

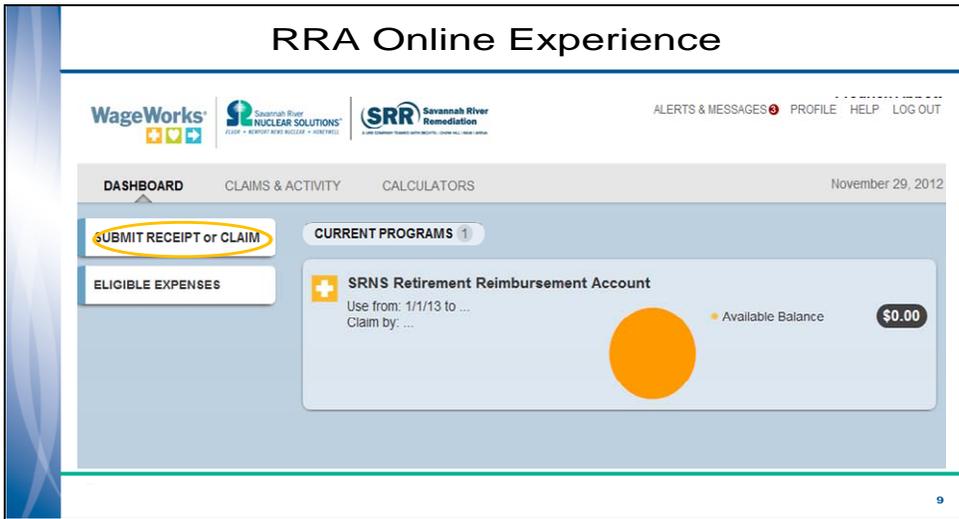
RRA Insurance Premium Pay My Provider Instructions



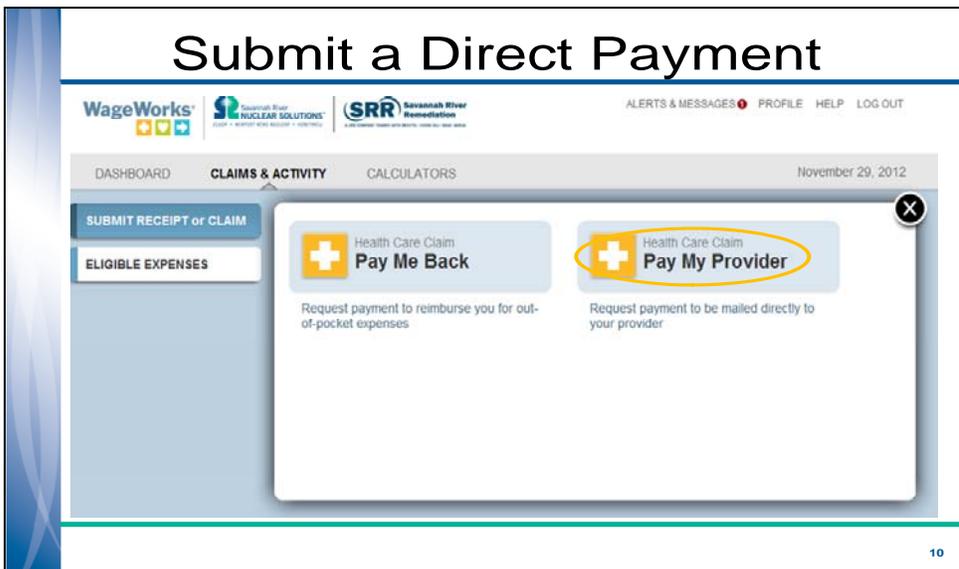
Pay My Provider

Pay My Provider is an option where regular recurring payments are issued directly to the service provider. To implement PMP the participant enrolls online via the WageWorks website.

1. Click on “Submit Receipt or Claim”



2. Then select “Pay My Provider.”



- Select either a One-Time Payment or recurring Monthly Payment option.

