Group HRA Virtual Office Hours

If you have questions about how your Group HRA works or how to file claims, please join OneDigital's virtual office hours

Wednesdays

7:30 – 8:30 AM Pacific
and
3:30 – 4:30 PM Pacific

First Thursday Evening of Every Month

7:30 – 8:30 PM Pacific

https://onedigital.zoom.us/j/3923270383
(Meeting ID: 392 327 0383)

We look forward to seeing you there!

Mae Hawkins
(971)346-8688
mae.hawkins@onedigital.com

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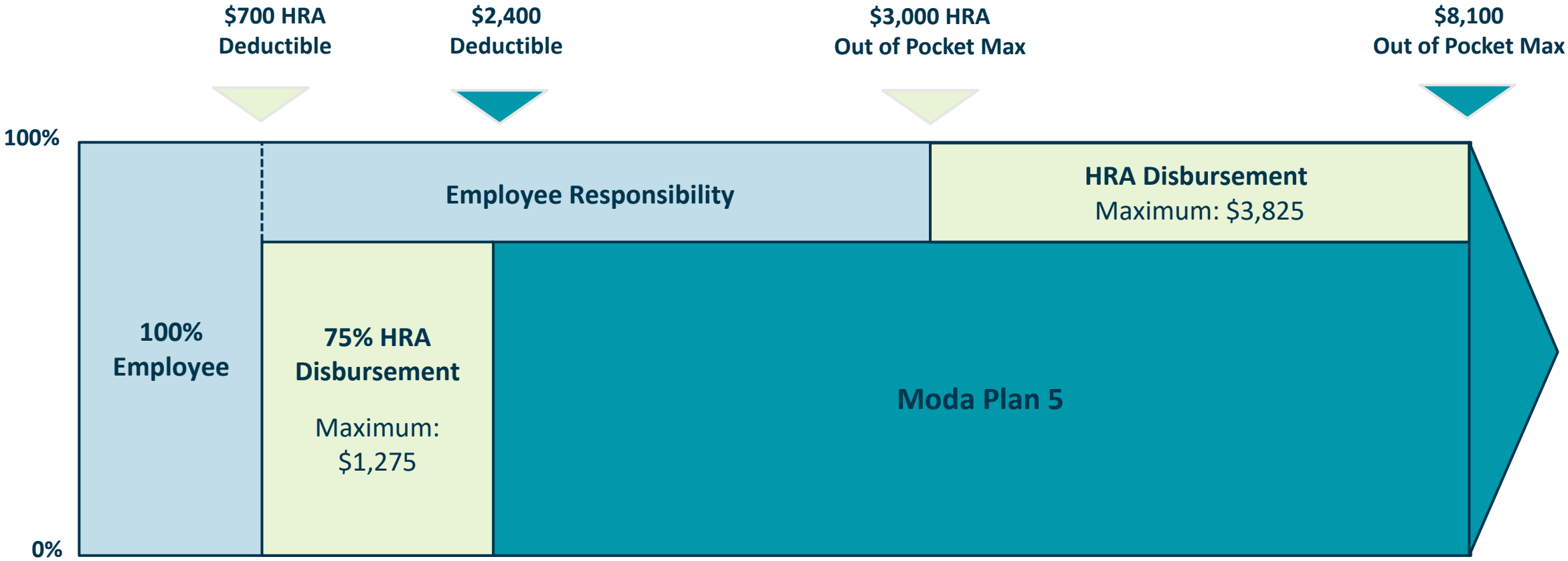
(986)236-4974
phaedra.anderson@onedigital.com

ONEDIGITAL

How Moda Plan 5 Works| 2025-26 Plan Year

Knappa School District Group HRA
Per employee and their covered, eligible dependents



Please Note: For Parties of 2 or More, the HRA Deductible will be $1,400.

Employee Paid | HRA – Employer Paid | Moda Paid

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How the Group HRA Plan Works| 2025-26 Plan Year

Knappa School District	Moda Plan 5 w/HRA
Deductibles (Individual / Family)	**$700 / $1,400**
Prior to HRA Reimbursements	$2,400 / $4,800
Out-of-Pocket (OOP) Maximum Per Person (deductible, prescriptions, coinsurance & copayments)	**$3,000 / $6,000**
Prior to HRA Reimbursements	$8,100 / $16,200

Please Note: For Parties of 2 or More, the HRA Deductible will be $1,400.

	Deductible		Co-Insurance, Copays & Rx		Moda
Eligible Claims	First $700	Next $1,700	First $1,875	Next $3,825	over $8,100

Who Pays & How Much (with Group HRA)	Employee $700	Employee 25% $425	Employee $1,875	HRA $3,825	Moda - 100%
		HRA - 75% $1,275	Moda pays their portion directly to the provider.		
Group HRA will cover in or out-of-network claims with the maximum total reimbursement amounts listed above.					

Employee Paid | HRA – Employer Paid | Moda Paid

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Knappa School District 4
Section 105 Health Reimbursement Arrangement
Employee Instruction Sheet – Moda Plan 5

Knappa School District 4 is continuing 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. They are working with Diversified Benefit Services, Inc. (DBS) to manage and administer the HRA. The program works as follows:

- Your employer implements changes to your Group Health Insurance Plan.
- You and/or your family members utilize your health plan as you normally would. When you use your health plan, 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.
- Claims Data will be sent electronically from the insurance company to DBS stating the amount of services applied toward the deductibles, coinsurance, and copays.
- As DBS receives the electronic information, the eligible expense amounts will be paid directly to you based on your employer's HRA reimbursement plan parameters.
- If you provide your email address to DBS, all notifications including claims received, reimbursements issued and requests for additional information will be sent to you via email.
- There are no claim forms to file for the HRA **except** in cases of dual health coverage, where EOB forms from both insurance carriers need to be submitted to DBS for processing.

