ALBEMARLE®

MERCER MARKETPLACE 365℠
RETIREE

MERCER MARKETPLACE 365
HRA INSTRUCTIONAL GUIDE

Please keep this guide in a convenient location so that you may refer to it as needed.

Contact us by:

Phone (toll-free): 1-800-685-6350

For deaf or hard of hearing individuals: dial 711 for Telecommunications Relay Service

Fax: 1-857-362-2999

Email: HRA@mercer.com

HRA portal: http://retiree.mercermarketplace.com/albemarle

CONTENTS

INTRODUCTION

UNDERSTANDING THE HRA

WELCOME TO YOUR HRA

Your former employer is providing a subsidy account for their retirees and eligible dependents. You may be reimbursed for eligible expenses based on your former employer's plan rules, which are outlined in your Summary Plan Description and legal plan document. Receipt of this instructional guide does not confirm your eligibility for the subsidy. Additionally, 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.

HOW THE PROCESS WORKS

Mercer Marketplace 365 assists you in the selection and enrollment into your individual health insurance plan(s). After you incur and pay an eligible expense, you submit a request for reimbursement to Mercer Marketplace 365. Your eligible expenses will be reimbursed with available funds from the HRA subsidy account funded by your former employer.

Your former employer establishes a reimbursement account and provides a subsidy.

You purchase a health plan. You pay premiums and health care costs.

You submit your claims for eligible expenses as defined by your former employer.

You receive your reimbursement based on the funds available in your account.

CHECKLIST

IMPORTANT! If you have any questions during any part of your submission process, please stop and contact your Benefits Counselor.

STEPS TO FOLLOW FOR SUCCESSFUL CLAIM REIMBURSEMENT SUBMISSIONS

Follow these steps so that each claim you submit has all of the necessary components and supporting documentation for successful reimbursement payout:

☐ **STEP 1**

Decide how you would like to receive reimbursement payments for approved claim requests

- **For direct deposit**: Enter your information in the online portal
  OR submit your banking information using a paper direct deposit form

OR

- **For a physical check:** Request reimbursement WITHOUT completing direct deposit banking information

☐ **STEP 2**

Choose what type of reimbursement claim you are submitting:

- **Automatic Reimbursement:** ONLY monthly premiums paid for policies issued by specific carriers with which Mercer Marketplace 365 contracts and directly enrolls you are eligible. **These need to be submitted yearly. IMPORTANT**: Automatic monthly reimbursements will stop on December 31st of each year (or when your account is depleted). To avoid a break in reimbursements, you must submit a new request for Automatic Reimbursement by December 15th of each year.

OR

- **One-Time Reimbursement:** These are reimbursement requests for all other types of eligible expenses that do not qualify for Automatic Reimbursement. **One-Time claim reimbursement requests need to be submitted with each requested payout.**

☐ **STEP 3**

Collect the necessary supporting documentation paperwork

☐ **STEP 4**

Decide how you will submit your claim for reimbursement to Mercer Marketplace 365:

- **Submit online using the portal.** Log into your online subsidy portal (using the website provided on the front cover of this guide). You must submit your claim request online and attach all the supporting documentation in order to access your HRA subsidy eligible funds

OR

- **Submit using paper forms.** Paper claim requests must be completed correctly and signed. Submit claim forms and attach all required supporting documentation to our HRA Claims department via mail, email or fax.

The remaining sections of this guide provide more detail on each of these steps for successful claim reimbursement submission.

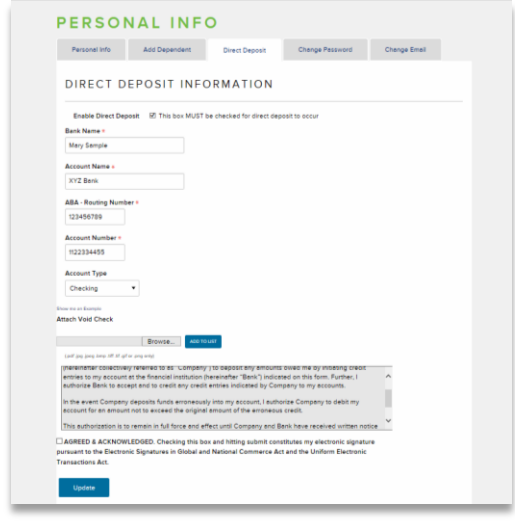
STEP 1

DECIDE HOW YOU WOULD LIKE TO RECEIVE REIMBURSEMENT PAYMENTS

Before you submit your first eligible claim, you should decide what method of reimbursement you would prefer: **direct deposit or a mailed physical check.** If you do not provide direct deposit information on the online HRA portal and do not submit a direct deposit form by mail, email, or fax, you will receive a mailed physical check to the address we have on file.

