COUNTY OF ORANGE
HEALTH REIMURSEMENT ARRANGEMENT (HRA)
Qualified Medical Expenses

Upon retirement and/or separation from service with the County of Orange, you become eligible to receive reimbursement for "Qualified Medical Expenses" under your County of Orange (HRA) Health Reimbursement Arrangement Plan.

Medical expenses available for reimbursement through the County of Orange HRA Plan are defined as and may include:

- Costs of diagnosis, cure, mitigation, treatment, or prevention of disease, and the costs for treatments affecting any part or function of the body.

- Payments for legal medical services rendered by physicians, surgeons, dentists, and other medical practitioners, which may include the costs of equipment, supplies, and diagnostic devices needed for these purposes.

- Medical care expenses primarily to alleviate or prevent a physical or mental defect or illness. Eligible expenses do not include expenses that are merely beneficial to general health, such as vitamins or a vacation.

- Out-of-pocket expenses – e.g. medical or dental insurance deductibles and copayments, or any other out-of-pocket medical expense that qualifies under IRC Section 213(d) with the exception of direct long term care expenses.

- Premiums you pay for insurance that covers the expenses of medical care, and the amounts you pay for transportation to get medical care, which include amounts paid for qualified long-term care services and limited amounts paid for any qualified long-term care insurance contract.

- Other medical expenses that may not be covered by a health insurance plan (e.g., vision, prescription drug, acupuncture, home health care, nursing home expenses, nursing services, organ transplants, therapy as a medical treatment, durable medical equipment, home improvements made to accommodate the home for a disabled condition, and any other retiree medical expense deductible under IRC Section 213(d)).

*Please consult IRS Publication 502, Medical and Dental Expenses on the IRS Web Site at http://www.irs.gov/ for a thorough discussion of the types of expenses that qualify under your HRA Plan. Also, these guidelines are subject to change with any changes to IRS regulations or to the County's Plan Document.

AC: 0912-5953

COUNTY OF ORANGE
HEALTH REIMURSEMENT ARRANGEMENT (HRA)
REIMBURSEMENT REQUEST INSTRUCTIONS

Upon retirement and/or separation from service with the County of Orange, you become eligible to receive reimbursement for "Qualified Medical Expenses" under your County of Orange (HRA) Health Reimbursement Arrangement Plan. ICMA-RC works with Meritain Health, the third party administrator that handles your County of Orange HRA claim reimbursement requests. Please read these instructions carefully before submitting a reimbursement request.

Reimbursements can be submitted daily either by online, mail or fax. Supporting documentation must be provided with each request. Supporting documentation for expenses include: Explanation of Benefits, Premium Notices, Receipts, or Itemized Bills. All documentation must include the patient's name, date(s) of service, service provided, insurance payment if applicable, and total patient out-of-pocket amount.

MAIL Instructions:

Mail the completed VantageCare RHS Benefits Reimbursement Request Form along with supporting documentation to Meritain Health at:

VantageCare RHS Plan
C/O Meritain Health
PO Box 30136
Lansing MI 48909-7611

FAX Instructions:

