Wente Benefits Program 2025
Frequently Asked Questions

Updated March 2025

Here are some acronyms that will be used throughout this document:

EVHC: This refers to the Anthem **Evolution HealthCare** Medical plan. This is Wente's Medical PPO option which utilizes the Anthem Blue Cross network.
HRA: **Health Reimbursement Account**. This refers to the account which Wente funds. Enrolled employees and enrolled family members can use these funds to pay for part of their medical deductible.
FSA: **Flexible Spending Account**. The FSA is an account that you put your own dollars into. The FSA pre-tax dollars can be used for qualified medical, dental, and vision expenses for you and your qualified dependents.

Below please find a Table of Contents outlining the questions covered in this document:

1. What are eligible expenses under the Dependent Care Flexible Spending Account?
2. When can I start using the funds in my Dependent Care FSA?
3. Will I receive a debit card if I enroll in Dependent Care FSA?

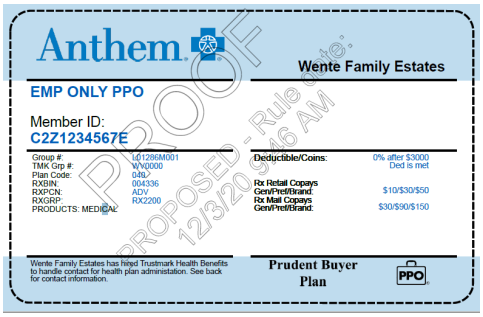
General: Page 14

1. Will I receive an ID card for my Guardian Dental or VSP Vision benefits?
2. How do I search for an in-network dental provider?
3. I am enrolled in medical coverage through Wente. Is Telehealth available to me?
4. How long can my dependent children stay on my medical, dental, and vision plans through Wente?

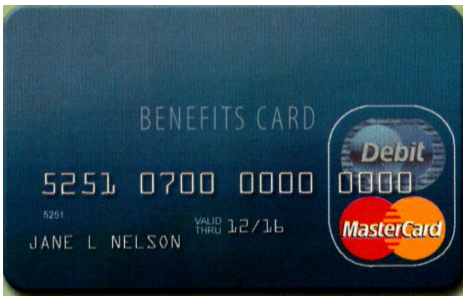
Anthem Evolution Healthcare Questions

1) What do the cards associated with the medical plan look like and when should I use them?

If you are enrolled in the Anthem EVHC Plan, you will receive two cards: a member ID card and an HRA debit card. If your spouse and/or children are on the plan, they will also receive a member ID card. The following image is of the member ID card. You should use this card when you seek services so that your provider or pharmacist can verify your insurance.



<u>You should use this card for bills associated with your medical plan, prescription drug copays, or when a provider insists on receiving payment for services up front:</u>



2) What should I do if I lose my Medical ID or HRA Card?

As it pertains to a request for a medical ID card, you can contact the Customer Service Unit at 877-877-3496 and request an ID card log into your account at myEVHC.com. Once on the landing page, select **My Links** and then click on the link "request an ID card".

If a member loses their HRA debit card or needs a replacement, the member can notify Marin Benefits by either calling 415-526-1401 or emailing helpdesk@marinbenefits.com. Marin Benefits will replace the debit card at no cost to you.

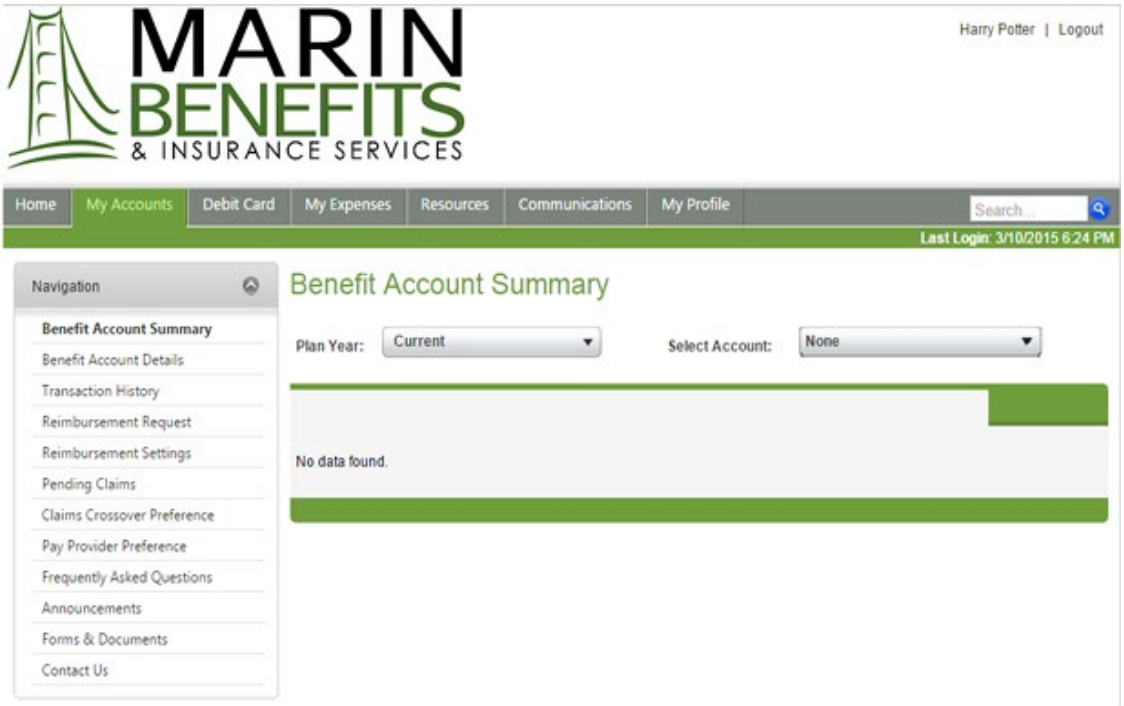
3) How do I access my Marin Benefits account online?