How to request direct deposit online:

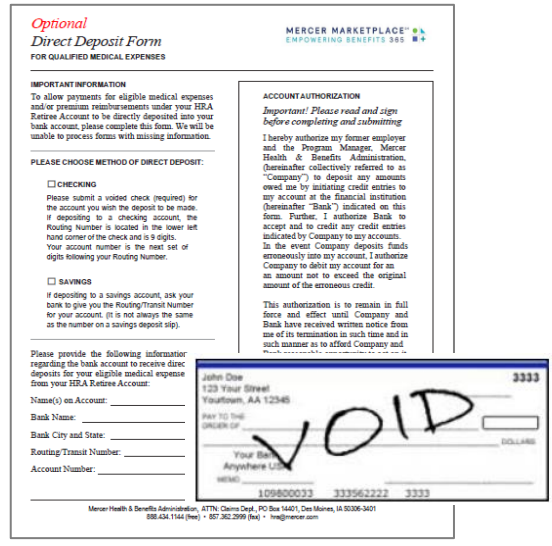
1. Log on to http://retiree.mercermarketplace.com/albemarle
2. To log in to your online HRA portal, refer to Step 4 in this guide for detailed instructions.
3. Next, click the “PERSONAL INFORMATION” box on the Welcome page.
4. Choose the “Direct Deposit” tab.
5. Enter your personal banking information.
6. Attach a copy of a voided check.
7. Check the “AGREED AND ACKNOWLEDGED” box at the bottom.



How to request direct deposit by mail, email or fax:

1. Complete the paper Direct Deposit Form (enclosed in this mailing or available from your Benefits Counselor)
2. Attach a copy of the voided check
3. Mail, form and voided check to:

   Mercer Health & Benefits Admin.
   Attn:Claims Dept.
   P.O. Box 14401
   Des Moines, IA 50306-3401
   Fax: 857-362-2999
   Email: HRA@mercer.com



STEP 2

TYPE OF CLAIM YOU ARE SUBMITTING

There are two types of claim requests as described below:

You may submit your claims as soon as you have incurred an expense.

AUTOMATIC REIMBURSEMENT REQUESTS:

- Only monthly premiums paid for most insurance carrier plan(s) contracted with and purchased through Mercer Marketplace 365 are eligible for automatic reimbursement.
- After your initial approved request each year, your premium reimbursements will automatically be paid on a specific day each month, which is shown in the online portal.
- You are required to submit a new Automatic Reimbursement Claim Request each year. By submitting your annual request by December 15th of each year, you can avoid a delay in reimbursement. Automatic monthly reimbursements are set up until December 31st of each calendar year.

ONE-TIME REIMBURSEMENT REQUESTS:

- Unlike automatic reimbursement requests, one-time reimbursement requests are submitted each time you want to be reimbursed for an eligible expense. One-time reimbursement requests can be submitted for any eligible insurance plan premiums that are not set up for automatic reimbursement.

STEP 3

UNDERSTANDING WHAT DOCUMENTATION IS NEEDED

SUBMITTING YOUR CLAIM WITH THE RIGHT DOCUMENTATION

Providing proper documentation will eliminate delays in processing the reimbursement of your claim. Whether you are submitting your claim using the online portal or a paper request form, copies of the supporting documents must accompany the claim.

Examples of required documentation for automatic reimbursement claims and one-time reimbursement claims are outlined below.

Sending the right documentation with your reimbursement request will help avoid denials of your claim.

	Automatic Reimbursement Claim	One-Time Reimbursement Claim
Eligible Insurance Premium	• **Carrier welcome letter or yearly premium notification must contain**: - name of insurance carrier - policyholder's name(s) - monthly plan premium - proof of payment **not** needed • **Monthly Premium Bill** - name of health insurance carrier - policyholder's name(s) - effective date of the policy - monthly plan premium - proof of payment **not** needed	• **Carrier welcome letter, monthly bill or yearly premium notification must contain:** - name of insurance carrier - policyholder's name(s) - effective date of the policy - monthly plan premium **AND** • **Proof of payment** (copy of bank statement, or copy of check or credit card statement) or monthly premium bill (showing the previous month's payment was received)

STEP 4

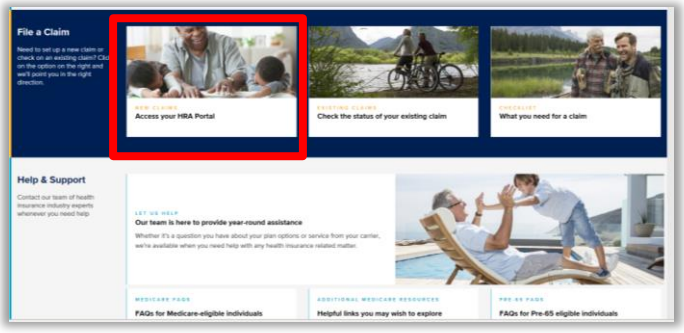
SUBMITTING YOUR CLAIM

TWO WAYS TO SUBMIT YOUR CLAIM FOR REIMBURSEMENT

When you have the proper documentation and are ready to submit your eligible expenses, you can do so through the **HRA portal**, or by submitting the paper forms **by mail, fax or email.**

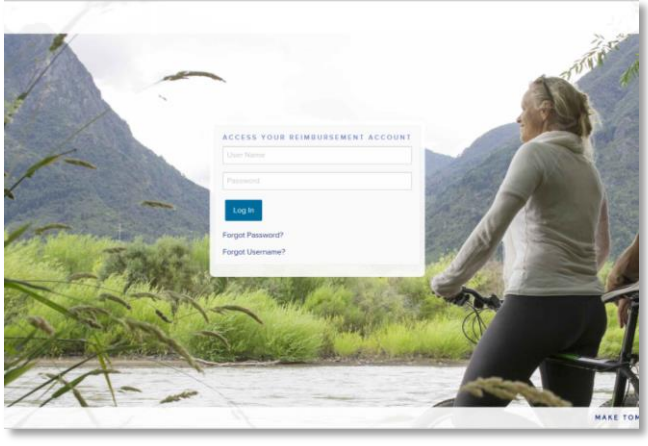
SUBMITTING THROUGH THE ONLINE PORTAL

Let's first make sure you are familiar with the **online portal**: how to find it, how to login, how to submit a claim, and how to take advantage of the other features you will find helpful to manage your HRA.



