NORTH Clackamas Schools

Member Guide

Using Your HMA Benefits | Additional Programs & Services | Health Plan Basics

HMA

Your Guide to Better Healthcare with HMA

Thank you for being a member of HMA (Healthcare Management Administrators, Inc.). Whether you are new to HMA or have been a member for years, we want to make sure you have the tools and resources you need to make the most of your health plan.

Your healthcare journey is a very personal experience. And, at times, it can be rather confusing and complicated. HMA is here, on the phone and online, to make it easy for you to find the answers you need to make more informed healthcare decisions. Whether you need to find a doctor, know what's covered on your plan, or need simple explanations of confusing healthcare terms, HMA is here to help you understand your benefits so that you can stay healthy and save money.

About this guide

Please take a few minutes to review this guide. It provides information about how to use your health plan benefits including:

- How to find an in-network healthcare provider
- How to submit a claim
- How to understand your explanation of benefits statements
- Online tools and resources available to help you along the way
- Additional programs and services offered as a complement to your health plan

This booklet is meant to be a summary of member services only. Benefits and coverage levels vary by plan, and are explained in more detail in your Summary Plan Description and other formal plan documents. Please refer to these documents for details on your medical coverage including deductibles, co-payments, co-insurance and covered services.

Getting Started with HMA

HMA is pleased to be your health plan administrator! We are here to help you create a healthier future by making the most of your benefits.

Where to start

Register on the HMA member portal

Access your benefit and claims information online at **www.accesshma.com**

Share your HMA ID card

Show your ID card to your healthcare providers and your pharmacy at your next visit.

Contact HMA if you have any questions

Call HMA's Customer Care Team M–F, 6 am–6 pm PT at **1-800-869-7093**

What can you do on the HMA member portal?

Search for doctors and hospitals in the HMA network.

Download or print a copy of your member ID card.

View benefits/ coverage information.

View claims details and account balances.

Download and submit member forms.

Connect to other HMA programs and services.

Access health and wellness discounts.

Ask HMA a question online via secure messaging.

How do you register for the HMA member portal?

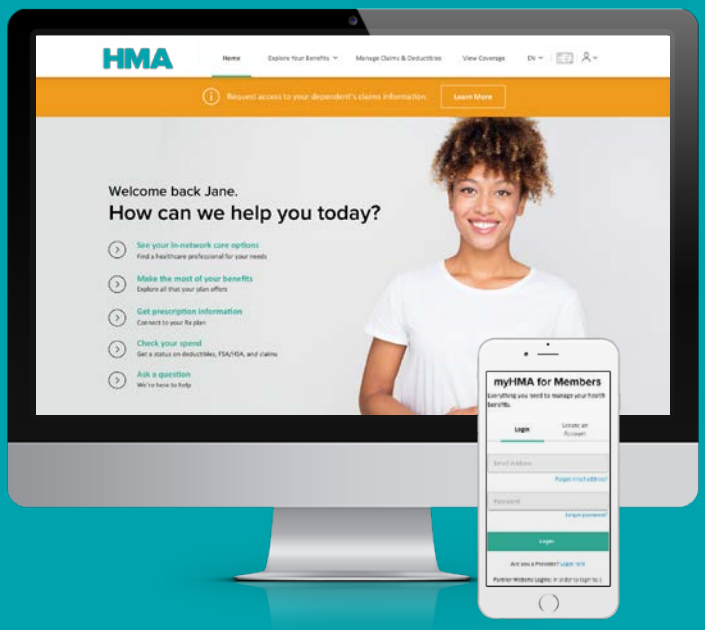
1. Go to **www.accesshma.com**
2. Select the *myHMA Member Login* button on desktop computers and *myHMA* button on smartphones and tablets on the top of the page.
3. If it is your first time on the member portal, you will need to register and create an account. Be sure to have your HMA member ID card available. You will be asked to enter your name, date of birth, and member ID number EXACTLY as they appear on your member ID card.

