

REIMBURSEMENT INSTRUCTIONAL GUIDE

PLEASE KEEP THIS
GUIDE IN A CONVENIENT
LOCATION SO THAT YOU
MAY REFER TO IT AS
NEEDED

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WELCOME TO YOUR ACCOUNT



THIS GUIDE WILL HELP
YOU UNDERSTAND
YOUR SUBSIDY
ACCOUNT, AS WELL AS:



— THE
REIMBURSEMENT
PROCESS



— HOW TO SIGN UP
FOR DIRECT
DEPOSIT



— THE TYPE OF
REIMBURSEMENTS
YOU MAY SUBMIT



— WHICH EXPENSES
ARE ELIGIBLE FOR
REIMBURSEMENT



— HOW TO SUBMIT
CLAIMS FOR
REIMBURSEMENT

Your former employer provides a subsidy for eligible participants to be reimbursed for eligible expenses. **The employer's Summary Plan Description and legal plan document outline the rules for eligibility and eligible expenses.** Receipt of this instructional guide does not confirm your eligibility for the subsidy.

This guide serves as a resource for submitting reimbursement requests. It reflects current process and documentation requirements based on IRS regulations. Process and documentation requirements are subject to change. If any conflict should arise between the descriptions in this instructional guide and the provisions of the subsidy plan, or if any provision is not explained or only partially explained, your rights will always be determined under the provisions of the plan document and the plan's administrative rules.

PLEASE KEEP THIS GUIDE SO YOU MAY REFER TO IT WHEN YOU SUBMIT YOUR REIMBURSEMENT CLAIMS.

CONTACT US

WHERE TO GO WHEN YOU HAVE QUESTIONS



O N L I N E

- Find valuable information and self-service options by accessing your subsidy portal 24/7 at <http://retiree.mercermarketplace.com/saudiaramco>
- View frequently asked questions and answers
- Enroll in direct deposit



C A L L

- You may contact us at 1-855-230-2064; from outside of the US please dial 515-243-1776, option 5 for Mercer Marketplace 365 Retiree
- Deaf or hearing impaired should dial 711 for Telecommunications Relay Service
- We can be reached Monday-Friday 8:00 a.m.-5:30 p.m. ET



F A X

- Send a fax to 1-857-362-2999, to the attention of the Claims Department
- Please include the participant's name in all correspondence



M A I L

- Send mail to the attention of the Claims Department
- P.O. Box 14401
Des Moines, IA 50306
- Please include the participant's name in all correspondence

UNDERSTANDING THE PROCESS

Our objective is to assist you in getting reimbursed for your eligible expenses as quickly and easily as possible. Below is an overview of the reimbursement process that is covered in more detail within this guide.

STEP 1



You pay for your eligible insurance premiums or health expenses

STEP 2



You determine how you want to receive your reimbursements

STEP 3



You request reimbursement from your subsidy account

STEP 4



Mercer reviews your claims and, if approved, reimburses you from your available subsidy account balance

STEP 1: YOU PAY FOR YOUR ELIGIBLE INSURANCE PREMIUMS OR HEALTH CARE EXPENSES

- You will arrange the method and frequency of premium payments directly with your insurance company
- You will pay all out-of-pocket expenses, such as copays, to your health care provider
- For all eligible expenses, save all receipts and supporting documentation to include with your reimbursement claim. To learn which expenses are eligible, please see page 7.

STEP 2: YOU DETERMINE HOW YOU WANT TO RECEIVE YOUR REIMBURSEMENTS

- Direct deposit
 - You may enroll in direct deposit online by visiting the subsidy portal or by completing the direct deposit form enclosed with this mailing
 - **Direct deposit is more convenient**—your reimbursements will be sent directly to your designated banking account
 - **NOTE: Direct deposit may take up to 30 days to activate, which means your first reimbursement after enrolling in direct deposit may be mailed in the form of a check**
- Physical check
 - If you do not enroll in direct deposit, you will receive a mailed physical check to the address we have on file

