claim any reimbursed expenses on my income tax return, and that I may be liable for payment of all related taxes including Federal, State, or City income tax and any associated penalties on the amounts paid for an expense improperly claimed under the provisions of this plan.

**DECLINE    ACCEPT**

**Success**

Service Start Date  
Mar. 11, 2019

Service End Date  
Mar. 11, 2019

Type  
Claim

Claimant  
Sophie Demonstration

Provider  
Test Doctor

Claim #  
1927

Provider  
Test Doctor

**ADD ANOTHER CLAIM**

- **Certify the information by selecting Decline or Accept**
- **Once Accept you will get Success message at top of next screen.**
- **Can add another claim or use main menu on top left to navigate to another screen**



## Login Problems



If you have issues logging in, please contact your administrator at



844-363-0071

# Knowledge Is Power

Learn more about the  
value of an HRA at  
[highmarkspendingaccounts.com](https://highmarkspendingaccounts.com)



# YOUR MEMBER WEBSITE

Helps you manage **your care**,  
**your costs**, **your coverage**  
and **your health**



# Online ... or on the phone!

highmarkbcbs.com or Dedicated Service Unit 1-866-267-3280