To comply with regulations that restrict access to a dependent's protected health information, members 13 years and older need to set up their own online account on the HMA member portal with their own unique email address. Once registered, the dependent can grant or deny parent / guardian access to their account. If you have any questions, please call our Customer Care team at **1-800-869-7093**.

Managing your health plan just got easier.

Healthcare Management Administrators is proud to provide secure access to your personal health plan details through our newly redesigned member portal.

Find plan details, network and ID card information, as well as an ongoing report of healthcare spending toward annual deductibles, out-of-pocket maximums and spending accounts.



Features:

- ✓ Manage your claims and deductibles
- ✓ Find an in-network doctor or hospital
- ✓ Connect to your prescription plan
- ✓ View, print, or share your ID card
- ✓ Verify your coverage for services and more!

Log in or create an account today at **www.accesshma.com**

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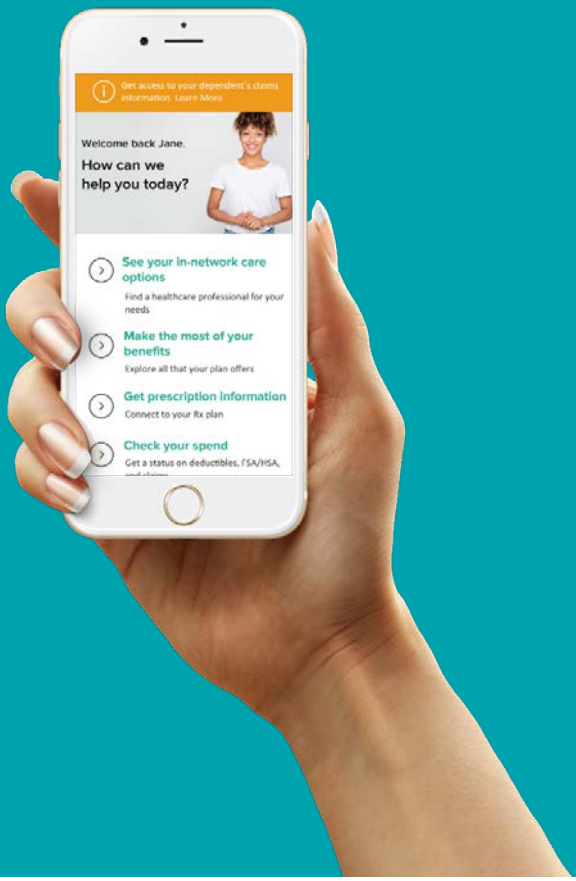
Healthcare at your fingertips.



Healthcare Management Administrators is proud to provide secure access to your personal health plan details through our new mobile app.

Find plan details, network and ID card information, as well as an ongoing report of healthcare spending toward annual deductibles, out-of-pocket maximums and spending accounts.

Get on-the-go access to health information and tools – all from your fingertips.

Log in or create an account today at accesshma.com

Download the app

Download on the App Store

GET IT ON Google Play

Features:

- ✓ Manage your claims and deductibles
- ✓ Find a in-network doctor or hospital
- ✓ View, print, or share your ID card
- ✓ Verify your coverage for services and more!

HMA

www.accesshma.com

Healthcare Management Administrators, Inc.

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Start Saving Money by Staying In-Network

Your plan gives you access to the largest healthcare provider networks in the Pacific Northwest.

Why is this important?