ACCESSING THE ONLINE PORTAL:

Start by visiting the online portal (as shown on the front cover of this guide). Scroll down to the "File A Claim" section. In the box shown outlined in red, click "NEW CLAIMS - Access Your HRA Portal."



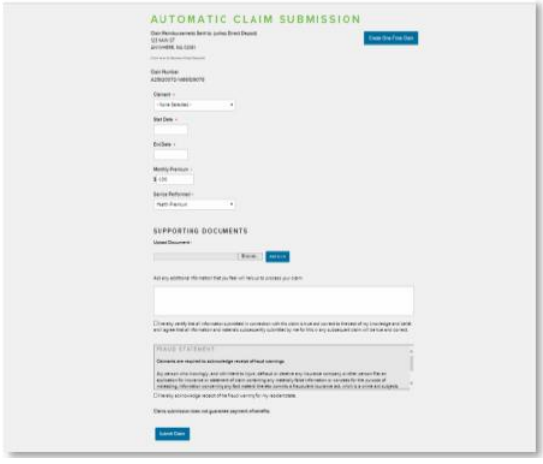
HOW TO LOG IN: Log in using your username and password (this is a secure site):

– Your username is your Social Security Number with no spaces or dashes (ex. 123456789).
– 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 %). See the box on the following page for username/password reset options.

WELCOME TO YOUR DASHBOARD: The HRA portal was designed to provide on-line support through our Resource Center. Our online video tutorials can be viewed as they walk you through “How-to” place a new claim or check an existing one. They will show you how to view account information and balances, easily update your personal information and learn more about your employer’s plan.

CREATE A CLAIM: To create a claim, you will click “CREATE A CLAIM” from the Dashboard shown above. You will have the option to create an automatic reimbursement claim or a one-time reimbursement claim. Once you complete all of the information in each of the fields and upload the appropriate documentation, simply click “SUBMIT CLAIM” and we will begin processing your request. You will have to enter claims individually, so simply follow 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 proof of payment (for one-time reimbursement claims); see Step 3 for a reminder of what documents are acceptable.

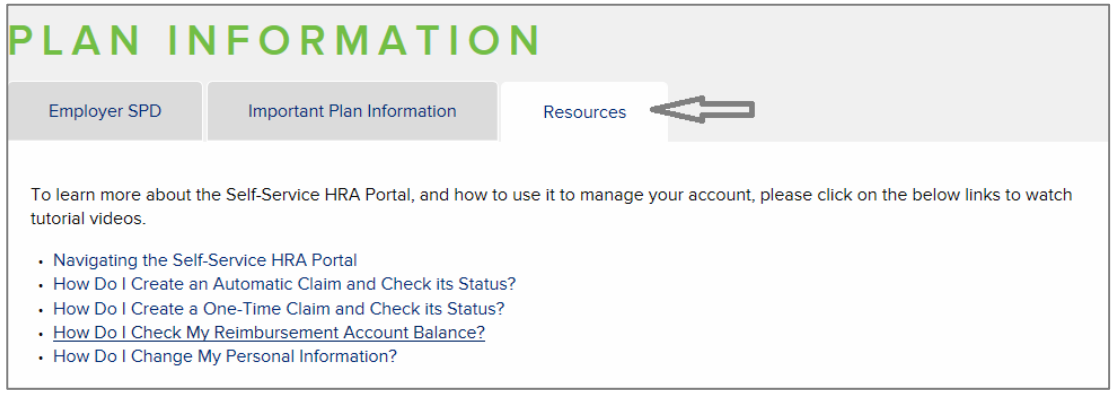


RETRIEVE YOUR PASSWORD: Lost your password? Let us help! If you have already used the portal and have provided your email address, click on “Forgot Password?” Type in your email address we have on file with Mercer Marketplace 365. If you don’t have an email on file, please call your Benefits Counselor and he or she will reset your password for you

SELF-SERVICE TUTORIALS

1. Click on PLAN INFORMATION from your dashboard.

2. Click on the RESOURCES tab on the plan information page.



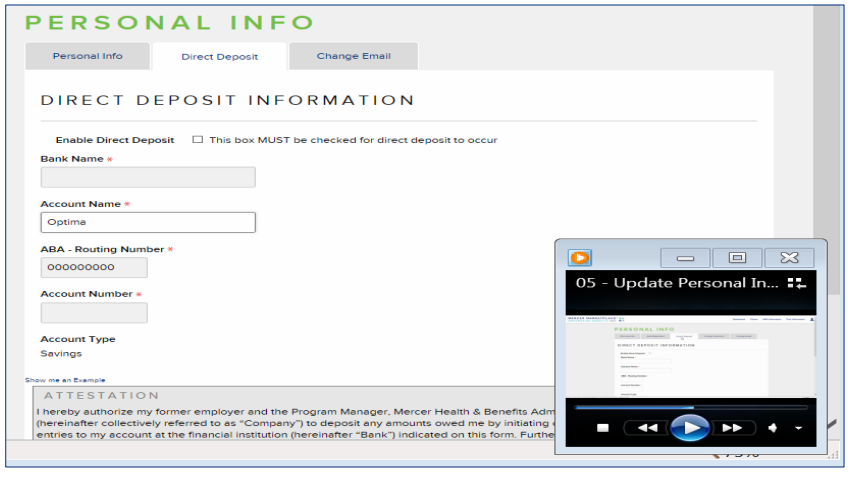
Once on the plan information page, click-on any of the self-service video tutorials. The videos play simultaneously as you place your new claim or check status. You can view, access or update all of our online features, by using any of the step-by-step video tutorials. Our goal is to make online claims convenient and easy. Additional assistance will always be provided by calling into our contact center. Our Benefits Counselors are there to provide additional support.

