MidAmerica

HOW TO FILE YOUR CLAIM

STEP 1

Complete ALL personal information in this section.

STEP 2

Medical Expenses

You, your spouse, and any qualifying dependents may seek reimbursement for eligible medical expenses from your HRA/FSA account. Qualifying dependents include taxable dependents and any children under the age of 27 at the end of the tax year.

This account may reimburse you for medically necessary expenses that have been rendered. IRS guidelines prevent reimbursement of non-health related expenses or for prepayment of services that have not been rendered. The type of service rendered determines claim eligibility as not all healthcare expenses are reimbursable.

Examples of Common Eligible Health Care Expenses:

- Office Visit Co-pays
- Physician Service Co-pays
- Prescription Co-pays
- Insurance Plan Coinsurance/Deductibles

Examples of Common Services that may require a Medical Necessity Form:
(Medical Necessity Forms must be signed by a healthcare provider and state a diagnosis)

- Counseling / Psychotherapy
- Physical/Occupational/Massage Therapy
- Acne or Other Dermatologic Treatments

For a full listing of eligible medical expenses, please visit IRS Publication 502: Medical and Dental Expenses. Please note that not all HRA/FSA plans allow for full 213(d) reimbursement. You may confirm what your plan allows by logging into your account at www.myMidAmerica.com and referencing your Plan Highlights. You may also contact Participant Services at (855) 329-0095 for additional assistance.

If your employer offers an FSA and HRA, both of which provide coverage for the same medical expenses, MidAmerica will process the reimbursement based on the ordering rules established in the plan.

For example, if the plan identifies that the FSA "pay first", your expense will be applied to the FSA until the balance is depleted and then automatically reimburse from the HRA

Documentation Requirements

All documentation must include the following 5 Keys of Verification:

- Date of service
- Description of service
- Cost of service
- Name of patient receiving the service
- Name of provider rendering the service

The above documentation requirements also apply to FSA Dependent Care claims.

Examples of Acceptable Documentation:

- Explanation of Benefits (EOB) – Detailed statement from the health insurance company explaining what services were paid for on your behalf and lists any personal financial responsibility you may bear. (PREFERRED DOCUMENT)
- Itemized Statement – Statement from the provider and cannot include a balance forward.
- Itemized Receipts – Credit card and other payment receipts
- Proof of Prescription – An itemized printout from the pharmacy or prescription receipt showing the Rx name or Rx number

Premium Expenses

You, your spouse, and any qualifying dependents may seek reimbursement for eligible premium expenses from your HRA account. Qualifying dependents include taxable dependents and any children under the age of 27 at the end of the tax year.

Premium expenses may include medical, dental, vision, long-term care coverage, Medicare, Medicare Prescription and Medicare supplement policies. IRS guidelines prevent reimbursement of pre-tax premiums, indemnity policies, or prepayment of coverage prior to 30 days in advance.

This account may reimburse you for past premium expenses or premium expenses that will become due within the next 30 days. This account may also reimburse you for premium expenses that reoccur monthly or annually, known as **recurring premiums**.

Recurring Premiums

- Recurring premiums reimbursements may be paid to you, to your employer, or to your insurance provider.
- Recurring premiums remain in effect through the policy end date. You must resubmit a new claim with supporting documentation when the policy renews or when there are changes to the policy at least 30 days in advance of the policy expiration date to ensure proper processing of reimbursement.

Establishing Recurring Premiums

- Complete the HRA/FSA Claim Form.
- Attach a premium notice from your insurance provider or a letter showing proof of premiums from your employer. These documents must include name of covered individual, name of provider, cost, and coverage period. **Payment coupons are not acceptable.**

Long-Term Care Premiums

- Long-Term Care Premiums cannot be set up as a recurring claim. Claims for reimbursement must be submitted each month or any time following the month of coverage.
- Reimbursement of long-term care premiums are subject to annual limits based on the year in which the payment is made. Annual limits are determined by the IRS and, as a result, proof of payment is required for all claims.

Public School Employees' Retirement System (PSERS) Premium Assistance

- If you meet the eligibility requirements, you can receive Premium Assistance only if you have an out-of-pocket premium from a medical plan offered through the Health Options Program or continue to participate in your former Pennsylvania school district (employer) approved plan.
- If you are receiving a monthly Premium Assistance, you must reduce your medical premium reimbursement request by this amount.