HRA Reimbursement Schedule – Moda Plan 5

Plan Year:	10/1/2025 – 09/30/2026
Eligible Expenses:	Medical Deductible, Coinsurance and Copays (including prescriptions) incurred under the Employer Sponsored Group Health Plan
Deductible In-network Level:	$2,400 Single / $4,800 Family
Single HRA Reimbursement Levels for the Plan Year:	
First $700 of in-network deductible expenses:	Employee Responsibility
Next $1,700 of in-network deductible expenses:	Reimbursed by the HRA @ 75% *($1,275 HRA / $425 Employee)*
Family HRA Reimbursement Levels for the Plan Year:	
First $1,400 of in-network deductible expenses:	Employee Responsibility
Next $3,400 of in-network deductible expenses:	Reimbursed by the HRA @ 75% *($2,550 HRA / $850 Employee)*
Co-Insurance & Copays In-network Level:	$5,700 (maximum 2 per family)*
Reimbursement Levels for the Plan Year:	
First $1,875 per in-network co-insurance & copays:	Employee Responsibility
Next $3,825 per in-network co-insurance & copays:	Reimbursed by the HRA

**** Family Coinsurance is subject to the Health Plan the District purchased.***

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Single - If you incur out-of-network expenses, the HRA will look at the first **$2,400** of deductible expenses and the first **$5,700** of coinsurance/copay expenses whether they are in or out of network, with maximum disbursements of the amounts listed above.

Family - If you incur out-of-network expenses, the HRA will look at the first **$4,800** of deductible expenses and the first **$5,700** of coinsurance/copay expenses whether they are in or out of network, with maximum disbursements of the amounts listed above.

Additional Information:

- You are responsible for paying the doctor and/or hospital bills. You will be reimbursed after health information has been electronically 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 92-day run-out period in which you may submit your claims.** 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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BENEFIT SERVICES, INC.
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Knappa School District 4
Health Reimbursement Arrangement
Employee Online Account Viewing Setup
(Provided by Diversified Benefit Services, Inc. (DBS))

As a Plan Participant, you have access to your account information through the DBS online account viewing system known as **A.S.A.P. ®** - Advanced Strategic Administration Program. This system allows you to view your claim and reimbursement information related to your Plan.

To begin viewing your information you will need to create your personal online account. (All information provided is securely encrypted and protected.)

CREATING YOUR ONLINE ACCOUNT

1. Go to the DBS website at DBSbenefits.com
2. Click 'User Login' located on the top right of your screen.
3. On the Login screen, click on "Create New Account"
4. Enter your employer PIN: **KnappaSD** (then click the red arrow)
5. Enter the New Account Information requested.
    a. Your Email address is required.
    b. You may choose any combination of characters (minimum of 8 characters) when entering your Login Name
    c. You may choose any combination of characters, 1 upper case, 1 lower case and 1 numeric when entering your Password.
6. When you are finished click "submit". A message will indicate that your account has been successfully created. You will also receive an email confirmation.
7. You may now logon with your Login Name and Password and view your current account information.

Still Have Questions? Contact:

DBS Customer Service
(800)234-1229
Monday – Friday
6:30 AM – 3:00 PM Pacific

DIVERSIFIED BENEFIT SERVICES, INC.

Excellence in Benefit Management Solutions

Direct Deposit Application

Participant Information (please print):

Employer Name: Knappa School District

Participant Name: _____ Last Four Digits of SS#: ☐☐☐☐

Participant Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Email Address: _____

Check Box for New Account/Change/Cancel (please select one):

☐ New Account ☐ Change Account ☐ Cancel Direct Deposit

Plan that you will Participate in for Direct Deposit

☒ Section 105 Health Reimbursement Arrangement

Participant Banking Information:

☐ Use banking information on file with the District

I would like my reimbursements to be deposited to the account listed below:

Financial Institution: _____

Routing # (nine digits): _____ (is usually between the ⑆ symbols on your check)

Account #: _____ (is usually between the ⑈ symbols on your check)

Account Type:

☐ Checking (attach a voided or cancelled check)

☐ Savings (Please DO NOT attach a deposit slip. Most deposit slips have the bank's *internal* routing number. Please obtain the proper routing number from your financial institution.)

Please Read the Terms and Sign Below

I hereby authorize Diversified Benefit Services, Inc. (DBS) to reimburse amounts owed to me by initiating credit entries to my account at the financial institution listed above. Additionally, I hereby authorize the financial institution to accept and to credit any credit entries initiated by DBS to my account. I acknowledge and agree that in the event DBS deposits or credits funds incorrectly to my account, and/or in the case of an overpayment (fraudulent, inadvertent, or otherwise), I authorize my employer to debit my account for an amount not to exceed the original amount of the incorrect credit. I also agree to immediately inform DBS if I become aware of an overpayment and agree to reimburse the Plan Sponsor. I understand that DBS is responsible for the successful transaction of funds into my account. I agree to hold DBS harmless from loss and to indemnify DBS, limited to the amount of the deposit.

Any dispute arising out of or in connection with this agreement, if not resolved through other methods, shall be determined in accordance with the laws of the State of Wisconsin.

This authorization is to remain in full force and effect until my employer and financial institution have received written notice from me of its termination. The written notice shall be delivered in such a manner as to afford my employer and financial institution reasonable time to implement the change.

Participant Signature: _____ **Date:** _____

Diversified Benefit Services, Inc.
P.O. Box 260
Hartland, WI 53029
(262) 367-3300, (800) 234-1229
Fax (262) 367-5938
DBSbenefits.com