ONLINE VIDEO TUTORIAL EXAMPLES

An icon will come up on your toolbar. Open the page you would like to edit or to create a claim and play the tutorial video as you're completing your task.

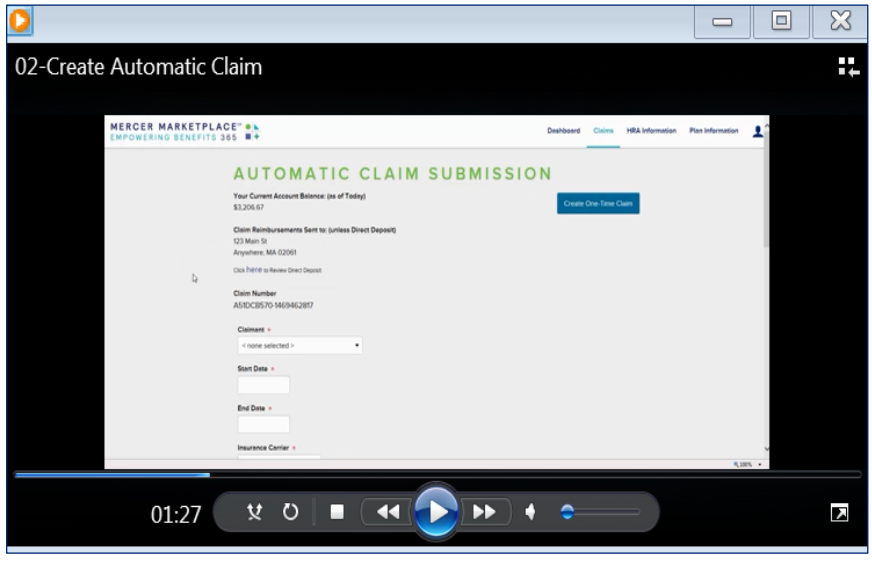
This video icon will be displayed on your toolbar when you click on the video link.

Tutorial video showing how to make banking updates in the personal info section



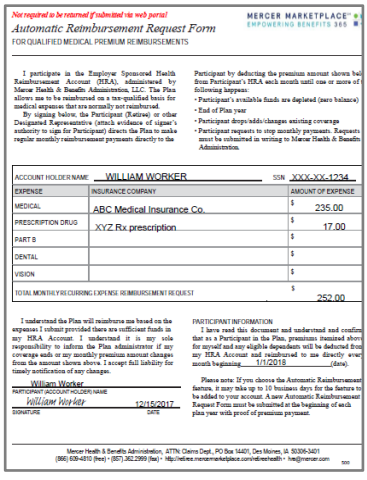
Submitting claims online through your HRA portal instead of using paper forms is an easy process.

Automatic claim submission video tutorial



AUTOMATIC REIMBURSEMENT CLAIM AND SUPPORTING DOCUMENTATION EXAMPLES Below is an example of a claim submission requesting monthly premium automatic reimbursements for a Medicare Supplement Health Insurance Plan and a Part D prescription plan. Both plans qualify for Automatic Reimbursement if they were purchased through Mercer Marketplace 365. These are examples of required supporting documentation for this type of claim.

Automatic Reimbursement paper request form



Not required to be returned if submitted via web portal

Automatic Reimbursement Request Form

FOR QUALIFIED MEDICAL PREMIUM REIMBURSEMENTS

MERCER MARKETPLACE® EMPOWERING BENEFITS 365

I participate in the Employer Sponsored Health Reimbursement Account (HRA), administered by Mercer Health & Benefits Administration, LLC. The Plan allows me to be reimbursed on a tax-qualified basis for medical expenses that are normally not reimbursed.

By signing below, the Participant (Retiree) or other Designated Representative (attach evidence of signer's authority to sign for Participant) directs the Plan to make regular monthly reimbursement payments directly to the Participant by deducting the premium amount shown below from Participant's HRA each month until one or more of the following happens:

- Participant's available funds are depleted (zero balance)
- End of Plan year
- Participant drops/adds/changes existing coverage
- Participant requests to stop monthly payments. Requests must be submitted in writing to Mercer Health & Benefits Administration.

ACCOUNT HOLDER NAME: WILLIAM WORKER SSN: XXX-XX-1234

EXPENSE	INSURANCE COMPANY	AMOUNT OF EXPENSE
MEDICAL	ABC Medical Insurance Co.	$ 235.00
PRESCRIPTION DRUG	XYZ Rx prescription	$ 17.00
PART B		$
DENTAL		$
VISION		$
TOTAL MONTHLY RECURRING EXPENSE REIMBURSEMENT REQUEST		$ 252.00

I understand the Plan will reimburse me based on the expenses I submit provided there are sufficient funds in my HRA 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.