STEP 3: YOU REQUEST REIMBURSEMENT FROM YOUR SUBSIDY ACCOUNT

- Submit a request for reimbursement of eligible expenses along with all supporting documentation
- For eligible premium expenses, you may have the option of Automatic Premium Reimbursement or Recurring Premium Reimbursement, depending on your insurance carrier
- Please see the following pages for more detail on the reimbursement types and supporting documentation required for each option

STEP 4: MERCER REVIEWS YOUR CLAIM AND IF APPROVED, REIMBURSES YOU FROM YOUR AVAILABLE SUBSIDY ACCOUNT BALANCE

- Once your request has been received, Mercer will review your legally required supporting documentation and determine if the claim is in good order
- If approved, you will receive payment by either direct deposit or a check in the mail, depending on how you have elected to receive your reimbursements (Step 2 above)

THREE DIFFERENT REIMBURSEMENT TYPES

UNDERSTAND WHICH ONE TO USE

Mercer Marketplace 365 has **three types** of reimbursement of your eligible healthcare expenses. Please read through each type below so you can understand the direction you should take for your reimbursement claim. **Automatic Premium Reimbursement is a NEW process this year, but may not be an option for all carriers and policies.**


What eligible expenses are you submitting and what type of reimbursement is available?

ELIGIBLE EXPENSE	AUTOMATIC PREMIUM REIMBURSEMENT	RECURRING PREMIUM REIMBURSEMENT	ONE-TIME REIMBURSEMENT
Health insurance premium	Available only for certain carriers for policies purchased through Mercer	Available only for policies purchased through Mercer	Available
Prescription Drug premium	Available only for certain carriers for policies purchased through Mercer	Available only for policies purchased through Mercer	Available
Dental premium		Available only for policies purchased through Mercer	Available
Vision premium		Available only for policies purchased through Mercer	Available
Medicare Part B premium, including Income-related monthly adjustment (IRMAA), if applicable		Available if deducted from Social Security Check	Available
Out-of-Pocket Expenses Include deductibles, copays, and coinsurance as well as certain medical, pharmacy, dental and vision expenses allowed by IRS Code Section 213(d) in IRS Publication 502 (https://www.irs.gov/pub/irs-pdf/p502.pdf)			Available
Prescription drug expenses while in Catastrophic phase of Medicare Part D Prescription Drug Plan			Available

Please visit your subsidy portal for a list of carriers and plans who allow for Automatic Premium Reimbursement; you will also find information on eligible expenses under your former employer's plan rules. You will locate this under the "Important Information" tile on the online portal dashboard.

AUTOMATIC PREMIUM REIMBURSEMENT

When to use	<p>You have this option for your premium reimbursement if:</p> <ul style="list-style-type: none">• You have enrolled in a qualifying health plan through Mercer• Your carrier allows for Automatic Premium Reimbursement; see the list of participating carriers and plans on the online portal or contact Mercer via phone to inquire
How it works	<ul style="list-style-type: none">• You opt-in to Automatic Premium Reimbursement by going to your subsidy portal, or by phone with the help of a benefits counselor• Mercer receives confirmation from your carrier that you have paid your premiums• You are automatically issued a reimbursement for your paid premiums on the next available payment date• Your opt-in election applies for as long as you remain enrolled in your eligible plan, even if your rate changes• There is no need to file a reimbursement claim unless you disenroll from the eligible plan either voluntarily or involuntarily, OR the carrier no longer allows for Automatic Premium Reimbursement
How to Opt-In	<p>You may establish your Automatic Premium Reimbursement election by going to your subsidy portal, or by phone with the help of a benefits counselor. To opt-in online:</p> <ul style="list-style-type: none">• Login to your subsidy portal• Select the 'Personal Information' tile• Select the 'Claims Reimbursement' tab• Click on the 'Automatic Reimbursement' button• Check the 'Opt-In' box and hit the 'Update' button <p>Once you have opted in, there are no forms to complete. If you later choose to opt-out of this reimbursement type for any reason, you must do so over the phone through a benefits counselor.</p>
When to expect reimbursements	<p>Reimbursement timing may vary and depends on your carrier. Your first reimbursement may take 6 to 8 weeks to arrive but that timeframe is not guaranteed.</p>
Keep in mind	<ul style="list-style-type: none">• This option does not provide the fastest method of reimbursement, but it provides the convenience of being automatically reimbursed without submitting documentation• You are not required to use Automatic Premium Reimbursement• Automatic Premium Reimbursement is available only for certain carriers and plans



If you have selected Automatic Premium Reimbursement as your reimbursement type, please do NOT send in a request for a different type of reimbursement for the same claim. You must first opt-out on the phone with a benefits counselor before selecting a different reimbursement type.