STEP 3

Please select your preferred method of reimbursement. If you are signing up for Direct Deposit for the first time, or if you are changing your bank information, provide your account information.

HOW TO FILE YOUR CLAIM

STEP 4

FSA Daycare/Dependent Care Expense

A Dependent Care Reimbursement Account (DCRA) allows you to pay for eligible dependent care expenses with pre-tax dollars, eliminating the need to take the annual Federal Tax Credit. A dependent is defined as a child under 13 years of age, or children 13 and over who are physically or mentally unable to care for themselves. A spouse or an elderly parent in your home who is physically or mentally unable to live independently also qualifies.

You can use any provider you choose; however, they may not be your own child if they are under age 19 and still claimed as a dependent. **Note:** You will need to obtain the provider's Federal Identification/Social Security Number for including on your tax filing.

If you have incurred expenses for the care of a dependent, please list their name(s) and ages(s). Copies of bills and receipts must also be attached to support your request for reimbursement. If those documents are not available, you must have the provider of service sign the appropriate space and indicate tax ID number on the front of this form.

Examples of Eligible DCRA Expenses:

- Daycare facility fees (including transportation, lunches, educational services)
- Before-school and after-school care
- Local day camp
- In-home babysitting fees (income must be claimed by your care provider)
- Nursery school and preschool (preschool expenses are eligible if the amount you pay for schooling cannot be separated from the cost of care

Examples of Ineligible DCRA Expenses:

- Diaper changing fees
- Fees for lessons (dance, piano, swim, etc.)
- Field trips
- Kindergarten
- Overnight camp expenses
- Transportation for daycare

Death Claim

If this distribution is on behalf of a deceased participant, you must provide a copy of the death certificate. Once we have received a copy of the death certificate, MidAmerica will keep it on file for reference for future claims. Therefore, MidAmerica only requires that a copy of the death certificate be sent once.

Recurring Premiums Cancellation

To cancel an existing, previously submitted recurring premium, indicate the premium type, reason for cancellation and effective date/month of the recurring premium cancellation. If you decide to reestablish the same recurring premium at a later date, you will be required to submit a new HRA/FSA Claim Form with supporting documentation.

STEP 5

SIGN the claim form. This is required on all submissions; otherwise the claim will not be processed.

ONLINE SUBMISSION

Claims may be securely submitted online at your convenience by following the instructions below:

- Go to www.myMidAmerica.com
- Select "Submit Claims" from the blue header at the top of the page.
- Select "Submit A One-Time Reimbursement Request" OR
- Select "Submit A Monthly Premium Reimbursement Request"
- Follow the prompts on the screen until you receive a confirmation of successful submittal

ADDITIONAL INFORMATION

Possible HRA Fees

HRA distributions may be subject to a $5.00 reimbursement fee assessed per paper claim (up to an annual maximum of six fees per calendar year). Depending on your Employer's HRA plan, online claims may be subject up to a $2.50 reimbursement fee per claim (up to an annual maximum of six fees per calendar year). To minimize fees and maximize interest, you may submit multiple claims at the same time and only pay one fee. Expenses do not expire and can be submitted at any time.

If your claim is being made payable to a third party (Insurance Provider or Employer) your claim will not be subject to a distribution fee. However, if the claim is being paid to you, your claim may be subject to a reimbursement fee. For more information specific to your Employer's HRA plan, please refer to your Plan Highlights.

HSA / HRA Interaction

If during the HRA plan year, you or your employer, or your spouse or spouse's employer contributed to a Health Savings Account (HSA), your HRA must be restricted for the plan year. While restricted, you can only seek reimbursement for dental, vision, preventative care, and premium expenses from your HRA.

Please review and complete the Account Restriction/ Suspension Form if you or your spouse is contributing to an HSA. Notice to restrict is irrevocable during the plan year. A change to remove the restriction must be received prior to the start of the next plan year.