To access your account online, you will need to register by selecting the register button atop the right corner of the home screen. After clicking the register button, complete the registration form. Choose a username and password and enter the required demographic information. Your **Employee ID** is your Social Security Number and your **Employer ID** is MBIWENTE.

4) How do I find out my HRA balance?

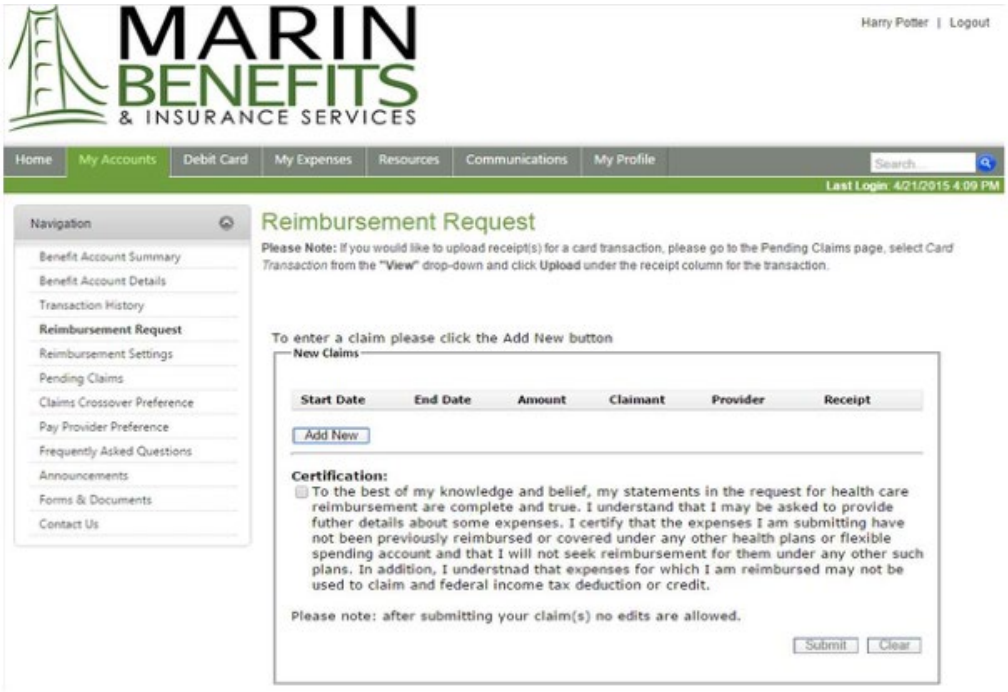
On the Anthem EVHC plan you have two options: you can log into your account at mywealthcareonline.com/marinbenefits to check your balance, or call the customer service line at 415-526-1401 option 1.

Once you log into your account, you can select **Benefit Account Summary** from *My Accounts*. You can also view Transaction history, pending claims, and more.



5) How do I request reimbursement for money I paid out of pocket because I forgot to bring my debit card with me?

You can submit a claim using a paper form or electronically via the Marin Benefits portal. Paper forms can be found under *Forms* on the Wente Benefits Site. When submitting a claim electronically, select **Reimbursement Request** from the *My Accounts* tab. Select **Add New** and fill out the required transaction information. Be sure to upload a copy of your medical receipts. **Note**: Once you submit your claim you are no longer able to edit it.



6) Should I have to pay up-front at a doctor's appointment on the Anthem EVHC plan?