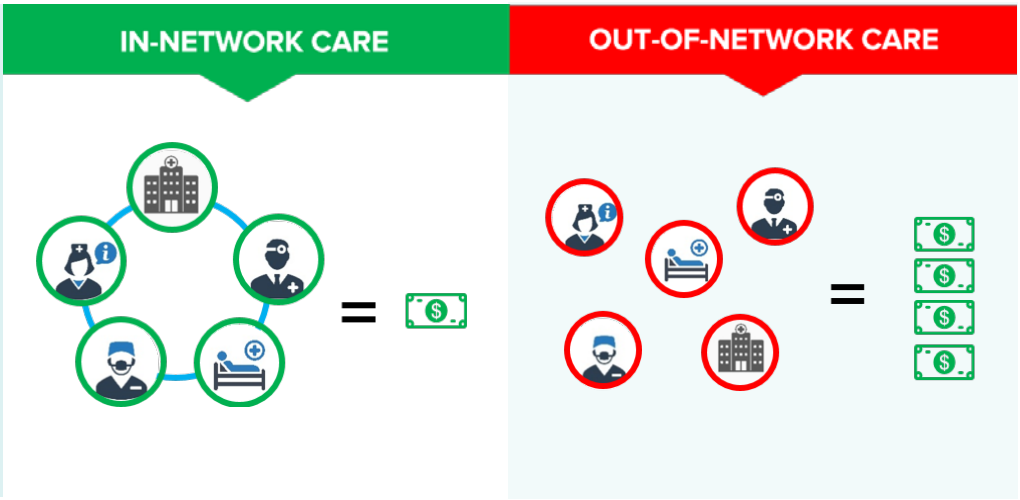
By staying in-network, you gain access to care at a network-discounted price and protection from balance billing. With out-of-network options, you are likely to pay more and are not protected from the risk of balance billing.

Why go in-network?

Each in-network provider has agreed to accept your plan's contracted rate as payment for services. Their costs are usually lower than those of out-of-network providers. They also agree to file claims for you and not bill you for charges beyond the contracted price.

What is a network?

A network is a group of doctors, hospitals, and other healthcare providers. This group has worked with us to get special prices just for you. When a healthcare provider is in your network, it's called “in-network."



How to make sure your care is in-network

Search for in-network providers on our website. Visit **accesshma.com**, log in to your **myHMA account**, and select Find a Local Doctor or Hospital.

Confirm in-network status directly with your provider before the service is rendered.

Always confirm all steps of your treatment are in-network. For example, your doctor may refer you to a **lab or specialist** not in your network that is likely to cost you more.

If you have any questions or need any help, contact our Customer Care team at **1-800-869-7093** M-F 6:00 AM – 6:00 PM PT.

Find a Doctor or Hospital in the HMA Network

Choose In-Network providers to ensure you receive quality care at the best price.

Visit **www.accesshma.com** and select the myHMA Member Login button on the top of the page for access to the full search experience. Have a question? Call our Customer Care Team at **1-800-869-7093** for assistance in finding an in-network healthcare provider.

Find an in-network doctor or hospital in Washington, Oregon, Idaho, or Utah

1. Log in to your myHMA account, select "Explore Your Benefits," and then select "Find a Local Doctor or Hospital."
2. Your home address will be the default location. You can also switch to your current location by clicking the arrow, or you can enter a new location.
3. Under "Select a Category," select "All Categories," or search for doctors by name, doctors by specialty, places by name, and places by type.
4. After you select a category, enter a specialty type (for example: primary care, OB/GYN, etc.) or a specific doctor's or hospital's name.
5. Refine your search results by using the filters on the left-hand side of your screen.
6. If you see this symbol, ⚠ be sure to read the important notes.

Find an in-network doctor or hospital in all other States

1. Log in to your myHMA account, select "Explore Your Benefits," and then select "Find National Doctor or Hospital."
2. Note that this search page looks different from the local search tool. Select either "Doctor" or "Facility" and be sure to read the "Important Note" before selecting the Continue button.
3. Enter your search criteria on the next page, then select the Continue button. Your search results will appear on the next page.

Prescription and Pharmacy Helpful Hints

If your pharmacy is not able to fill your prescription or process your pharmacy benefits, refer to these questions to help you determine the source of the problem and possible solution.

Does the pharmacy have your most up-to-date information?

Make sure to show your current HMA member ID card each time you fill a prescription. The pharmacy may have an incorrect or old ID card on file. Also, be sure the pharmacy is using the RxID number on the front of your ID card and not your Employee ID number. If the pharmacy needs assistance, it can contact the Pharmacy Benefits number on the back of your ID card.

Is the prescription covered under your plan?