William Worker
PARTICIPANT/ACCOUNT HOLDER NAME

William Worker 12/15/2017
SIGNATURE DATE

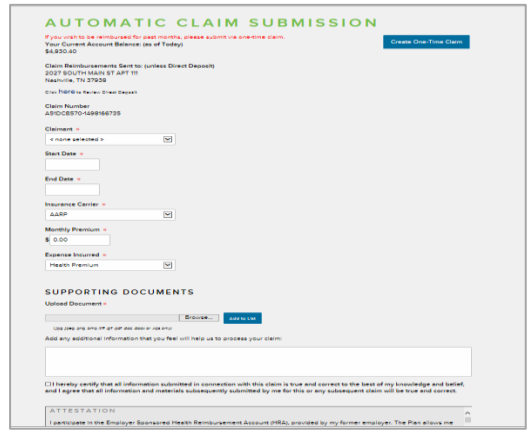
PARTICIPANT INFORMATION

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 HRA Account and reimbursed to me directly every month beginning 1/1/2018 (date).

Please note: If you choose the Automatic Reimbursement feature, it may take up to 10 business days for the feature to be added to your account. A new Automatic Reimbursement Request Form must be submitted at the beginning of each plan year with proof of premium payment.

Mercer Health & Benefits Administration, ATTN: Claims Dept., PO Box 14401, Des Moines, IA 50306-3401
(866) 636-4810 (fax) • (867) 362.2999 (fax) • http://retiree.mercermarketplace.com/mrbenefits • hrs@mercer.com

Automatic Reimbursement online submission website



AUTOMATIC CLAIM SUBMISSION

If you wish to be reimbursed for past months, please submit via one-time claim.

Your Current Account Balance: (as of Today)
$4,830.40

Create One-Time Claim

Claim Reimbursements Sent to: (unless Direct Deposit)
2027 SOUTH MAIN ST APT 111
Nashville, TN 37209

Claim Number
ASIDCB570-1499166735

Claimant *
< none selected >

Start Date *

End Date *

Insurance Carrier *
AARP

Monthly Premium *
$ 0.00

Expense Incurred *
Health Premium

SUPPORTING DOCUMENTS

Upload Document *
Browse... Add to List

Add any additional information that you feel will help us to process your claim.

I hereby certify that all information submitted in connection with this claim is true and correct to the best of my knowledge and belief, and I agree that all information and materials subsequently submitted by me for this or any subsequent claim will be true and correct.

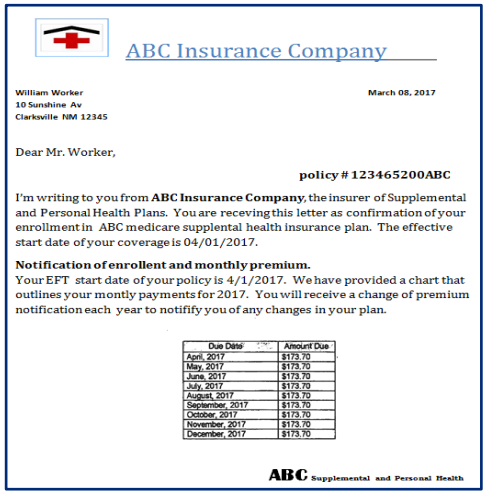
ATTESTATION

I participate in the Employer Sponsored Health Reimbursement Account (HRA), provided by my former employer. The Plan allows me

PROOF OF PREMIUM/PROOF OF COVERAGE

Supporting documentation MUST be included regardless of how the claim is submitted, online or by paper. Paper requests require copies submitted via mail, email OR fax. For online requests, copies must be attached through the online portal as a .pdf or .jpg attachment. **Acceptable supporting documentation is outlined in detail in Step 3 of this guide**. Examples of welcome letters are below. These are mailed directly to you from your insurance company after enrollment.

ABC Insurance/welcome letter proof of premium/coverage



ABC Insurance Company

William Worker
10 Sunshine Av
Clarksville NM 12345

March 08, 2017

Dear Mr. Worker,

policy # 123465200ABC

I'm writing to you from **ABC Insurance Company**, the insurer of Supplemental and Personal Health Plans. You are receving this letter as confirmation of your enrollment in ABC medicare supplental health insurance plan. The effective start date of your coverage is 04/01/2017.

Notification of enrollent and monthly premium.
Your EFT start date of your policy is 4/1/2017. We have provided a chart that outlines your montly payments for 2017. You will receive a change of premium notification each year to notifify you of any changes in your plan.

Due Date	Amount Due
April, 2017	$173.70
May, 2017	$173.70
June, 2017	$173.70
July, 2017	$173.70
August, 2017	$173.70
September, 2017	$173.70
October, 2017	$173.70
November, 2017	$173.70
December, 2017	$173.70

ABC Supplemental and Personal Health

Prescription Drug/welcome letter proof of premium/coverage

XYZ Part D Insurance

William Worker
10 Sunshine Av
Clarksville NM 12345

Rx-ID 00034567RX

Dear Mr. Worker,

March 13,2017

Thank you for enrolling in XYZ Part D Insurance plan (PDP). XYZ Part D insurance Co. is a Prescription Drug Plan that is approved by Medicare. Medicare has approved your enrollment in XYZ Part D Insurance (PDP) beginning on 4/1/2017.