Not at an in-network provider. In-network providers should wait for the Plan to tell them how much to charge you. Please request that the provider bill you. If they require payment up front, they may not be an in-network provider. To check if a provider is in-network, see Anthem Evolution Healthcare Question #9 in this document, "How do I search for an in-network provider on the Anthem EVHC plan?".

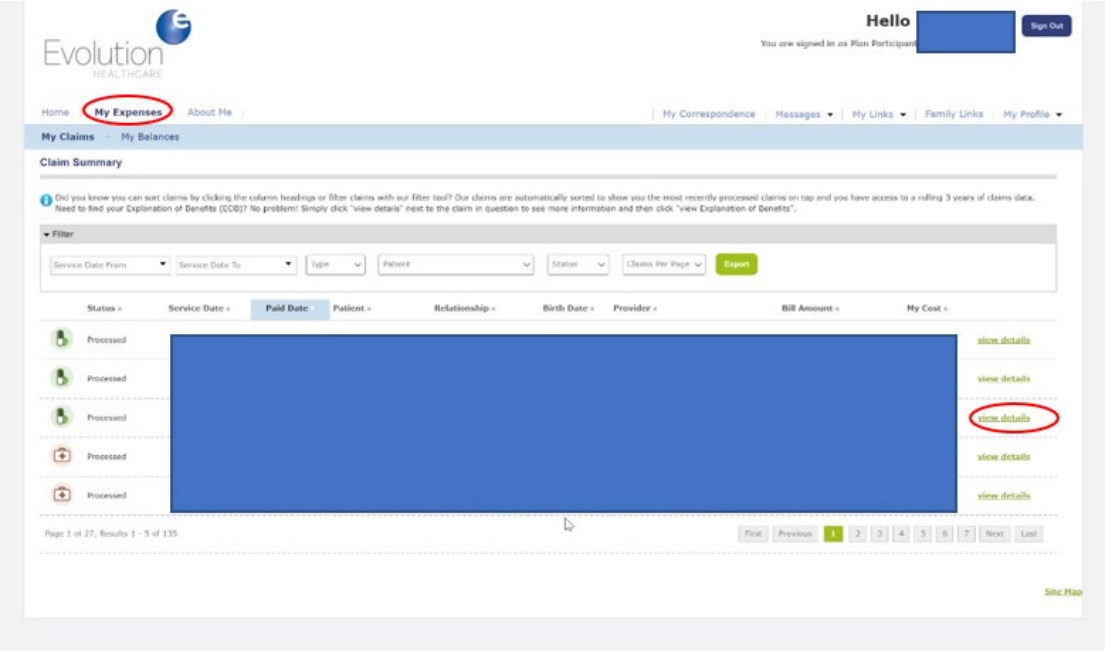
If a provider is trying to charge you your full deductible when you know that you have already met some or all of your deductible, call EVHC for assistance at 877-877-3496. If your provider will not see you without up front payment, you may use your Marin Benefits HRA debit card; however, if the provider charges more than the Plan requires, you will have to work with the provider to obtain overpaid dollars.

7) Marin Benefits is requesting substantiation for one of my services. What do I need to do?

Many purchases made with your debit card will be auto-substantiated, meaning no further documentation is required; however, making purchases at certain merchants or for certain items, does require substantiation. Marin Benefits will notify you if a purchase requires additional documentation (substantiation). If you receive a request, it is important that you respond promptly as a failure to do so could result in your card being temporarily suspended.

For employees enrolled in the Anthem EVHC Plan, you will need to submit an Explanation of Benefits. This document shows the provider, date(s) of service, services performed, and the costs of those services. The easiest way to obtain this document is through the myevhc.com member website. Once logged in, simply follow these steps:

- Select **My Expenses** from the top left corner under the Evolution Healthcare logo.
- Once you select this, you will see a listing of claims based on date of service with the most recent listed first. Navigate to the claim you would like to view.
- Select **View Details** on right-hand side of specific claims to view Explanation of Benefits.
- Expenses that reflect *Deductible* responsibility are eligible for reimbursement from your HRA.
- You may also view the claim history of specific dependents under the age of 18. If the member is over the age of 18, they must register separately and grant you access to view their claim data.
- **Your Anthem EVHC Explanation of Benefits is the document you must provide as substantiation for your claim if requested.**