RECURRING PREMIUM REIMBURSEMENT

When to use	<p>You have this option for your premium reimbursement if:</p> <ul style="list-style-type: none">• You have enrolled in a qualifying health plan through Mercer Marketplace 365• You have NOT established an Automatic Premium Reimbursement claim for this premium expense
How it works	<ul style="list-style-type: none">• You submit a Recurring Premium Reimbursement request along with supporting documentation• Once your premium request is approved you will receive recurring, monthly premium reimbursements for the calendar year• You will only submit one request for each calendar year, or each time your premium rate changes
Submitting a claim	<p>You may submit a Recurring Premium Reimbursement claim by using your subsidy portal or the paper form located in the back of this guide.</p>
Documentation required	<p>All Recurring Premium Reimbursement claims require third-party documentation showing proof of expense and coverage, and must include the following information:</p> <ul style="list-style-type: none">• Covered participant's name• Premium type• Proof of coverage, typically in the form of a letter you receive from your insurance carrier, that includes carrier name, policy effective date and monthly premium amount <p>For Medicare premiums deducted from your Social Security check, use the Social Security Benefit Award Letter issued by the Social Security Administration (SSA) each year, typically mailed during the month of October or November, as your third-party documentation.</p>
When to expect reimbursements	<p>Reimbursement typically occurs once per month. More detail about expected reimbursement dates can be found online in your subsidy portal under the 'Important Information' tile.</p>
Keep in mind	<p>Annual submission and all required documentation must be submitted each calendar year. You may submit your request at any time during the year; payments will commence after your documentation is processed. Recurring Premium Reimbursements are distributed according to the schedule posted in your subsidy portal.</p>

ONE-TIME REIMBURSEMENT

When to use	This option is available for any eligible expense. You should only choose this option for your <i>premium</i> reimbursement if you have NOT established an Automatic Premium Reimbursement or Recurring Premium Reimbursement claim for the premium expense.
How it works	<ul style="list-style-type: none"> • You submit a One-Time Reimbursement claim for your eligible expense • Once your request is approved you will receive one-time reimbursement of the expense on the next available payment date • You will submit a new request each time you have an eligible expense that you would like reimbursed
Submitting a claim	You may submit a One-time Reimbursement claim by using your subsidy portal or the paper form located in the back of this guide.
Documentation required	<p>All One-Time Reimbursement claims require third-party documentation showing the information outlined below:</p> <ul style="list-style-type: none"> • Covered participant's name • Expense type (premium or out-of-pocket expense) • Proof of coverage (for premium expenses) • Amount of incurred expense • Date of premium or service • One of the following as proof of payment: <ul style="list-style-type: none"> – an invoice from a provider that reflects any payment made during the visit – a prescription drug receipt from your retail or mail-order pharmacy that includes the pharmacy name, address, date of prescription, prescription number and the covered participant's name – copy of front and back side of canceled check, or proof of bank or credit card transaction that identifies the provider, date, and amount of payment
When to expect reimbursements	More detail about expected reimbursement dates can be found online in your subsidy portal under the 'Important Information' tile. One-time reimbursements are generally processed between 7 and 10 business days after receiving your request. Once your request is approved you will receive one-time reimbursement of the expense on the next available payment date.
Keep in mind	One-time reimbursement requests are submitted individually for each eligible expense.