Some prescriptions may be excluded from your plan — even ones you've filled before, if there has been a change on a formulary, or list of covered drugs. Call the Pharmacy Benefits number on the back of your ID card to determine if your prescription is currently covered. If not, a generic equivalent or similar drug may be available for you to fill. In some cases, a new prescription from your doctor may be required.

Does the prescription require a prior authorization?

Your doctor may prescribe a medication that required prior authorization due to your plan's formulary (list of covered drugs). In those cases, your doctor will need to request a prior authorization, either by phone or by fax, in order for the drug to be covered under your health plan.

You and your doctor will be notified after the information provided by your doctor is reviewed to determine if the medication meets the criteria for coverage. If the prior authorization is approved, the pharmacy will fill your prescription.

If your doctor changes the dosage or frequency of your prescription, or increases the number of refills, your doctor may need to re-authorize your prescription before the pharmacy can fill it.

If you are still experiencing a problem, or if you need a prescription immediately and your benefits are being denied at the pharmacy, **contact the Customer Care Team**. We're open 6 am–6 pm PT, Monday through Friday, at **1-800-738-3924.**

Using Your Health Plan Benefits When You Travel

When you're a Healthcare Management Administrators (HMA) member, you have the peace of mind knowing that wherever you are, you are able to access your health plan benefits.

Coverage across the country

No matter where you are in the United States, you will be covered under your HMA Plan. You have access to the network and savings discounts negotiated with healthcare providers in each state.

Around the world

Coverage terms with non-US providers may be different. Before leaving the United States, verify your international benefits with HMA's Customer Care Team at **1 -800-869-7093.**

How to access your national coverage:

- Always carry your current HMA member ID card with you.
- To find in-network doctors and hospitals, log in to the myHMA member portal at **www.accesshma.com** and click on "Find a doctor or hospital."
- Call HMA's Customer Care Team at **1-800-869-7093** for any required pre-certification or pre-authorization.
- When you arrive at the in-network doctor's office or hospital, show them your HMA member ID card. The provider can find on the back of the card the information and contact details to inquire about your benefit coverage and to find out how to submit the claim.

How to submit a claim to the HMA member portal:

1. Visit **www.accesshma.com** and then click the myHMA Member Login button at the top of the page.
2. After logging in to the myHMA member portal, from the top of the screen, select "Manage Claims and Deductibles."
3. Select the "Submit a Claim" button.
4. To submit a claim, you will first need to attach the following three (3) documents:
    1. The completed Medical Claim Form.
    2. The itemized bill from your healthcare provider.
    3. The itemized receipt showing proof of payment.
5. After your claim is submitted, you can visit the "Manage Claims and Deductibles" page to view your claim status.

Note: Claims may take up to 25 days to appear in your myHMA portal.

In an emergency, go directly to the nearest hospital.

How to Submit a Claim to HMA

If you select an out-of-network provider, you may be asked to pay the bill upfront. If your procedure or service is covered under your health plan, you can receive reimbursement according to your Plan's available out-of-network benefits, subject to any applicable deductibles or co-pays. Below you will find steps to follow to submit your claim.

Step 1. Check to make sure that the service is covered by your health plan.

View your benefit plan information, which is available on the HMA member portal at **www.accesshma.com**. As an option, you can always confirm benefits with HMA's Customer Care team by calling **1-800-869-7093** or sending them a secure message on the member portal.

Step 2. Download and print a copy of the HMA Medical Claim Form.

1. Visit **www.accesshma.com** then select the Member button
2. Select "Download Member Forms" then select "Medical/Dental/Vision Claim Form"

Step 3. Take the form *and* your HMA member ID card to your healthcare provider.

1. Complete Sections 1, 4, 5, and 7 of the Medical Claim Form before arriving at your appointment
2. Have your healthcare provider complete Sections 2 and 3
3. Show your member ID card to your provider. Make sure they make a copy for their records (even if they "don't take insurance")
4. Discuss payment arrangements with your provider. Sign and date Section 6 if you are required to pay for services up front.

Step 4. Submit the completed Medical Claim Form, your itemized bill* and receipt to HMA.