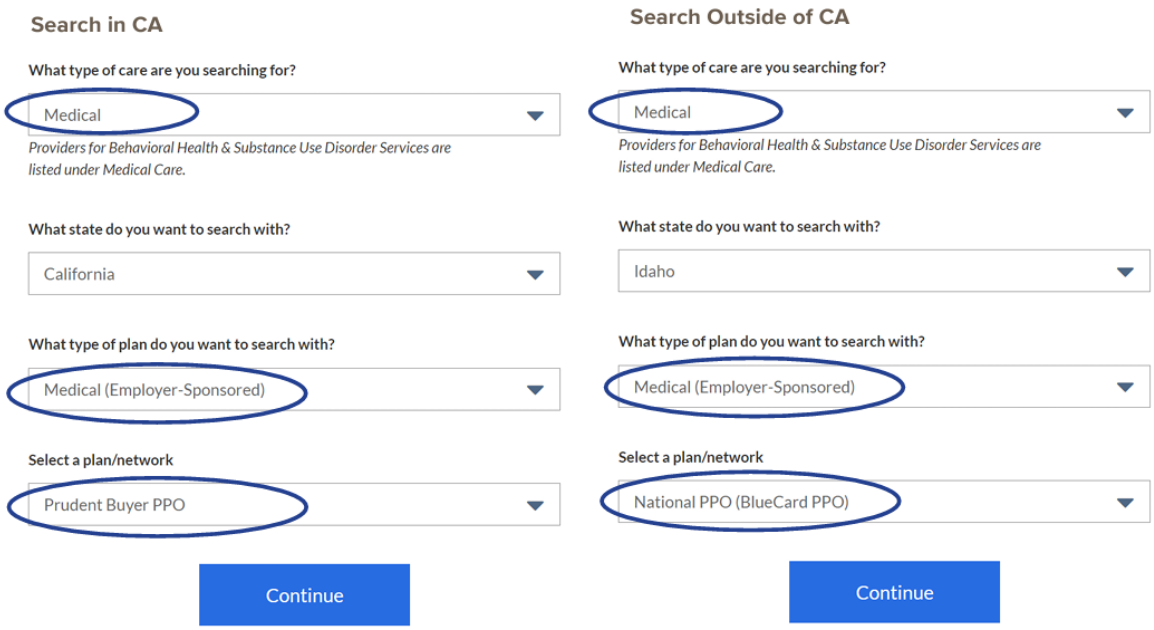
8) How do I submit a claim for an out of network claim on the Anthem EVHC Plan?

If you are on the EVHC plan and seek care from a non-network provider, you will need to submit the claim manually in order to get credit towards your deductible and out of pocket maximum accruals. To submit the claim, fill out and follow the instructions on this Claim Form.

9) How do I search for an in-network provider on the Anthem EVHC plan?

You can visit www.anthem.com/ca to search the Anthem provider list as a guest by following the steps below:

1. Visit www.anthem.com/ca
2. Select **Find Care** at the top right of the home page
3. Make sure the **Guests** tile is selected
4. Make the below selections in the following drop down menus (shown in the screen shots below)



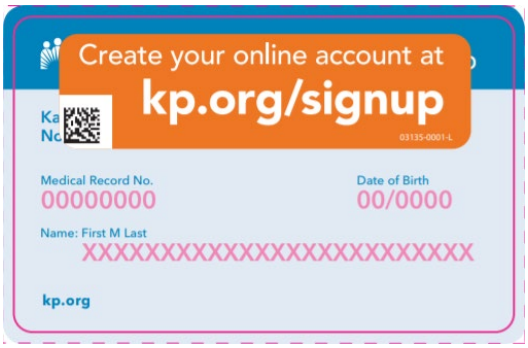
5. Select **Continue**
6. Enter your **Zip Code**
7. Select **Provider** criteria
    1) Who do I contact for pharmacy related questions/inquiries related to my Anthem EVHC plan?

10) Who do I contact for pharmacy related questions/inquiries related to my Anthem EVHC plan?

Members enrolled in the Anthem EVHC plan will use MedImpact as the administrator for the pharmacy portion of their healthcare plan. The pharmacy information can be found on your Anthem EVHC ID card. You can also contact MedImpact by calling toll free at 844-336-2675. Members can also register for the online portal to access their pharmacy benefits at www.medimpact.com

Kaiser HRA Questions

1. **What do the cards associated with the Kaiser medical plan look like and when should I use them?**
   If you are enrolled in the Kaiser plan you will receive two cards: a member ID card and an HRA debit card. The following image is of the member ID card. You should use this card when you seek services so that your provider or pharmacist can verify your plan information.