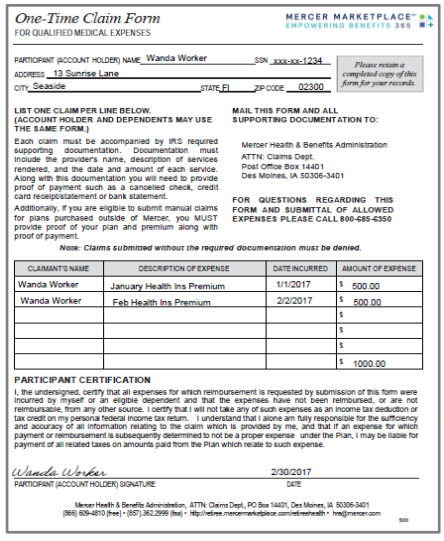
How will my coverage work?
As of 4/1/2017, you should begin using XYZ Part D Insurance (PDP) network pharmacies to fill your prescriptions. If you use an out-of-network pharmacy except in an emergency, XYZ Part D Insurance (PDP) may not pay for your prescriptions. You can find network pharmacies in your area by looking in your pharmacy directory.

How much is my premium?
The Premium for your plan is $17.00
If you think you qualify for extra help with your prescription drug costs, but you don't have or can't find proof, please call XYZ Part D Insurance Co at 1-800-123-4567. Thank you again, for choosing to enroll in XYZ Part D Insurance health Insurance Plan.

XYZ Part D Insurance Co.

ONE-TIME CLAIM REIMBURSEMENT AND SUPPORTING DOCUMENTATION

Supporting documentation MUST be included regardless of how the claim is submitted, online or by paper. Paper requests require copies submitted via mail, email OR fax. For online requests, copies must be attached through the online portal as a .pdf or .jpg attachment. **Acceptable supporting documentation is outlined in detail in Step 3 of this guide.**



One-Time Claim Form
FOR QUALIFIED MEDICAL EXPENSES

MERCER MARKETPLACE® EMPOWERING BENEFITS 365

PARTICIPANT (ACCOUNT HOLDER) NAME Wanda Worker SSN xxx-xx-1234
ADDRESS 13 Sunrise Lane
CITY Seaside STATE FL ZIP CODE 02300

Please retain a completed copy of this form for your records.

LIST ONE CLAIM PER LINE BELOW. (ACCOUNT HOLDER AND DEPENDENTS MAY USE THE SAME FORM.)

Each claim must be accompanied by IRS required supporting documentation. Documentation must include the provider's name, description of services rendered, and the date and amount of each service. Along with this documentation you will need to provide proof of payment such as a cancelled check, credit card receipt/statement or bank statement.

Additionally, if you are eligible to submit manual claims for plans purchased outside of Mercer, you MUST provide proof of your plan and premium along with proof of payment.

Note: Claims submitted without the required documentation must be denied.

MAIL THIS FORM AND ALL SUPPORTING DOCUMENTATION TO:

Mercer Health & Benefits Administration
ATTN: Claims Dept.
Post Office Box 14401
Des Moines, IA 50306-3401

FOR QUESTIONS REGARDING THIS FORM AND SUBMITTAL OF ALLOWED EXPENSES PLEASE CALL 800-685-6350

CLAIMANT'S NAME	DESCRIPTION OF EXPENSE	DATE INCURRED	AMOUNT OF EXPENSE
Wanda Worker	January Health Ins Premium	1/1/2017	$ 500.00
Wanda Worker	Feb Health Ins Premium	2/2/2017	$ 500.00
			$
			$
			$
			$ 1000.00

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.

Wanda Worker 2/30/2017
PARTICIPANT (ACCOUNT HOLDER) SIGNATURE DATE

Mercer Health & Benefits Administration, ATTN: Claims Dept, PO Box 14401, Des Moines, IA 50306-3401
(866) 609-4810 (free) • (857) 362.2999 (fax) • http://retiree.mercermarketplace.com/retireehealth • hrw@mercer.com

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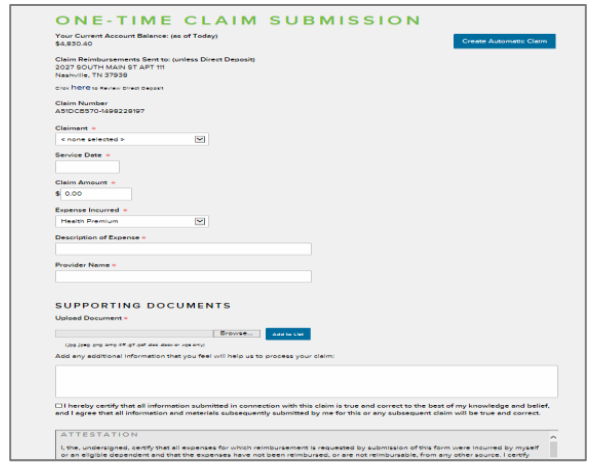


ONE-TIME CLAIM SUBMISSION

Your Current Account Balance: (as of Today)
$4,830.40

Create Automatic Claim

Claim Reimbursements Sent to: (unless Direct Deposit)
2027 SOUTH MAIN ST APT 111
Nashville, TN 37938

Click here to Review Direct Deposit

Claim Number
A51DC8570-1499229197

Claimant *
< none selected >

Service Date *

Claim Amount *
$ 0.00

Expense Incurred *
Health Premium

Description of Expense *

Provider Name *

SUPPORTING DOCUMENTS

Upload Document *
Browse... Add to List
(.doc .docx .jpg .png .tif .gif .pdf .xls .xlsx or .zip only)

Add any additional information that you feel will help us to process your claim:

☐ I hereby certify that all information submitted in connection with this claim is true and correct to the best of my knowledge and belief, and I agree that all information and materials subsequently submitted by me for this or any subsequent claim will be true and correct.