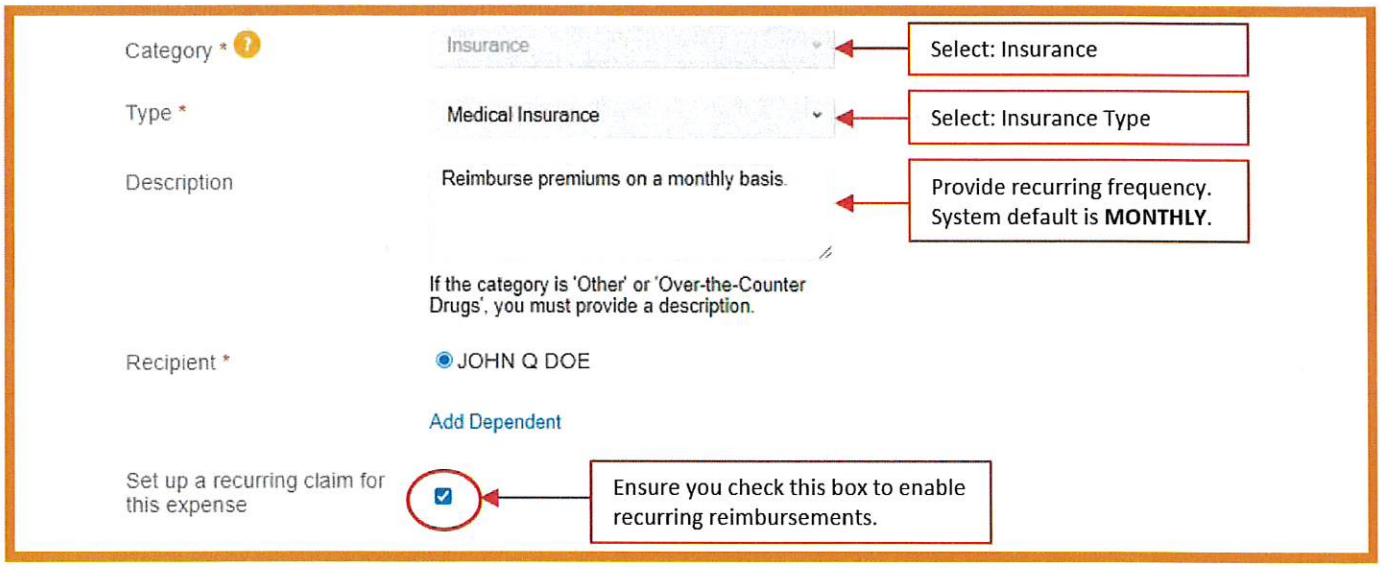
Fax the completed VantageCare RHS Benefits Reimbursement Request Form along with supporting documentation to Meritain Health at 1-888-665-8495.

MERITAIN® HEALTH

An Aetna Company

How to File Recurring Claims Using the Participant Retiree Health Claims Portal

Instead of faxing or mailing recurring claim requests, you can submit them online using the participant retiree health claims portal.



After accessing your online portal, your home page is easy to navigate:

- On the home screen, select the option to file a claim.
- **Upload your supporting documentation. Documentation may consist of: itemized bills, Explanation of Benefits (EOBs), premium notices and/or itemized receipts.**
  - **Documentation must show that the premium is paid after taxes and include the following: (i) insurance carrier; (ii) type of insurance; (iii) policy holder's name; (iv) amount; and (v) coverage period.**
- Next, add the following details requested on the *Claim Details* screen.

Please note:

- Once your recurring setup is complete, you will receive a *Recurring Claim Complete* notification.
- Recurring requests will default to a frequency of monthly unless otherwise noted.
- All online recurring submissions must be paid to the participant directly.
- **Any request to change or stop an existing recurring setup must be submitted to Meritain Health® by completing the Reimbursement Request Form found under the *Tools and Support Menu*.**

Have any questions, or need more information? We can help. Please contact the Meritain Health Customer Service team at 1.888.587.9441, weekdays 8:00 AM-5:00 PM ET.

ONLINE Instructions:

Complete the online Claims Entry Submission Form (see instructions below), Print the confirmation page and fax or mail the confirmation page along with supporting documentation to Meritain Health.

1. Log in to your ICMA-RC account at www.icmarc.org using your Account Access User ID and Password. If you do not have one, click on "Request an Initial Password".
2. Next, click on "My Account View" and select from the submenu, "RHS Claims".
3. At the "RHS Claims" Welcome Screen, select "Submit your RHS Claims".
4. Click "select" beside the account you wish to be reimbursed from.
5. Enter the information in the submission form:
   Service from date – the date of service or beginning of a multi-day service
   Service to date – the date of service or end of a multi-day service
   Amount – Enter in dollars and cents (i.e. $160.48)
   Claimant – the person the service is for
   Provider – the company providing the service
6. Select "Enter Claim".
7. Review and confirm the claim information entered.
8. Then electronically "Sign" your form by selecting a submission method, and entering your social security number. Print the confirmation page and return along with supporting documentation to Meritain Health. All documentation for online claims must be received by Meritain Health within 30 days of claim submission. Any claims unsubstantiated after 30 days will be denied.