   <u>You should use this card for all services through the Kaiser plan (doctors' offices, lab work, etc.):</u>

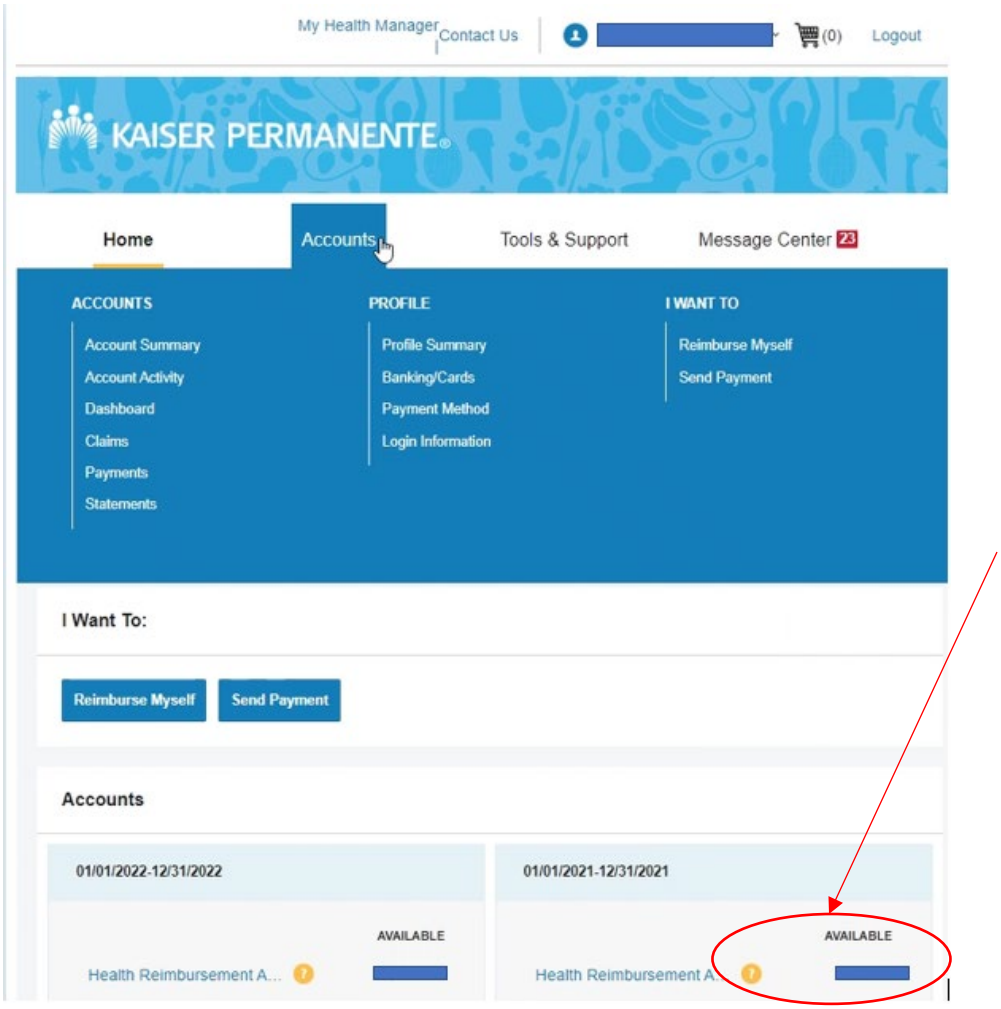
2. **What should I do if I lose my Medical ID or HRA Card?**

   To order a new replacement ID, card a member can call Member Services at 1-800-464-4000 and ask for a new card. Alternatively, whoever has access to the portal can order a new ID card for the member as well. ID cards typically take 7-10 business days to be received after being shipped to the address on file.

   If a member loses their HRA debit card and needs a replacement, they can either order this online or call Kaiser's Health Payment Services team. Sign into kp.org/healthpayment, select "Tools & Support" from the top of the home page, click "Report Card Lost or Stolen" under the "How Do I?" section, then select "Order Replacement" on the following screen. By phone, call 1-877-761-3399, Monday through Friday (except holidays) from 5 a.m. to 7 p.m. Pacific.

3. **How do I find out my HRA balance?**

   On the Kaiser Plan, sign into kp.org/healthpayment using your kp.org user ID and password. Your available balance will be provided on the home screen under "Accounts." You can also call 877-761-3399 Monday-Friday 5am – 7pm PST.