HOW TO SUBMIT A REIMBURSEMENT CLAIM REQUEST ONLINE

1. Navigate to the website address shown on the bottom of each page of this guide.
2. Scroll down to the 'File a Claim' section and click to access your subsidy portal.
3. You will be directed to the portal log in screen.
 - Your username is your Social Security Number with no spaces or dashes (ex. 123456789).
 - Upon first visit, your password is your Date of Birth in the format MMDDYYYY (ex. March 17, 1945 is 03171945).
 - **IMPORTANT**: you will be prompted to change your password the first time you log in. The new password must be a minimum of 8 alphanumeric characters (at least 1 capital letter, at least 1 lowercase letter and at least 1 special character like #, \$ or %).
4. Click 'CREATE A CLAIM' from the dashboard. You will be directed to a new page that outlines all three reimbursement types. **If you select Automatic Premium Reimbursement you will have the option to review participating carriers and move to the Claims Authorization tab to opt-in to this reimbursement type.** If you select Recurring Premium Reimbursement or One-Time Reimbursement, you will move to an online submission screen. Once you complete all of the information in each of the fields and upload the appropriate documentation, click 'SUBMIT CLAIM,' and we will begin processing your request.
5. Please enter claims individually by following the same procedure for additional claims that need to be reimbursed. Remember that you will also need to provide electronic copies of your proof of premium and/or proof of payment; see the information listed in prior sections for a reminder of what is required.

IF YOU WOULD PREFER TO SUBMIT YOUR CLAIM BY MAIL, PLEASE USE THE FORM(S) AT THE BACK OF THIS GUIDE, MAKING SURE TO PROVIDE COPIES OF ALL OF THE NECESSARY DOCUMENTATION SO THAT YOUR CLAIM CAN BE APPROVED IN A TIMELY MANNER. PLEASE RETAIN YOUR ORIGINAL DOCUMENTS.

FREQUENTLY ASKED QUESTIONS

If my claim states ‘Approved for Payment’, when will I receive my payment?

It may take 5-7 business days for funds to be paid. Note: if you have not selected direct deposit, please allow an additional 2-3 days for a physical check to be received in the mail.

What if I have not received the necessary documentation from my insurance carrier?

Contact your insurance carrier and request a document that contains: the covered participant's name, premium type (health and prescription drug plan premium only), start date of your new policy, monthly premium amount, and name of insurance provider.

What if I have not received my Social Security Benefit Award letter to use as third-party documentation?

For lost documents, you may request a “Proof of Income” letter by contacting the Social Security Administration at 1-800-772-1213 (TTY 1-800-325-0778) or www.ssa.gov.

How do I find the list of carriers participating in Automatic Premium Reimbursement?

Log in to your subsidy portal and select the “File a Claim” tile. Select the Automatic Premium Reimbursement option. The election screen will appear. Click on the “Show Carriers” button to see the list of participating carriers. Alternately, you can select the “Plan Information” tile and navigate to the Frequently Asked Questions section which also has a link to the carrier list.

If I submit paper claim forms, who needs to sign them?

The account holder or Power of Attorney (POA) must sign all claim forms prior to submitting for reimbursement. Unsigned forms will delay your reimbursement.

What do I do if my reimbursement claim request is denied?

If your reimbursement claim request is denied, you will receive a letter in the mail stating the reason for the denial with instructions on next steps you can take.

Do my subsidy funds roll over if I do not use them in a calendar year?

Please reference the Plan Information tile, found on the dashboard of your subsidy portal, to understand if your account allows for the rollover of funds.

When can I use previous year balance on current year claims?

If your account allows for the rollover of funds, you can use previous year balances on current year claims after the runout period. Reference the Plan Information tile on your subsidy portal for the runout period.

How do I reset my subsidy portal password?

On the login screen, select ‘Forgot Password’ and an email will be sent to you if you have provided a valid email address. Please note that **three (3) incorrect password entries will result in your portal access being locked** for 24 hours. If this occurs, and you have an email address on file, you will be able to reset the password yourself. If you do not have an email address on file, you will need to phone the Mercer Marketplace 365 contact center or simply wait for the 24-hour time period to pass.

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FORMS

USE THE FOLLOWING FORMS ONLY IF YOU ARE UNABLE TO SUBMIT ONLINE

Remember, it's easy to log in to your subsidy portal to establish a Recurring Premium Reimbursement request, submit a One-Time Reimbursement request, or enroll in Direct Deposit.

If you would prefer to submit a reimbursement request by mail or fax, complete the appropriate claim forms enclosed in the back of the guide (either Recurring Premium Reimbursement or a One-Time Reimbursement) and provide the supporting documentation required for each claim.