ATTESTATION

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

PROOF OF PREMIUM/COVERAGE AND PROOF OF PAYMENT EXAMPLES

Proof of premium/coverage AND proof of payment are required for all one-time claim reimbursements. **Acceptable supporting documentation is outlined in detail in Step 3 of this guide.** Below are examples of an insurance company invoice with policyholder name, start date and amount of premium and a bank statement showing the first and second payment clearing the policyholder's account to provide proof of payment.

Health Insurance Welcome Letter
PROOF OF PREMIUM/COVERAGE

Blue Health Insurance

Statement Date: 1/1/2017

Blue Health Monthly Billing Statement

Policy holder: Wanda Worker
Account #2000000
Effect Policy Date 1/1/2017

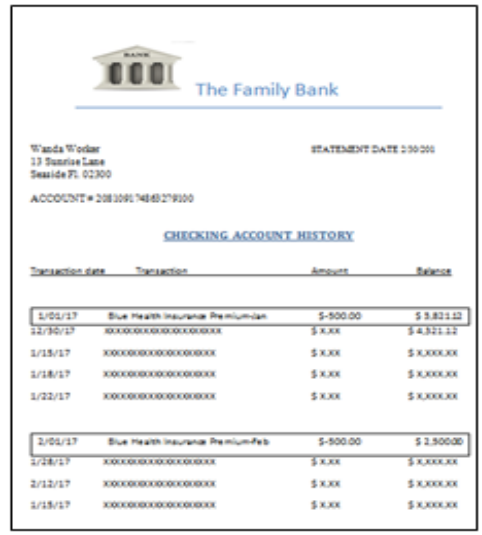
Thank you for enrolling in Blue Health Insurance. The start date of your policy is Jan 1st 2017. And your monthly premium is $500.00 Please set up ongoing payments with our easy EFT draft forms enclosed. Or call our offices 1-800-123-4567 for assistance in choosing a payment method.

DATES:	DESCRIPTION:	AMOUNT:
	Previous Balance	$ 500.00
1/28/2017	Jan 1st Payment Received	- $ 500.00
		$ 0.00
	Current Balance	
2/28/2017	payment due Feb 1st	
	Pay This Amount	**$500.00**

Blue Health Insurance

AND

Bank Statement
PROOF OF PAYMENT



The Family Bank

Wanda Worker
13 Sunrise Lane
Seaside FL 02300

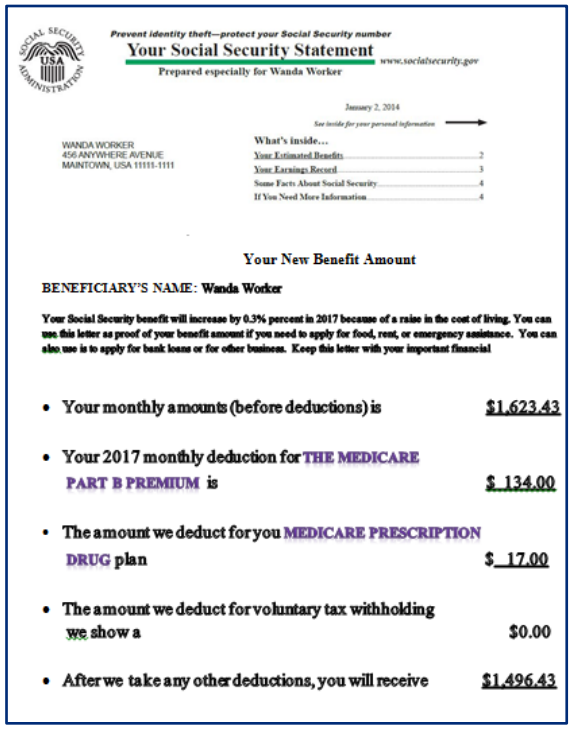
STATEMENT DATE 2/30/201

ACCOUNT # 2081091748482 79100

CHECKING ACCOUNT HISTORY

Transaction date	Transaction	Amount	Balance
1/01/17	Blue Health Insurance Premium-Jan	$-500.00	$ 3,821.12
12/30/17	xxxxxxxxxxxxxxxxxx	$ X.XX	$ 4,321.12
1/15/17	xxxxxxxxxxxxxxxxxx	$ X.XX	$ X,XXX.XX
1/18/17	xxxxxxxxxxxxxxxxxx	$ X.XX	$ X,XXX.XX
1/22/17	xxxxxxxxxxxxxxxxxx	$ X.XX	$ X,XXX.XX
2/01/17	Blue Health Insurance Premium-Feb	$-500.00	$ 2,500.00
1/28/17	xxxxxxxxxxxxxxxxxx	$ X.XX	$ X,XXX.XX
2/12/17	xxxxxxxxxxxxxxxxxx	$ X.XX	$ X,XXX.XX
1/15/17	xxxxxxxxxxxxxxxxxx	$ X.XX	$ X,XXX.XX

Supporting documentation using COLA statement. This is a Cost of Living Adjustment (COLA) statement. The Social Security Administration sends this statement in December of each year. If you allow for deductions from your Social Security check, you can use this statement for **Part D prescription drug plans** and **Medicare Advantage plans**.



Prevent identity theft—protect your Social Security number

Your Social Security Statement www.socialsecurity.gov

Prepared especially for Wanda Worker

January 2, 2014

See inside for your personal information

WANDA WORKER
456 ANYWHERE AVENUE
MAINTOWN, USA 11111-1111

What's inside...