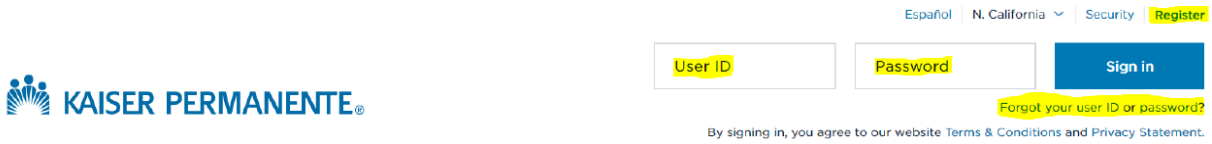
4. **How do I request reimbursement for money I paid out of pocket because I forgot to bring my debit card with me?**

   Use the following claim form and follow the instructions on the form: Kaiser HRA Claim Form When you request reimbursement, you will need to provide supporting documentation in the form of: Explanation of Benefits (EOB), Itemized Receipt, and/or Bill. Please see the instructions below on how to pull EOBs from kp.org. Members can also bypass the below instructions by going to KP.org/eob and signing in. This will bypass the need to navigate through various sections of KP.org and get you directly to My Documents. Accessing EOBs Online:

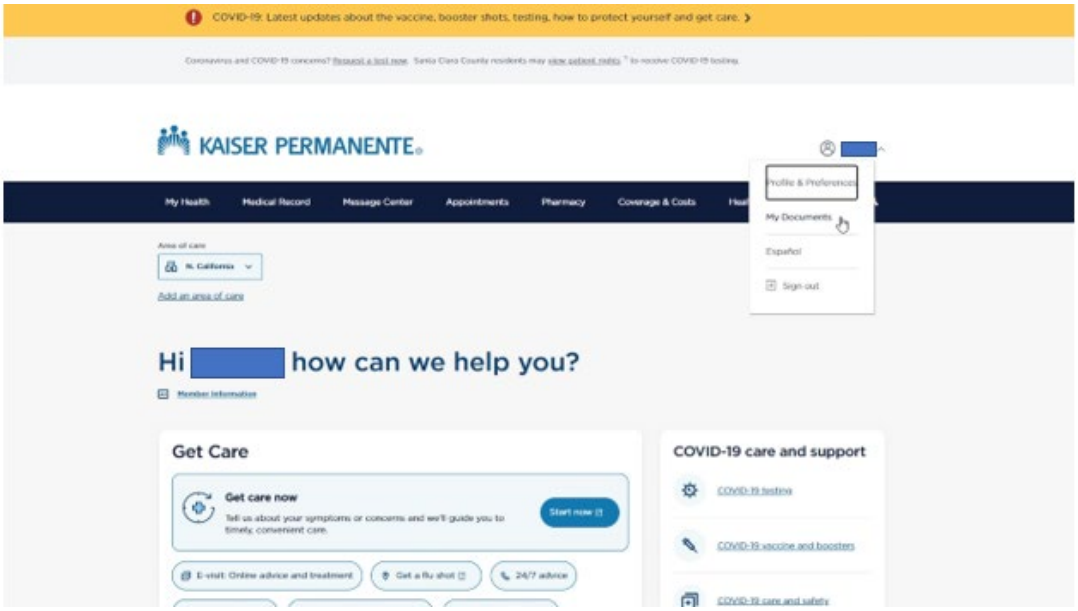
   1) Type in your User ID and Password to sign on to your account.
   2) Click on My Documents in the Utility Menu dropdown:
   3) On My Documents, EOBs are available in the Coverage & Benefits category.
   4) If you need real time support with KP.org, you can contact the Member Services Contact Center at 1-800-464-4000.

5. **How do I review a history of my claims or retrieve an Explanation of Benefits (EOB)?**

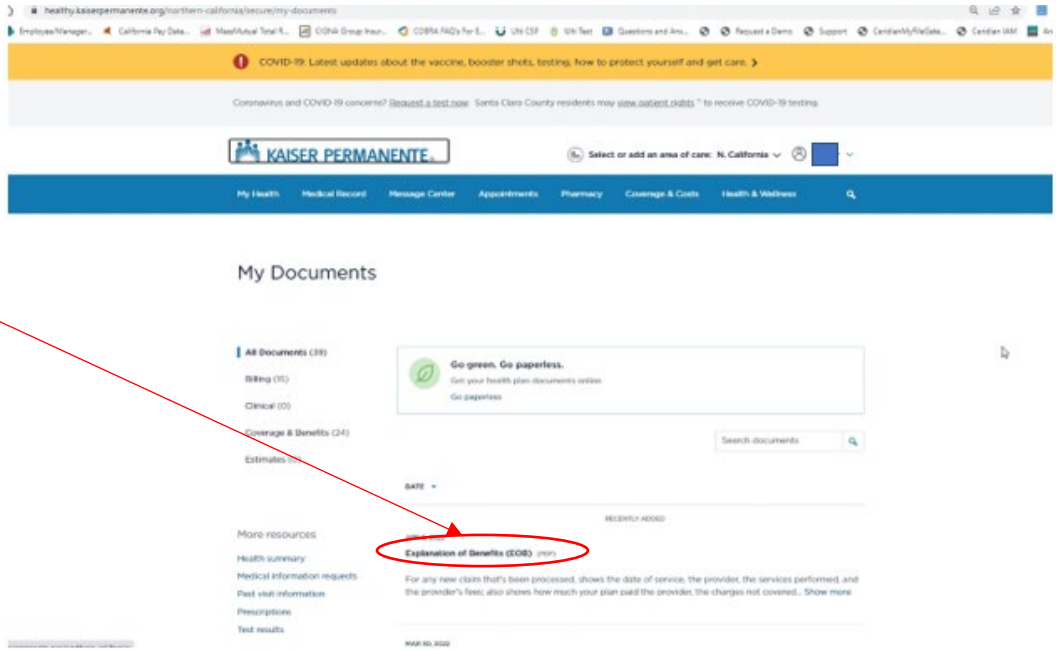
1) Sign into www.kp.org with your User ID and Password. If you have forgotten your User ID or Password, you may retrieve that information using the links provided. If you have not registered at www.kp.org you will need to do so before you are able to continue.