You can do this one of three ways:

- Upload to the HMA member portal
- Mail to the address on the top of the form
- Fax to the number on the top of the form

**An itemized bill is one that contains the provider's name and address, their Federal Tax ID Number, date of service, procedure(s) performed, and the nature (diagnosis) of the accident or illness being treated.*

How to submit a claim using the HMA member portal:

1. Visit **www.accesshma.com** then select the myHMA Member Login button on the top of the page
2. After logging in to the myHMA member portal, on the top header of the screen, select "Manage Claims and Deductibles"
3. Select the "Submit a Claim" button
4. To submit a claim, you will first need to attach the following three (3) documents:
   1. The completed Medical Claim Form
   2. The itemized bill from your healthcare provider
   3. The itemized receipt showing proof of payment
5. After your claim is submitted, you can visit the "Manage Claims and Deductibles" page to view your claim status

Note: Claims may take up to 25 days to appear in your myHMA portal

All claims for reimbursement must be submitted within one year of the date the service was provided.
Select an in-network provider to avoid submitting a claim and unexpected bills.
To check the network status of a provider, visit **accesshma.com/find-a-provider**.

How to Sign-Up for Electronic EOBs

The Explanation of Benefits (EOB) is a document that is generated when HMA processes a claim submitted by you or your healthcare provider. EOBs can help you better understand how your health plan works. You may receive these in the mail, but you can also access them electronically.

Go paperless

1. Visit **www.accesshma.com** and select the myHMA Member Login button on the top of the page.
2. Log in to your member portal and select the member icon located on the top right.
3. Select “Communication Preferences” on the drop-down menu.
4. Select “email” under EOB communication preferences.
5. Once signed up, you will start receiving EOB notices in your email after you receive healthcare services and your claims are processed. They will be from our vendor, Redcard, with the subject line “Your Electronic EOB Has Arrived!” This email is simply a notification that you have an EOB available to view from your Member Portal.

Access your EOBs online

1. Visit **www.accesshma.com** and select the myHMA Member Login button on the top of the page.
2. Log in to your member portal and select “Manage Claims & Deductibles” located on the top navigation bar.
3. Select the claim number.
4. Select “View EOB for this claim.”
5. A PDF version will open that you can download or print.

Understanding Your Explanation of Benefits (EOB)

What is an Explanation of Benefits?

Commonly referred to as an "EOB," the Explanation of Benefits document is generated when HMA processes a claim submitted by you or your healthcare provider. The EOB is not a bill, it simply explains how your health plan benefits were applied to that particular claim.

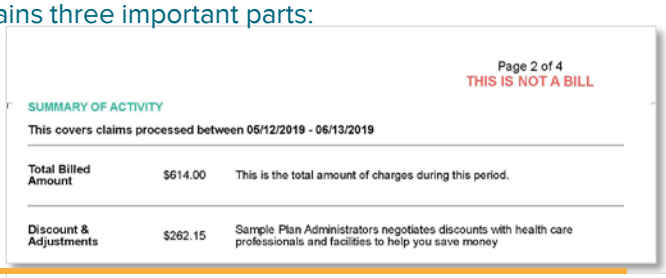
What am I supposed to do with this information?

Each time you receive an EOB, review it closely and compare it to the bill or statement from your healthcare provider. If you have any questions, HMA's contact information can be found on the first page of every EOB. Information on your appeal rights is included at the end of the document.

How to read your EOB

A lot of information is packed into an EOB. An EOB contains three important parts:

1 A summary of activity shows the claims processed between the date(s) of treatment, discounts and adjustments, amounts not covered, what the plan paid, amount owed, and the amount saved.