If you would prefer to enroll in Direct Deposit by mail, we have also included a paper Direct Deposit form.

You should make a copy of all forms you submit so you can retain the originals for your records. You may request additional claim forms from your benefits counselor, or simply make copies of these forms prior to completing.

As a reminder, there are no forms to complete for an Automatic Premium Reimbursement; you may establish your Automatic Premium Reimbursement by going to your online subsidy portal, or by phone with the help of a benefits counselor.



MERCER MARKETPLACE 365SM RETIREE

RECURRING PREMIUM REIMBURSEMENT CLAIM FORM

Use this form for reimbursement of eligible premiums for qualifying plans purchased through Mercer Marketplace 365 Retiree. Refer to the back page of this form for instructions on how to complete the information below. **NOTE: Do not complete this form if you have signed up for Automatic Premium Reimbursement.**

To qualify for your reimbursement, you must provide third-party documentation that includes the information on the back of this form. Please CHECK each reimbursement request qualification as you complete them.

<input type="checkbox"/> Account Holder SSN (No dashes)	Former Employer Name	Total Pages
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
Account Holder Last Name:	First Name	
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	
Email Address:	Daytime Phone Number (No Dashes):	
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	

Name and Relationship	Premium Type	Start Date	End Date	Amount
John Doe – Spouse	Medical	01/01/20XX	12/31/20XX	\$XXX.XX

PARTICIPANT CERTIFICATION I have read this document and understand and confirm that as a Participant in the Plan, premiums itemized above for myself and any eligible dependents will be deducted from my subsidy Account and reimbursed to me directly every month beginning _____ (date). I understand the Plan will reimburse me based on the expenses I submit provided there are sufficient funds in my subsidy Account. I understand it is my sole responsibility to inform the Plan administrator if my coverage ends or my monthly premium amount changes from the amount shown above. I accept full liability for timely notification of any changes. I, the undersigned, certify that all expenses for which reimbursement is requested by submission of this form were incurred by myself or an eligible dependent and that the expenses have not been reimbursed, or are not reimbursable, from any other source. I certify that I will not take any of such expenses as an income tax deduction or tax credit on my personal federal income tax return. I understand that I alone am fully responsible for the sufficiency and accuracy of all information relating to the claim which is provided by me, and that if an expense for which payment or reimbursement is subsequently determined to not be a proper expense under the Plan, I may be liable for payment of all related taxes on amounts paid from the Plan which relate to such expense.

ACCOUNT HOLDER SIGNATURE DATE

RECURRING PREMIUM REIMBURSEMENT CLAIM FORM

USE THIS FORM for reimbursement of eligible healthcare premiums for plans purchased through Mercer Marketplace 365 Retiree. Do not submit this form if you have signed up for Automatic Premium Reimbursement. Refer to the online portal for more information on Automatic Premium Reimbursement.

Remember, for a faster, more convenient method, submit online, using the website shown in your Reimbursement Instructional Guide.

Submit the completed claim form and required documentation through one of the following methods:

Mail: Mercer Health & Benefits Admin.,
P.O. Box 14401, Attn: Claims Department
Des Moines, IA 50306-3401

Fax: 1-857-362-2999, Attn: Claims Department

Please include the participant's name in all correspondence, regardless of submission method. If mailing, retain all originals and only mail copies.

Submitting this form provides ongoing monthly reimbursements for premiums for the calendar year. Annual submission is required each year even if your plan does not change. If submission occurs after the start of the year previous months will be paid retroactively. **Please note:** Your first premium reimbursement may take 4 to 6 weeks to arrive.

Documenting Your Reimbursement Request — All premium reimbursement requests require third-party documentation showing each item below:

- Covered Participant's Name (e.g. John Doe)
- Premium Type (e.g. Medical)
- Date of Service (e.g. 01/01/20XX–12/31/20XX)
- Monthly Amount (e.g. \$XXX.XX)
- Name of Provider (e.g. AARP)

For Medicare premiums deducted from your Social Security check, use the Social Security Benefit Award Letter issued by the Social Security Administration (SSA) each year, typically during the month of October or November, as your third party documentation.

Watch for this document to arrive in the mail.