Your New Benefit Amount

BENEFICIARY'S NAME: **Wanda Worker**

Your Social Security benefit will increase by 0.3% percent in 2017 because of a raise in the cost of living. You can use this letter as proof of your benefit amount if you need to apply for food, rent, or emergency assistance. You can also use is to apply for bank loans or for other business. Keep this letter with your important financial

- Your monthly amounts (before deductions) is $1,623.43
- Your 2017 monthly deduction for THE MEDICARE PART B PREMIUM is $ 134.00
- The amount we deduct for you MEDICARE PRESCRIPTION DRUG plan $ 17.00
- The amount we deduct for voluntary tax withholding we show a $0.00
- After we take any other deductions, you will receive $1,496.43

FORMS

USE THE FOLLOWING FORMS FOR PAPER SUBMISSION

To submit **a reimbursement request by mail, email or fax,** complete the appropriate claim form (either Automatic Reimbursement or a One-Time Reimbursement) and provide the supporting documentation outlined in Step 3. We have also included a Direct Deposit form in this guide.

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

Not required to be returned if submitted via web portal

MERCER MARKETPLACE 365℠
RETIREE

Automatic Reimbursement Request Form

FOR QUALIFIED MEDICAL PREMIUM REIMBURSEMENTS

I participate in the Employer Sponsored Health Reimbursement Account (HRA), administered by Mercer Health & Benefits Administration, LLC. The Plan allows me to be reimbursed on a tax-qualified basis for medical expenses that are normally not reimbursed.

By signing below, the Participant (Retiree) or other Designated Representative (attach evidence of signer's authority to sign for Participant) directs the Plan to make regular monthly reimbursement payments directly to the Participant by deducting the premium amount shown below from Participant's HRA each month until one or more of the following happens:

- Participant's available funds are depleted (zero balance)
- End of Plan year
- Participant drops/adds/changes existing coverage
- Participant requests to stop monthly payments. Requests must be submitted in writing to Mercer Health & Benefits Administration.

ACCOUNT HOLDER NAME _____ **SSN** _____

EXPENSE	INSURANCE COMPANY	AMOUNT OF EXPENSE
MEDICAL		$
PRESCRIPTION DRUG		$
TOTAL MONTHLY RECURRING EXPENSE REIMBURSEMENT REQUEST		**$**

I understand the Plan will reimburse me based on the expenses I submit provided there are sufficient funds in my HRA 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.

PARTICIPANT (ACCOUNT HOLDER) NAME

SIGNATURE DATE

PARTICIPANT INFORMATION

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 HRA Account and reimbursed to me directly every month beginning_____(date).

Please note: If you choose the Automatic Reimbursement feature, it may take up to 10 business days for the feature to be added to your account. A new Automatic Reimbursement Request Form must be submitted at the beginning of each plan year with proof of premium payment.

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One-Time Claim Form

FOR QUALIFIED MEDICAL EXPENSES

MERCER MARKETPLACE 365℠
RETIREE

PARTICIPANT (ACCOUNT HOLDER) NAME _____ SSN _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

Please retain a completed copy of this form for your records.

LIST ONE CLAIM PER LINE BELOW.

Each claim must be accompanied by IRS required supporting documentation. Documentation must include the provider's name, description of services rendered, and the date and amount of each service. Along with this documentation you will need to provide proof of payment such as a cancelled check, credit card receipt/statement or bank statement.

Additionally, if you are eligible to submit manual claims for plans purchased outside of Mercer, you MUST provide proof of your plan and premium along with proof of payment.

MAIL THIS FORM AND ALL SUPPORTING DOCUMENTATION TO:

Mercer Health & Benefits Administration
ATTN: Claims Dept.
Post Office Box 14401
Des Moines, IA 50306-3401

FOR QUESTIONS REGARDING THIS FORM AND SUBMITTAL OF ALLOWED EXPENSES PLEASE CALL 800-685-6350

Note: Claims submitted without the required documentation must be denied.

CLAIMANT'S NAME	DESCRIPTION OF EXPENSE	DATE INCURRED	AMOUNT OF EXPENSE
			$
			$
			$
			$
			$
			$

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.

PARTICIPANT (ACCOUNT HOLDER) SIGNATURE DATE

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Optional
Direct Deposit Form
FOR QUALIFIED MEDICAL EXPENSES

MERCER MARKETPLACE 365℠
RETIREE

IMPORTANT INFORMATION

To allow payments for eligible medical expenses and/or premium reimbursements under your HRA to be directly deposited into your bank account, please complete this form. We will be unable to process forms with missing information.

PLEASE CHOOSE METHOD OF DIRECT DEPOSIT:

☐ **CHECKING**

Please submit a voided check (required) for the account you wish the deposit to be made. If depositing to a checking account, the Routing Number is located in the lower left hand corner of the check and is 9 digits. Your account number is the next set of digits following your Routing Number.

☐ **SAVINGS**

If depositing to a savings account, ask your bank to give you the Routing/Transit Number for your account. (It 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 your eligible medical expenses from your HRA:

Name(s) on Account:_____

Bank Name:_____

Bank City and State:_____

Routing/Transit Number:_____

Account Number:_____

ACCOUNT AUTHORIZATION

Important! 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)*

_____
SOCIAL SECURITY NUMBER *(last four digits)*

_____
SIGNATURE

_____
DATE

MERCER MARKETPLACE 365[SM]
RETIREE