The screenshot shows the 'Instructions' page for 'HEALTH CARE PAY MY PROVIDER CLAIM'. At the top, there are logos for WageWorks, Savannah River Nuclear Solutions, and SRR Savannah River Remediation. The page title is 'HEALTH CARE PAY MY PROVIDER CLAIM' with a date of 'January 12, 2013'. Below the title are 'BACK' and 'NEXT' buttons. A progress indicator shows steps 1 through 5, with step 1 highlighted. The main content area is titled 'Instructions' and contains the following text:

Before You Start
Have your receipt or contract in front of you. Enter one receipt or contract at a time.

Follow These Steps

- 1 Enter Service Date(s).
- 2 Enter Item Details.
- 3 Enter Provider.
- 4 Review and Submit Claim.
- 5 Upload Receipt(s).

At the bottom of the instructions are two large yellow buttons: 'Make One-Time Payment' and 'Make Recurring Monthly Payments'.

- Enter invoice/account information if available from your provider. These are optional fields that are sent along with the check to your provider and utilized to further identify your account. Enter the desired date for payment. **At least ten (10) days advance notice is required. Enter the first date of service.** For example, Feb. 1st for February premium. Select the number of payments to be made. Then hit the "Next" button.

The screenshot shows the 'Enter Service Date(s)' form. At the top, there are logos for WageWorks, Savannah River Nuclear Solutions, and SRR Savannah River Remediation. The page title is 'HEALTH CARE PAY MY PROVIDER CLAIM' with a date of 'January 12, 2013'. Below the title are 'BACK' and 'NEXT' buttons. A progress indicator shows steps 1 through 5, with step 1 highlighted. The main content area is titled 'Enter Service Date(s)' and contains the following text:

Enter the following as displayed on the receipt or contract you will submit to verify this claim. All information will be verified when your claim is processed.

Invoice Number Optional. Assigned by your provider.

Account Number Optional. Assigned by your provider.

First Requested Payment Date Day you want first payment mailed.

First Payment Service Date First day of care covered by first requested payment.

Number of Payments

- Verify the payment schedule and hit the “Next” button.

HEALTH CARE PAY MY PROVIDER CLAIM January 13, 2013

1 2 3 4 5

Enter Service Date(s)

Payment Date	Service Date
23-Jan-13	02-Jan-13
23-Feb-13	02-Feb-13
23-Mar-13	02-Mar-13
23-Apr-13	02-Apr-13
23-May-13	02-May-13
23-Jun-13	02-Jun-13
23-Jul-13	02-Jul-13
23-Aug-13	02-Aug-13
23-Sep-13	02-Sep-13
23-Oct-13	02-Oct-13
23-Nov-13	02-Nov-13
Total	11 Payments

- Select “Premium” as the Description of Service from the drop down menu. Enter the amount and the name of the retiree or dependent and hit the “Next” button.

HEALTH CARE PAY MY PROVIDER CLAIM January 13, 2013

1 2 3 4 5

Enter Item Details

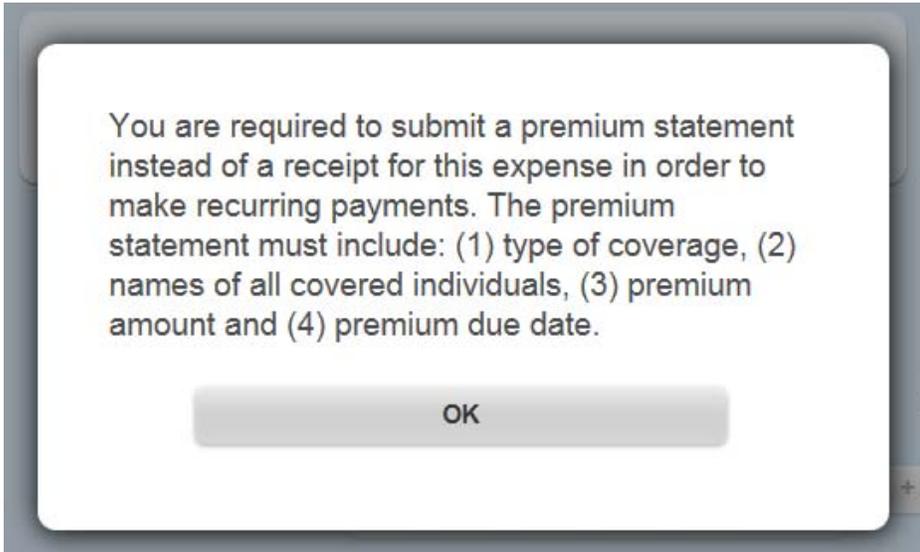
Enter the following as displayed on the receipt or contract you will submit to verify this claim. All information will be verified when your claim is processed.