For lost documents you can request a "Proof of Income" letter by contacting the Social Security Administration at 1-800-772-1213 (TTY 1-800-325-0778) or www.ssa.gov, or contact your insurance carrier and request a document that contains the five items listed above.

Account Holder Information:

The account holder may be the retiree or spouse, depending on your plan's rules. If you have a Household account, the primary account holder must sign; if you have an Individual account, the account holder must sign. Please refer to the letter you received from Mercer Marketplace 365 Retiree to understand if you have a Household or Individual account. Call Mercer if you have questions about your account type.

Reimbursement Request Information:

This section must be completed with a line for each premium reimbursement requested.

Action: A request must be submitted each time you have a new policy, at the first of a new year, when a change in your premium occurs or if a policy ends for any reason during the calendar year. Enter: "New Policy", "Premium Change" or "End of Policy."

Relationship: Include the relationship between the account holder and the person requesting the premium reimbursement (e.g. self).

Premium Type: Refer to your Reimbursement Instructional Guide (e.g. Medical, Prescription Drug).

Start Date: This is usually January 1st of each new year or the effective date of the coverage period, such as when a participant becomes Medicare-eligible.

End Date: This is typically December 31st, or could be earlier if there is a change in your current plan, there is a change in reporting by your carrier, or the death of a covered participant.

Monthly Amount: This amount must match the amount on the supporting document.

Certification Requirement:

Carefully read the certification requirements before signing.

DIRECT DEPOSIT!

Expedite your payments by signing up for direct deposit today. Refer to your Reimbursement Guide for instructions on how to log into the portal and complete the necessary information for your reimbursements to be made by direct deposit.

ONE-TIME REIMBURSEMENT CLAIM FORM

Use this form for reimbursement of any eligible expenses. You should only choose this option for your premium reimbursement if you have NOT established an Automatic Premium Reimbursement or Recurring Premium Reimbursement for the premium expense. Refer to the back page of this form for instructions on how to complete the information below.

To qualify for reimbursement, you must provide third-party documentation that includes the information on the back of this form. Please CHECK each reimbursement qualification item as you complete them.

Account Holder SSN (No dashes) Former Employer Name Total Pages

[] [] [] [] [] [] [] [] [] []		
---	--	--

Account Holder Last Name: First Name

[] []	[] []
---	---

Email Address: Daytime Phone Number (No Dashes):

	[] []
--	---

Date of Service	Type of Expense	Covered Participant Name	Relationship	Amount Requested
01/01/20XX	Medical	John Doe	Spouse	\$XXX.XX

PARTICIPANT CERTIFICATION

I, the undersigned, certify that all expenses for which reimbursement is requested by submission of this form were incurred by myself or an eligible dependent and that the expenses have not been reimbursed, or are not reimbursable, from any other source. I certify that I will not take any of such expenses as an income tax deduction or tax credit on my personal federal income tax return. I understand that I alone am fully responsible for the sufficiency and accuracy of all information relating to the claim which is provided by me, and that if an expense for which payment or reimbursement is subsequently determined to not be a proper expense under the Plan, I may be liable for payment of all related taxes on amounts paid from the Plan which relate to such expense.

_____ ACCOUNT HOLDER SIGNATURE	_____ DATE
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ONE-TIME REIMBURSEMENT CLAIM FORM

USE THIS FORM for reimbursement of any eligible expenses. You should only choose this option for your premium reimbursement if you have NOT established an Automatic Premium Reimbursement or Recurring Premium Reimbursement claim for the premium expense.

Remember, for a faster, more convenient method, submit online, using the website shown in your Reimbursement Instructional Guide.

Submit the completed claim form and required documentation through one of the following methods:

Mail: Mercer Health & Benefits Admin.,
P.O. Box 14401, Attn: Claims Department
Des Moines, IA 50306-3401

Fax: 1-857-362-2999, Attn: Claims Department

Please include the participant's name in all correspondence, regardless of submission method. If mailing, retain all originals and only mail copies.

A One-Time Reimbursement claim provides a single reimbursement for any eligible expenses. Please refer to your company-specific plan rules for details on medical expenses your plan allows.