2) On the homepage, click the drop-down menu next to your name and select “My documents”:



3) View “Explanation of Benefits (EOBs)” and find the EOB that corresponds with the date of service in question.



6. **What is the vision coverage under the Kaiser HRA plan? Can I use my Kaiser HRA card to pay for a vision claim?**

   The Kaiser plan is medical only. You can receive a medically necessary vision exam through Kaiser and it can run through the plan / you can use your HRA. However, the Kaiser plan is not vision insurance. Vision hardware (glasses / lenses / contacts / contact fitting exam) are not covered on the plan. As a Kaiser member you have access to their vision supplies and services (which is discounted) but you are responsible for the cost and you cannot use your HRA dollars for this. If you choose to get your vision exam at Kaiser, but have the VSP coverage, you would be best served to take that prescription to an in network VSP provider to fill the prescription.

   The vision insurance through VSP covers exams and materials (lenses / frames / contacts) at one location. For more information, visit: VSP Vision Benefit Summary

BRI Flexible Spending Account Questions

1. **What do the cards associated with the BRI FSA plan look like and when should I use them?**
   If you enroll in the **Health Care FSA plan,** you are setting aside your own pre-tax dollars to spend on qualified medical expenses. This should be used for medical expenses that you incur AFTER your HRA is exhausted, for medical expenses that are not covered by the medical plan, or for dental and/or vision expenses for you and your qualified expenses. The FSA plan is administered by BRI (Benefit Resources Inc)

   Below are images of the FSA debit card that you may have. Note that both of the below cards are valid. Which card you have depends on when you began participating in the FSA plan.

   Here is a picture of an older version of the FSA card:

   Here is a picture of the newest vision of the FSA card:

2. **How do I register an online account with BRI?**
   Registering with BriWeb and/or downloading the BRiMobile App is a convenient and streamlined way to access and utilize your FSA account. Both provide a secure resource for accessing FSA balances, transaction details, online claims submission, and more. To register, visit participant.briweb.com/login. Select the blue "Register an Account" link. Follow the instructions provided. When registering, the company code is: WENTE and the member ID is your SSN.

3. **What should I do if I lose my FSA debit Card?**
   It is recommended that you report a lost card immediately by calling Benefit Resource at (800) 473-9595 or logging on to BRiWeb and clicking "View Card Status." You can request replacement cards through the same process.

4. **Where can I check my FSA account balance?**
   There are several ways you can determine your Account balance:

1) Your Account balance will be displayed on the Explanation of Benefits (EOB) issued with each reimbursement check/Direct Deposit advice.
2) You can access Account information 24/7 when you log into the participant website or by the BRiMobile app for mobile device users.
3) Call the automated QuickBalance Line at (877) 342-0825. This line can also be accessed by calling Participant Services at the number below and selecting Option 1.
4) To speak to a representative about your balance, you may call Benefit Resource Participant Services at (800) 473-9595, Monday – Friday, 8am – 8pm (Eastern Time)

5. **How do I request reimbursement for money I paid out of pocket because I forgot to bring my debit card with me?**
   You can submit a claim through the BRI Mobile App or through a desktop computer. You will need to register for a BRI account to do this. When registering, the company code is: wente and the member ID is your SSN. For detailed instructions with screen shots for submitting a claim, visit this link: Submitting Claims - Walk Through | BRI | Benefit Resource. You will need a few pieces of information available to submit the claim: the name of the service provider, the type of service, any items purchased or services rendered, the dates of service, the claim amount, and the plan year during which the charge was incurred. A copy of the receipt will be required to submit the claim.