Description Premiums ▼

Amount \$ 200.00 Your out-of-pocket cost.

Patient Name Select Name ▼ + ADD NEW PATIENT

You are reminded to submit a premium statement from your provider. Coupon slips are also acceptable. This supporting documentation is only required once when setting up recurring monthly payments. Select the “OK” button.



- 7. Select the Provider from the list or add a new provider name.



- Confirm the summary and hit the “Submit Claim” button. Payment(s) will be made in the amount requested based on your available balance when this payment is processed. Future payments may be cancelled up to ten (10) business days prior to the requested payment date.

WageWorks® Savannah River NUCLEAR SOLUTIONS™ SRR Savannah River Remediation

LOG OUT

HEALTH CARE PAY MY PROVIDER CLAIM January 13, 2013

1 2 3 4 5

BACK **Review and Submit Claim** SUBMIT CLAIM

Provider BLUE CROSS BLUE SHIELD OF GEORGIA PO BOX 541020 LOS ANGELES, CA 30907 (877) 860-0015	Account Number 100000 Invoice Number 10000	First Service Date Jan 02 2013
Expense Description Premiums	Patient	Payment Amount \$200.00

Requested Payment Dates
23-Jan-13 and every month thereafter for 10 months
Following approval of claim, review of receipt, and verification of available balance to make payment.

- Follow the instructions to scan and upload the invoice, contract or valid documentation from your computer.

HEALTH CARE PAY MY PROVIDER CLAIM January 19, 2013

1 2 3 4 5

BACK **Submit Receipt** NEXT

- Description of service or purchase.
- Provider or merchant name.
- Patient name.
- Your cost.
- Monthly premium statement for indicated item(s)

Choose One of These Options

a Submit an electronic version of your receipt online NOW. Recommended! This is the fastest way to get your claim processed.	b Submit an electronic version of your receipt online LATER.	c Print a claim form and send via fax or mail.
--	---	---