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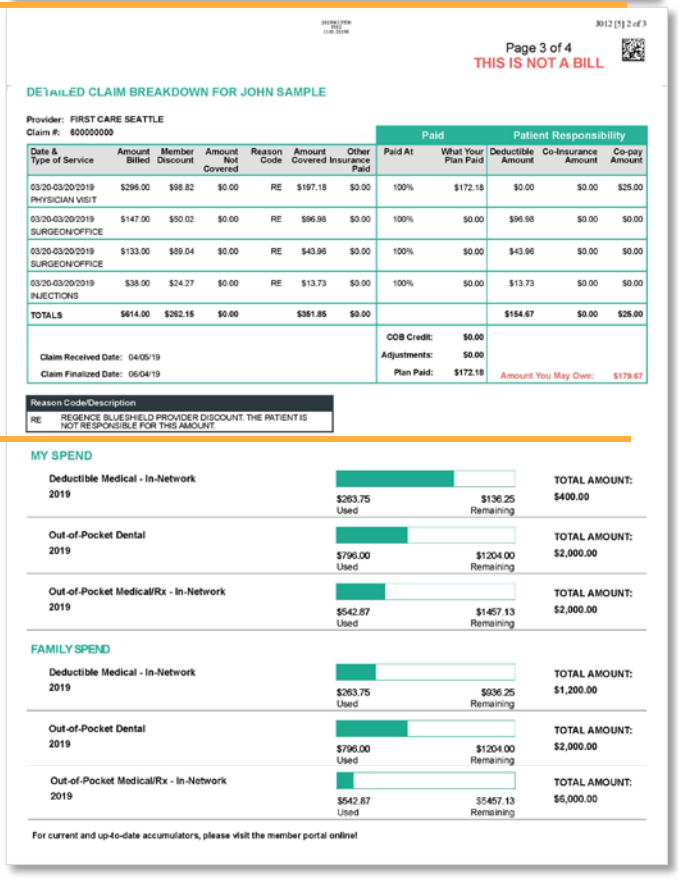
THIS IS NOT A BILL

SUMMARY OF ACTIVITY

This covers claims processed between 05/12/2019 - 06/13/2019

Total Billed Amount	$614.00	This is the total amount of charges during this period.
Discount & Adjustments	$262.15	Sample Plan Administrators negotiates discounts with health care professionals and facilities to help you save money

2 An easy-to-read claims breakdown section shows detailed explanations and reason codes. Here you will see more information on what was paid, any copays, and what may be your responsibility to pay.



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THIS IS NOT A BILL

DETAILED CLAIM BREAKDOWN FOR JOHN SAMPLE

Provider: FIRST CARE SEATTLE
Claim #: 600000000

Date & Type of Service	Amount Billed	Member Discount	Amount Not Covered	Reason Code	Amount Covered	Other Insurance Paid	Paid: Paid At	Paid: What Your Plan Paid	Patient Responsibility: Deductible Amount	Patient Responsibility: Co-Insurance Amount	Patient Responsibility: Co-pay Amount
03/20-03/20/2019 PHYSICIAN VISIT	$296.00	$98.82	$0.00	RE	$197.18	$0.00	100%	$172.18	$0.00	$0.00	$25.00
03/20-03/20/2019 SURGEON/OFFICE	$147.00	$50.02	$0.00	RE	$96.98	$0.00	100%	$0.00	$96.98	$0.00	$0.00
03/20-03/20/2019 SURGEON/OFFICE	$133.00	$89.04	$0.00	RE	$43.96	$0.00	100%	$0.00	$43.96	$0.00	$0.00
03/20-03/20/2019 INJECTIONS	$38.00	$24.27	$0.00	RE	$13.73	$0.00	100%	$0.00	$13.73	$0.00	$0.00
TOTALS	$614.00	$262.15	$0.00		$351.85	$0.00			$154.67	$0.00	$25.00

COB Credit:	$0.00
Adjustments:	$0.00
Plan Paid:	$172.18
Amount You May Owe:	$179.67

Claim Received Date: 04/05/19
Claim Finalized Date: 06/04/19

Reason Code/Description	
RE	REGENCE BLUESHIELD PROVIDER DISCOUNT. THE PATIENT IS NOT RESPONSIBLE FOR THIS AMOUNT.

3 The last sections, My Spend and Family Spend, display how much of the claim was applied toward your deductible. It also shows the remaining amount needed to meet your deductible, as well as how close you are to your out-of-pocket maximum for the year.