Important Notes:

- Pre-tax premiums are not eligible for reimbursement. Eligible after-tax insurance premiums include: Health/Medical, Dental, Vision, and Long Term Care.
- Recurring reimbursements can be set up monthly or quarterly as requested. A reimbursement form must be sent for any premium amount changes or to end a recurring reimbursement.

Questions?

Reimbursement inquiries: If you need information concerning your reimbursement requests, contact Meritain Health at 1-888 587-9441.

Balance inquiries: If you have questions about your County of Orange HRA account balance or want to check the status of your reimbursement requests, you can do so online by logging in to www.icmarc.org using your Account Access User ID and Password.

VANTAGECARE RETIREMENT HEALTH SAVINGS (RHS) PLAN
BENEFITS REIMBURSEMENT REQUEST FORM - Page 1 of 2

- Complete this form and send with supporting documentation to **VantageCare RHS Plan, c/o Meritain Health, Inc., P.O. Box 30136, Lansing, MI 48909-7611** or fax to 888-665-8495 for processing. Alternatively, you may submit reimbursements and documentation online via Account Access (www.icmarc.org/login). Select your RHS plan and then Claims to get to the Meritain Health claims portal.
- For privacy and security reasons, ICMA-RC removed Social Security Number as an identifier on this form. Please provide your ICMA-RC Reference Code instead of your Social Security Number. If you do not know your Reference Code, it is available through Account Access on the My Profile tab and on your ICMA-RC statements.
- Each form of documentation must contain the date(s) of service, provider name, provider address, description of treatment, service or supply, amount charged, insurance payments, as well as the name of the claimant. ***Supporting documentation may consist of: Itemized Bills, Explanation of Benefits, Premium Notices, Itemized Receipts.***
- Eligible claim expense(s) for reimbursement must be incurred on or after your eligibility date. Generally, claims should be submitted within two years from the date of the expense, but this limit may vary among plans. If you have questions regarding this limit or your claims, please contact Meritain at 888-587-9441.

PLEASE NOTE: *SIGNATURE IS REQUIRED FOR PROCESSING.* Do **not** submit claims for charges eligible under your insurance or Medicare. A medical care expense may not be reimbursed from a Flexible Spending Account (FSA) if the expense has been reimbursed or is reimbursable under any other accident or health plan. If a medical care expense is eligible for coverage by both a Health Reimbursement Arrangement (HRA) and a health FSA, amounts available under a HRA must be exhausted before reimbursement may be made from a health FSA. This requirement does not apply to medical care expenses which are reimbursed from a health FSA but are not reimbursable by a HRA. In no case may a participant be reimbursed for the same medical care expense by both a HRA and a health FSA. Do **not** submit claims for services provided prior to your benefit eligibility date. Claims are processed upon receipt of documents in good order.

If you are able to access funds from your RHS plan in the same year in which you contribute to your Health Savings Account (HSA) administered through another provider, please consult your tax advisor prior to submitting reimbursement to your RHS account. There are specific rules governing HSAs when an employee is also enrolled in a HRA, like the RHS plan, that may affect the tax treatment of the HSA contributions.

Part A: Plan and Participant Information

Employer Plan Number _____ Employer Name _____ State _____

Participant Name (Last, First, and Middle Initial) _____

Reference Code _____

Daytime Phone Number

(___ ___ ___) ___ ___ ___ – ___ ___ ___ ___
Area Code

Address

Street _____

City _____ State _____ ZIP _____

NOTE: If this is a new address, please contact ICMA-RC at 800-669-7400 to update your address. Your check will be mailed to the address on file with ICMA-RC.

Part B: Request for Reimbursement of Non-Recurring Expenses

Use this section to request a reimbursement of non-recurring expenses (e.g., co-payments, medications, out-of-pocket expenses).

Summary of Healthcare Expenses

Incurred Date*	Applicant's Full Name (last, first, middle initial)	Provider (e.g. doctor name/pharmacy name)	Claim for (self, spouse, dependent child, other dependent)	Description of Service	Amount to be Reimbursed
					$
					$
					$
				Total reimbursement request:	$

** Incurred date is the date of service, not the billing or payment date.*

READ CAREFULLY AND SIGN BELOW FOR PROCESSING.