Eligible reimbursement requests may include deductibles and copays, and insurance premiums for plans for which Recurring or Automatic Reimbursement is either not available or set up.

Other qualifying out-of-pocket expenses may include Social Security premiums such as Part B related expenses.

Documenting Your Reimbursement Request — All reimbursement requests require third-party documentation showing each item below:

FOR OUT-OF-POCKET EXPENSES:

- Covered Participant Name (e.g. John Doe)
- Provider Name
- Date of Service (e.g. 01/01/20xx)
- Expense Type (e.g. Medical premium, office visit co-pay, etc.)
- Proof of Expense Amount (e.g., invoice or receipt from provider that identifies the participant name and service date and description, an Explanation

of Benefits from insurer that identifies amount owed by participant)

- Proof of Payment (e.g., front and back side of cancelled check, receipt, statement from provider showing payment, bank or credit card statement)

FOR PREMIUM EXPENSES:

- Covered Participant Name (e.g. John Doe)
- Insurer Name
- Premium Type (e.g. medical, dental)
Date of Coverage (e.g. 01/01/20xx–12/31/20xx)
- Premium amount (e.g., statement or invoice from insurer)
- Proof of Payment (e.g., front and back side of cancelled check, receipt or statement from insurer, bank or credit card statement)

For Medicare premiums deducted from your Social Security check, use the Social Security Benefit Award Letter issued by the Social Security Administration (SSA) each year, usually during the month of October or November, as your third party documentation. Watch for this document to arrive in the mail.

Account Holder Information:

The account holder may be the retiree or spouse, depending on your plan's rules. If you have a Household account, the primary account holder must sign; if you have an Individual account, the account holder must sign. Please refer to the letter you received from Mercer Marketplace 365 Retiree to understand if you have a Household or Individual account. Call Mercer if you have questions about your account type.

Reimbursement Request Information:

Complete this section to indicate:

- Date of Service
- Type of Coverage (e.g. Medigap)
- Covered Participant Name
- Relationship to the account holder
- Amount Requested, which should be the entire expense you incurred/paid.

Certification Requirement:

Carefully read the certification requirements before signing.

DIRECT DEPOSIT!

Expedite your payments by signing up for direct deposit today. Refer to your Reimbursement Instructional Guide for instructions on how to log into the portal and complete the necessary information for your reimbursements to be made by direct deposit.

DIRECT DEPOSIT FORM- for qualified expenses

This is an optional form.

IMPORTANT INFORMATION:

To allow payments for reimbursement of eligible expenses and/or premium(s) under your subsidy to be directly deposited into your bank account, please complete this form. **We will be unable to process forms with missing information.**

PLEASE CHOOSE THE TYPE OF ACCOUNT:

CHECKING

Submit a voided check (required) for the account you wish the deposit to be made. The routing number is the 9-digit number located in the lower left hand corner of the check. Your account number is the next set of digits following your routing number.

SAVINGS

List your account number and routing/transit number below. Ask your bank to provide you with the routing/transit number for your account. The routing/transit number is not always the same as the number on a savings deposit slip.

Please provide the following information regarding the bank account to receive direct deposits for reimbursements from your subsidy:

Name(s) on the Account: _____

Former Employer Name: _____

Bank Name: _____ Bank City/State: _____

Routing/Transit Number: _____

Account Number: _____

.....
ACCOUNT AUTHORIZATION: *Please read and sign before completing and submitting.*

I hereby authorize my former employer and the Program Manager, Mercer Health & Benefits Administration, (hereinafter collectively referred to as "Company") to deposit any amounts owed me by initiating credit entries to my account at the financial institution (hereinafter "Bank") indicated on this form. Further, I authorize Bank to accept and to credit any credit entries indicated by Company to my accounts. In the event Company deposits funds erroneously into my account, I authorize Company to debit my account for an amount not to exceed the original amount of the erroneous credit.

This authorization is to remain in full force and effect until Company and Bank have received written notice from me of its termination in such time and in such manner as to afford Company and Bank reasonable opportunity to act on it.

PARTICIPANT NAME (please print)

SSN (LAST 4 DIGITS)

SIGNATURE

DATE

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MERCER MARKETPLACE 365SM
RETIREE

ASC