MY SPEND

Deductible Medical - In-Network 2019	$263.75 Used	$136.25 Remaining	TOTAL AMOUNT: $400.00
Out-of-Pocket Dental 2019	$796.00 Used	$1204.00 Remaining	TOTAL AMOUNT: $2,000.00
Out-of-Pocket Medical/Rx - In-Network 2019	$542.87 Used	$1457.13 Remaining	TOTAL AMOUNT: $2,000.00

FAMILY SPEND

Deductible Medical - In-Network 2019	$263.75 Used	$936.25 Remaining	TOTAL AMOUNT: $1,200.00
Out-of-Pocket Dental 2019	$796.00 Used	$1204.00 Remaining	TOTAL AMOUNT: $2,000.00
Out-of-Pocket Medical/Rx - In-Network 2019	$542.87 Used	$5457.13 Remaining	TOTAL AMOUNT: $6,000.00

For current and up-to-date accumulators, please visit the member portal online!

I am still confused. Where can I go to better understand how my health plan works?

We are here to help. If you have additional questions, please contact HMA's Customer Care Team at **1-800-869-7093** M-F 6:00 AM - 6:00 PM PT.

What You Need to Know About Paying for Your Healthcare

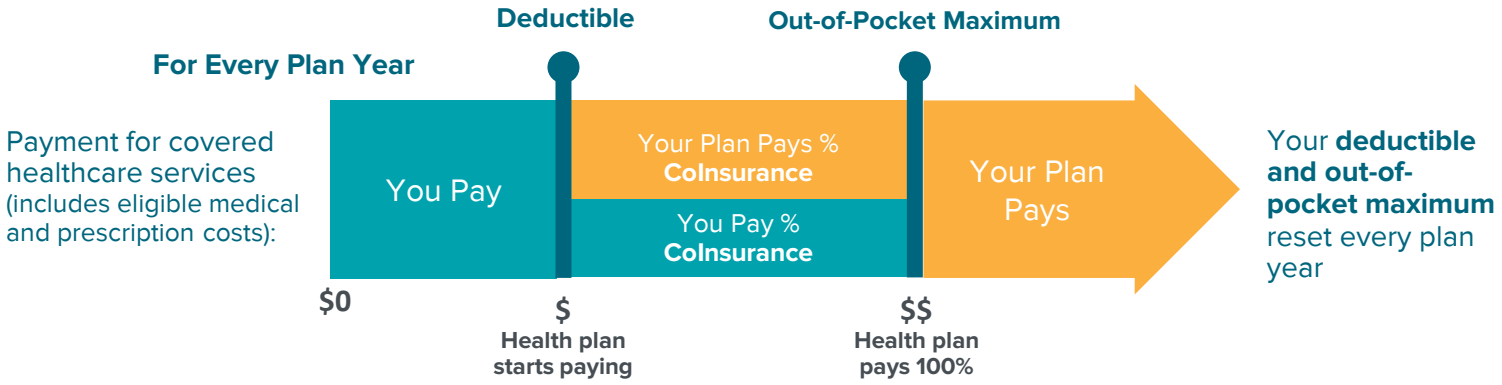
Key terms

Your **copay** is the fixed amount you pay for a covered healthcare service. This is usually paid at the time you receive the service. The dollar amount can vary by the type of service (doctor office visit vs. ER visit) .

Your **deductible** is the amount you pay for covered healthcare services before your health plan starts to chip in.
Note: Preventive services such as wellness exams and cancer screenings are generally not subject to the deductible.

Your **coinsurance** is the percentage you pay for covered healthcare services after your deductible has been met.

Your **out-of-pocket maximum** is the most you will pay for covered healthcare services in a given plan year.



Joe's Healthcare Journey

Joe makes an appointment with his doctor for his annual wellness exam. Preventive services are covered at 100% (in-network) and the deductible is waived. That means Joe does not have to pay anything.

A few months later, Joe needs an X-ray. He has not yet met his **deductible** for the plan year so he has to pay the full amount.