Account Suspension/Cancellation

To receive the advance Premium Tax Credit (PTC), you are required to either temporarily suspend your HRA or permanently opt-out of your HRA, forfeit your account balance and waive any future contributions. Should you choose to suspend your HRA, you, your spouse and any qualifying dependents will cease to have access to the HRA during the suspension and will be ineligible to submit or incur expenses for reimbursement; however, your employer is still able to contribute to your account during the suspension and your account will continue to earn interest.

To reinstate your account status, you will be required to send in a written notice requesting to unsuspend your account. Please be advised that the account becomes available at the start of the plan year following the request to unsuspend. To select either option, please use the Account Suspension/Cancellation Form.

HRA / FSA Consolidated Claim Form

Did you know you can submit your claim online? For detailed instructions or to submit online please visit myMidAmerica.com

Return this completed form to:
Mail: MidAmerica Administrative & Retirement Solutions
Attn: HRA, P.O. Box 24927, Lakeland, FL 33802
Email: claims@MyMidAmerica.com | **Fax:** (863) 577.4460 | **Ph:** (855) 329-0095

STEP 1 PARTICIPANT INFORMATION

Employer
Date of Birth (mm/dd/yyyy) __ __ - __ __ - __ __ __ __

First Name
Last Name
M.I.
Social Security Number __ __ __ - __ __ - __ __ __ __

Mailing Address
City
State
Zip
Telephone

Email Address
Check if permanent address change:
Is this your current employer? Yes
If no, separation date?

STEP 2 CLAIM INFORMATION

NOTE: Choose one or both options.

Approved claims are processed within 7-10 business days. Be sure to attach acceptable documentation as outlined in the instructions. Failure to provide the requested information or acceptable documentation may delay your request. Applicable distribution fees will be deducted from the total eligible claim amount (per IRS guidelines).
For PSERS Retirees: *If you are receiving PSERS monthly premium assistance, you must reduce your medical premium reimbursement request by this amount.*

OPTION 1 ONE-TIME EXPENSES

NOTE: Choose one: HRA Only FSA only FSA then HRA*

Complete the following table for any one-time eligible expenses incurred by the participant, spouse, or eligible dependent. Expenses may include (one-time) premiums, long-term care, prescriptions, medical, dental, or vision. For a complete list of eligible expense, please visit IRS Publication 502: Medical and Dental Expenses.

Date of Expense	Name of Service Provider	Name of Covered Participant, Spouse, or Eligible Dependent	Service Provided	Amount to Reimburse
**FSA funds used until exhausted, followed by HRA funds.*			Total One-Time Claim Expenses:	

OPTION 2 RECURRING HRA PREMIUM EXPENSES

Complete the following table for any recurring HRA premium expenses incurred by the participant, spouse, or eligible dependent. Expenses submitted here will be established as recurring automatic disbursements paid monthly. The amount to reimburse will be paid via the payment option(s) selected in Step 3.

Policy Effective Date	Name of Insurance Provider	Name of Covered Participant, Spouse, or Eligible Dependent	Type of Insurance Premium	Group Insurance? (Yes/No)	Policy Expiration Date	Payable To: (Self, Employer, Provider)	Amount to Reimburse
						Total Recurring Premium Expenses:	

PLEASE INITIAL ALL BELOW: *(**Note**: Initials are required for processing. Please review claim instructions for additional information.)*

____ I understand that I cannot simultaneously participate in a Health Reimbursement Arrangement (HRA) and receive an advance Premium Tax Credit (PTC). Any receipt of a PTC while receiving reimbursements from my HRA can result in adverse tax consequences, per IRS regulations.

____ I understand my recurring premium expense(s) remain in effect and reimbursable through the policy expiration date. I understand I am required to renew my recurring claim in advance of the policy expiration by submitting a new claim form and updated policy documentation for approval.

____ I understand if at any time prior to the policy expiration date my premium amount changes, I begin to receive an advance Premium Tax Credit (PTC), or the policy terminates, I must notify MidAmerica to avoid potentially adverse tax consequences per IRS regulations.

STEP 3 PAYMENT OPTIONS

NOTE: Choose options that apply from Step 2.

Please note one-time expenses from Step 2, Option 1 are payable to Self only and recurring premiums can be paid to Self, Employer, or Provider.