The undersigned certifies all expenses for which reimbursement or payment is claimed by submission of this form were incurred by the participant, the participant's spouse, or the participant's eligible dependents while the undersigned was eligible to receive benefits under the RHS Plan. The undersigned also certifies as follows:

- The medical expenses have not been reimbursed and are not reimbursable under any other health/dental plan or Medicare.
- The undersigned is responsible for requesting cessation of automated reimbursement of recurring expenses when the expense is no longer being incurred, and will retain sufficient documentation for all recurring expenses. Meritain Health, Inc. reserves the right to periodically request documentation for all automated payment requests.

The undersigned understands he/she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim. The undersigned understands he/she will be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan for non-qualifying expenses.

Signature _____ **Date** _____

VANTAGECARE RETIREMENT HEALTH SAVINGS (RHS) PLAN
BENEFITS REIMBURSEMENT REQUEST FORM - Page 2 of 2

Participant Name (Last, First, and Middle Initial) _____

Reference Code _____

Part B: Request for Reimbursement of Recurring Expenses

Use this section to request automated reimbursement of recurring expenses (e.g. insurance premiums). **Note:** Payment must be made to the account holder. Payment will **not** be made directly to an insurance company or other third party.

You are responsible for ensuring automated reimbursements are for qualifying medical expenses. You are also responsible for ensuring automated reimbursements are stopped if you are no longer incurring the expense(s). You must provide documentation of the recurring expense with this request, and you must retain sufficient documentation for all recurring expenses. Supporting documentation must show the premium is paid with after-tax funds and include the following: (i) Insurance Carrier; (ii) Type of Insurance; (iii) Policy Holder's Name; (iv) Amount; and (v) Coverage Period. Meritain Health, Inc. reserves the right to periodically request documentation for all automated payment requests.

1. ☐ **BEGIN** recurring reimbursement of $_____

Beginning Date: Insert date you wish payments to begin ___ ___ / ___ ___ / ___ ___ ___ ___ (MM/DD/YYYY)

Frequency (Check one): ☐ Annual ☐ Quarterly ☐ Monthly

Ending Date: Insert date of last payment ___ ___ / ___ ___ / ___ ___ ___ ___ (MM/DD/YYYY)

2. ☐ **CHANGE** recurring payment amount from $_____ to $_____

Effective date of change ___ ___ / ___ ___ / ___ ___ ___ ___ (MM/DD/YYYY)

3. ☐ **END** recurring payment of $_____

Ending Date: Insert date of last payment ___ ___ / ___ ___ / ___ ___ ___ ___ (MM/DD/YYYY)

Note: Payments will continue until your account is depleted, unless an ending date is provided. Any changes to your payment must be received by Meritain Health at least 10 business days prior to next payment. Otherwise the change will take effect on the next scheduled reimbursement.

READ CAREFULLY AND SIGN BELOW FOR PROCESSING.

The undersigned certifies all expenses for which reimbursement or payment is claimed by submission of this form were incurred by the participant, the participant's spouse, or the participant's eligible dependents while the undersigned was eligible to receive benefits under the RHS Plan. The undersigned also certifies as follows:

- The medical expenses have not been reimbursed and are not reimbursable under any other health/dental plan or Medicare.
- The undersigned is responsible for requesting cessation of automated reimbursement of recurring expenses when the expense is no longer being incurred, and will retain sufficient documentation for all recurring expenses. Meritain Health, Inc. reserves the right to periodically request documentation for all automated payment requests.

The undersigned understands he/she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim. The undersigned understands he/she will be liable for payment of all related taxes, including federal, state, or local income tax on amounts paid from the Plan for non-qualifying expenses.

_____ _____

Signature **Date**

PLEASE RETAIN A COPY FOR YOUR RECORDS

Send completed form to: VantageCare Retirement Health Savings (RHS) Plan, c/o Meritain Health, Inc., P.O. Box 30136, Lansing, MI 48909-7611 • 888-587-9441