It is flu season and Joe does not feel well. He makes an appointment with his doctor. When he checks into the office, he pays a **co-pay**.

Later in the year, Joe's appendix burst and he needs emergency surgery. He has already met his deductible so he only has to pay his share of the **co-insurance** until he reaches the **out-of-pocket maximum**. From that point on, his health plan will pay the rest.

If Joe gets sick again before the end of the plan year, his health plan will pay 100% of the covered services.

HMA

www.accesshma.com

Free Preventive Care*

Your health plan includes free preventive services when visiting an in-network provider.

***Ask your healthcare provider to find out which covered preventive services are right for you based on your age, gender, and health status.**

- Annual health screenings
- Detection and Prevention of Future Risk for Illness & Disease
- Immunizations
- Blood Pressure, Blood Sugar & Cholesterol Checks

For Males

	Ages 18-39	Ages 40-49	Ages 50-64	Ages 65-74	Ages 75+
☐ Prostate Exam	—	Based on individual risk, family history	Offered yearly, based on recommendation	Offered yearly, based on recommendation	Offered yearly, based on recommendation
☐ Testicular Exam	Yearly	Yearly	Yearly	Yearly	Yearly
☐ Colonoscopy	—	Based on family history	Based on family history	Based on family history	Based on family history
☐ Cholesterol Test	Every 5 years	Every 5 years	Every 5 years	Every 5 years	Every 5 years
☐ Diabetes Screening	Overweight patients with a risk factor for prediabetes	Patients age 45+ who are overweight	Offered yearly, based on recommendation	Offered yearly, based on recommendation	Offered yearly, based on recommendation
☐ Lung Cancer	—	—	One time if history of smoking	One time if history of smoking	One time if history of smoking
☐ Dental Exam	1-2 times a year	1-2 times a year	1-2 times a year	1-2 times a year	1-2 times a year
☐ Influenza Vaccine	Annually	Annually	Annually	Annually	Annually
☐ Tetanus Diphtheria Booster Vaccine	Every 10 years	Every 10 years	Every 10 years	Every 10 years	Every 10 years
☐ Shingles Vaccine	—	—	One dose after age 50, even if you have had shingles before		

For Females

	Ages 18-39	Ages 40-49	Ages 50-64	Ages 65-74	Ages 75+
☐ Mammogram	Based on family history	Yearly at age 45	Yearly until 54; every 2 years for age 55+	Every 2 years	Based on individual cancer risk
☐ Pap Smear	Every 3 years beginning at age 21	Every 5 years	Every 5 years	Every 5 years	Based on physicians recommendation
☐ Pelvic Exam	Yearly	Yearly	Yearly	Yearly	Yearly
☐ Clinical Breast Exam	1-3 years	Yearly	Yearly	Yearly	Yearly
☐ Colonoscopy	—	Based on family history	Based on family history	Based on family history	Based on family history
☐ Diabetes Screening	Overweight patients with a risk factor for prediabetes	Patients age 45+ who are overweight	Offered yearly, based on recommendation	Offered yearly, based on recommendation	Offered yearly, based on recommendation
☐ Lung Cancer	—	—	One time if history of smoking	One time if history of smoking	One time if history of smoking
☐ Dental Exam	1-2 times a year	1-2 times a year	1-2 times a year	1-2 times a year	1-2 times a year
☐ Influenza Vaccine	Annually	Annually	Annually	Annually	Annually
☐ Tetanus Diphtheria Booster Vaccine	Every 10 years	Every 10 years	Every 10 years	Every 10 years	Every 10 years
☐ Shingles Vaccine	—	—	One dose after age 50, even if you have had shingles before		

HMA

Sources: United States Preventative Services Task Force, the Advisory Committee on Immunization Practices, the American College of Cardiology/American Heart association Task Force on Practice Guidelines, and the American Academy of Family Practices.

Please note: This chart is only a guideline. Contact your healthcare provider to determine which tests and examinations best meet your healthcare needs. Please refer to your plan summary or contact our Customer Care at **1-800-869-7093** for more information on plan benefits for these services.