Submit Receipt Online NOW

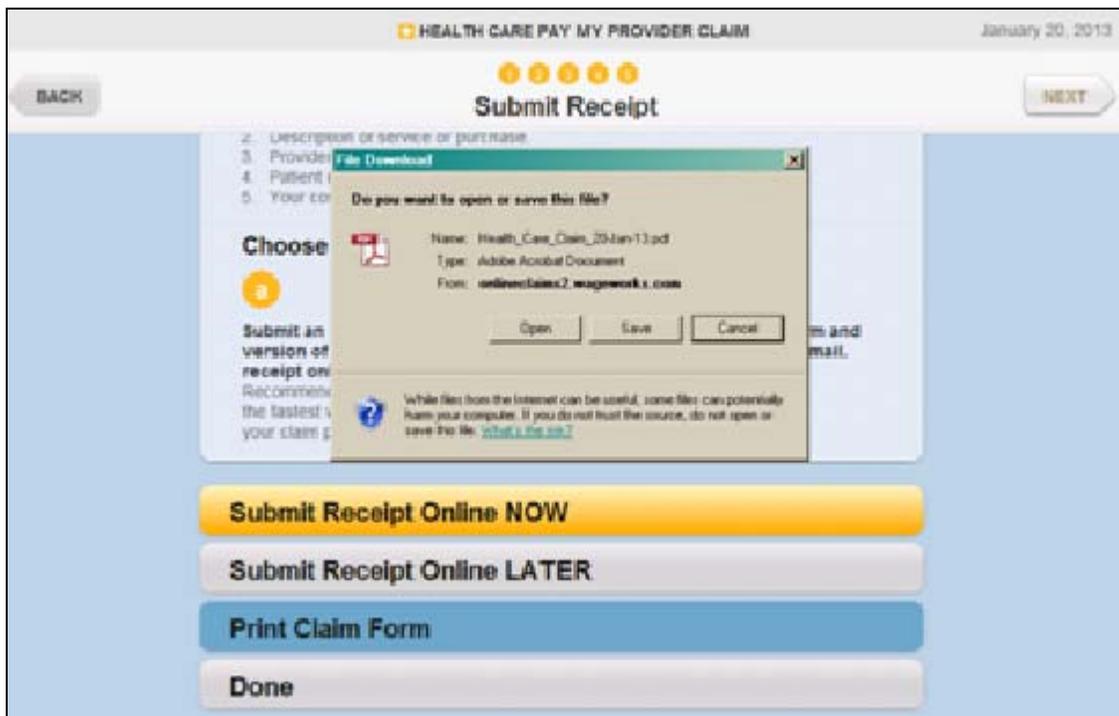
Submit Receipt Online LATER

Print Claim Form

10. Participants can also print the documentation and fax to 877-353-9236 or mail to: Claims Administrator, P.O. Box 14053, Lexington, KY 40512
11. Include documentation showing monthly premium amount from the insurance company (examples of different types of acceptable documentation is listed below)
 - a. Coupon Slips from the insurance company
 - b. Itemized Statement from the insurance company
 - c. Letter from the insurance company

Documentation must include:

- a. Participant name (name(s) covered individual)
 - b. Healthcare company provider name
 - c. Date(s) of service (coverage period)
 - d. Type of service (type of coverage)
 - e. Premium amount
12. Emails will be sent when the payment(s) are made to the participants email address on file with WageWorks. No partial payments are made if there is not enough balance in the account. Any discrepancies are communicated by email notification. Recurring payments will need to be set up each plan year so new documentation will be needed at the beginning of each plan year.
 13. To print the information, select "Print Claim Form" and select "Open" to open the file. Select the "printer" icon in the upper left hand part of the screen to print the document.





HEALTH CARE ONLINE PMP CLAIM

Online Pay My Provider Proof of Service

www.wageworks.com

TOLL-FREE FAX: 1-877-353-9236

FAX EACH CLAIM FORM SEPARATELY TO ENSURE QUICK PROCESSING.

Or, mail to Claims Administrator, PO Box 14053, Lexington, KY 40512



PMP ID: **OHCPMP1000187827**

Account Holder: Tester Two

Program Sponsor: |

CERTIFICATION AND AUTHORIZATION

I certify that the information on this form is accurate and complete. I am requesting reimbursement for eligible deductible expenses incurred by myself or an eligible dependent while I was a participant in the plan. (Patient & Relationship is assumed to be Self unless otherwise indicated.) I have already received these products and services and confirm that by requesting reimbursement here that I have not and will not seek reimbursement of this expense from any other plan or party. If I am covered under more than one health care account, reimbursement will be made according to the payment order determined by those plans and as stated on the WageWorks Web Site. Use of this service indicates my acceptance of the WageWorks User Agreement at www.wageworks.com (available upon registration; enter user name and password or click on First Time User? link).

INSTRUCTIONS:

- 1 Fax only ONE FORM and its corresponding appropriate proof of service at a time.
- 2 Submit this form along with the Provider signature or the appropriate proof of service (such as an itemized bill or explanation of benefits that contains: date of service, description of service, provider name, cost, and name of person receiving care)