OPTION 1 SELF

How would you like to receive your reimbursement? Choose one: Check in the mail New Direct Deposit Direct Deposit (already on file with MidAmerica)

If you selected New Direct Deposit, please provide your banking information below. Your HRA/FSA distributions may be deposited directly into your account or joint account with your spouse at your bank or other financial institution.

NEW DIRECT DEPOSIT INSTRUCTIONS:

Bank Name

Account Number

ABA Routing Number

Name on Account

Account Type (i.e: Savings, DDA)

OPTION 2 INSURANCE PROVIDER or EMPLOYER

NOTE: Choose one: Insurance Provider My Employer

Payee Name

Policy # / ID #

Address

City

State

Zip

Telephone

STEP 4 ADDITIONAL INFORMATION

NOTE: Choose any that apply.

FSA Daycare / Dependent Care Provider and Dependent Information:

Complete if any of the above expenses were daycare or dependent care expenses.

Dependent Name

Age

Dependent Name

Age

PROVIDER INFORMATION **Note**: Required if bills/receipts are unavailable

Provider Signature

Provider Tax ID

Signature Date (mm/dd/yyyy)

Death Claim:

Upon the death of a participant, the participant's surviving spouse and/or eligible dependents may submit a death claim for reimbursement of eligible expenses for themselves or final medical expenses incurred by the participant until the vested account balance is exhausted. Distributions on behalf of a deceased participant require a photocopy of the death certificate. Please reference Plan Highlights for more information regarding beneficiaries. Please provide payment name and the address below.

Name on Account

Address

Cancellation of Recurring Premium:

Indicate which previously submitted recurring premium you would like to cancel below, the reason for cancellation, and effective date of the cancellation .

Premium Type

Reason for cancellation

Effective Date

Premium Type

Reason for cancellation

Effective Date

STEP 5 AUTHORIZATION

I request payment from the reimbursement account for the expenses listed above in Step 2. To the best of my knowledge, my statements on this form are true and complete. I certify that all expenses for which reimbursement or payment is claimed were incurred either by me, my spouse or my eligible dependent(s). I understand that a medical expense is considered incurred when medical care is provided to me or my eligible dependent(s), not when I am formally billed, charged or have paid for the medical care. Therefore, I understand that insurance premiums must be incurred prior to reimbursement, and I cannot be reimbursed for an entire year of premiums in advance. I certify that the medical expenses in this claim are eligible for reimbursement and are "qualifying expenses" as defined by the Internal Revenue Code Section 213(d). I understand that if these medical expenses are not qualified medical expenses I may be liable for the payment of all related taxes on amounts received pursuant to this claim. I certify that the medical expenses claimed are not covered by insurance and have not been reimbursed or cannot be reimbursed under any other health plan coverage. I certify that I have not previously submitted this claim for reimbursement and that this is not a duplicate claim. I take full responsibility for the accuracy of all information I have provided. I further understand that reimbursed expenses cannot be claimed as a credit on my personal income tax return.

If I provided direct deposit information in Step 3 of this claim form, I authorize MidAmerica Administrative & Retirement Solutions to deposit my HRA and/or FSA claims directly into my account until I give further written notice to MidAmerica. I understand that it may take up to 72 business hours from the time MidAmerica processes my payment for the funds to post to my designated bank account. Also, I grant MidAmerica the right to correct any electronic funds transfer resulting from an erroneous overpayment by debiting my account to the extent of such overpayment.

As part of the Affordable Care Act, the DOL has mandated employees be permitted to either irrevocably suspend their HRA for a fixed period of time or permanently opt-out of the HRA by forfeiting their account balance and waiving any future contributions. Electing either option would preserve the eligibility of an individual to claim a Code § 36B premium tax credit, otherwise known as a Premium Subsidy for Healthcare Exchange coverage. Should you choose to suspend your HRA, you, your spouse and any qualifying dependents will cease to have access to the HRA during the suspension and will be ineligible to incur any new expenses for reimbursement during the suspension. For your account to be reactivated, MidAmerica must receive a written notice requesting the account be unsuspended. Please be advised that the account becomes available at the start of the plan year following the request to unsuspend. Please use the Account Suspension/Cancellation form available at www.myMidAmerica.com.

Participant Signature

Signature Date (mm/dd/yyyy)