6. **Can I use my FSA dollars for dependents whether or not they are enrolled benefits?**
   FSA dollars can be used to pay for any covered expenses for yourself or any qualified (IRS) dependent. The dependent does not need to be enrolled in benefits through Wente. You can use your FSA dollars to pay for qualified out-of-pocket medical, dental, or vision expenses. Please note, for medical expenses related to your medical plan through Wente, you would only use your FSA dollars after you have established that the HRA will not cover the expenses.

7. **Can I request additional debit cards for my dependents?**
   You can request additional debit cards by calling (800) 473-9595. However, additional cards will all have the name of the employee on the card.

BRI Health Care Flexible Spending Account Questions

1. **What are eligible expenses under the Health Care Flexible Spending Account?**
   Health Care FSA eligible expenses are qualified medical products and services and over-the-counter (OTC) drugs and medicines (including dental and vision). Common eligible expenses include: Copayments, coinsurance, deductible, dental care, vision care, eyewear, chiropractic services, etc. For a more detailed list of eligible expenses please visit: https://www.benefitresource.com/resources/eligible/.

2. **When can I start using the funds in my HCFSA?**
   Your full plan year election will be made available to use on the first day of the plan year.

3. **Will I receive a debit card if I enroll in Health Care FSA?**

A debit card will be issued to you if you enroll in the Health Care FSA account. Please note, debit cards are good for 2-3 years, you will not receive a new card each year unless your card is set to expire or needs to be replaced.

BRI Dependent Care Flexible Spending Account Questions

1. **What are eligible expenses under the Dependent Care Flexible Spending Account?**
   You can pay for expenses that enable you or your spouse to be gainfully employed, look for work, or attend school full-time. Common eligible expenses include: before and after school care, child care, in-home dependent care, day care in a facility, nursery school, and adult care.

2. **When can I start using the funds in my Dependent Care FSA?**
   Unlike a Medical FSA, your entire Dependent Care FSA balance is not available at once. Dependent Care funds become available as they are deposited from payroll.

3. **Will I receive a debit card if I enroll in Dependent Care FSA?**
   Unlike Health Care FSA, you will not receive a debit card for the Dependent Care FSA plan. For Dependent Care expenses, you can submit a claim with your itemized receipt or supporting documentation. Claims can be submitted three ways:
   - Online at BenefitResource.com
   - Through the BRiMobile app
   - By faxing/mailing a claim form

Other General Questions

1. **Will I receive an ID card for my Guardian Dental or VSP Vision benefits?**
   No. Guardian and VSP do not issue ID cards for members.

   For Guardian, members can give their provider the following information: Dental Group 00374462 and the employee's name. Alternatively, members can view print out an ID card anytime using the following steps.

   Register and log in to Guardian Anytime at the following link: Login & Register | Guardian (guardianlife.com). From the menu options, select "Forms & materials" and then "Obtain forms and materials". Select the ID Cards hyperlink. Note: Only the registered member, not their dependents can view, print or order ID cards.

   To view or print an ID card, click the "View/Print" button for the respective ID card. If desired, you can print the ID card after it opens. Note: If the card does not open in a new window, disable the pop-up blocker.

   For VSP, when you visit an in-network provider, they can typically verify your coverage using the employee's SSN. You can also create an account online at www.vsp.com. Click on "Create an Account" in the top right-hand corner and follow the prompts. Once logged in, click on "Member Details" and "My Member ID card" to print it.

2. **How do I search for an in-network dental provider?**
   The Wente dental plan is through Guardian and uses the Dentalguard Preferred network. You can find an in-network provider using this link:
   1. Visit Find a Dentist (guardiananytime.com)
   2. Make sure the **PPO** bullet is selected
   3. Enter your **Location**, **Miles**, and dentist name (if applicable)

3. **I am enrolled in medical coverage through Wente. Is Telehealth available to me?**
   Anthem EVHC Plan:
   Yes. ON the EVHC plan, you can visit Teladoc.com or call 1-800-TELADOC (835-2362). Teledoc gives you 24/7/365 access to U.S. board-certified doctors from home, from work, or while traveling. This service has no charge associated with it.

   Kaiser Plan:
   Yes. On the Kaiser plan, you can also be set up with a Teladoc visit. There is typically no charge associated with a Telehealth appointment. You can book directly with your care team or through the appointment and advice contact center at 866-454-8855.

4. **How long can my dependent children stay on my medical, dental, and vision plans through Wente?**
   Dependent children can stay on the plans through the end of the month following their 26th birthday. In some cases, unmarried children with developmental, mental, or physical disability may remain eligible for coverage past the dependent age limit. If you believe your child continues to meet eligibility requirements, please contact Human Resources for further guidance.