



MERCER MARKETPLACE 365<sup>SM</sup>  
RETIREE

# MERCER MARKETPLACE 365 RRA 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): 1-866-435-5135

Dial 711 (deaf or hard of hearing individuals)

Fax: 1-857-362-2999

Email: [HRA@mercer.com](mailto:HRA@mercer.com)

RRA portal: <http://retiree.mercermarketplace.com/comcastnbcu>



## CONTENTS

Introduction: Understanding the RRA process .....	3
Checklist: Steps to follow for a successful claim reimbursement .....	4
Step 1: Reimbursement method - direct deposit or paper check.....	6
Step 2: Types of claims - automatic and one-time .....	7
Step 3: Documentation needed for claims .....	8
Step 4: How to submit your claim.....	9
Forms: Use these if you would prefer to submit your claims on paper .....	18

# INTRODUCTION

## UNDERSTANDING THE RRA

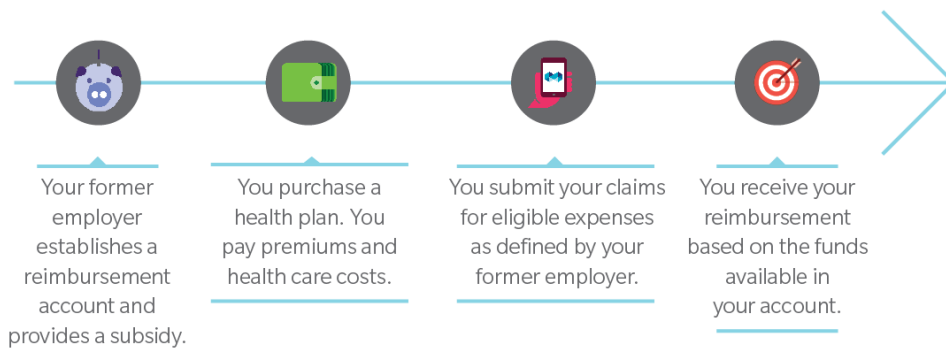
### WELCOME TO YOUR RRA

Your former employer is providing a subsidy account for their retirees and eligible dependents. The subsidy account is called a Retiree Reimbursement Account, or “RRA”. You and your eligible dependents 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.

Beginning January 1, 2018, Mercer Marketplace 365 will administer your reimbursements and will provide you with one point of contact for all your insurance and reimbursement needs. Your RRA amount can be accessed through the online portal or by contacting Mercer Marketplace 365. Please note that eligible spouses will have an individual RRA established in their name.

### HOW THE PROCESS WORKS

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 subsidy account funded by Comcast NBCUniversal.



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

# CHECKLIST

## 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 on 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**

Determine what type of reimbursement claim you are submitting:

- **Automatic Reimbursement:** ONLY monthly premiums with specific carriers that Mercer Marketplace 365 directly enrolls you in and Medicare Part B Premiums are eligible. **Automatic reimbursement requires yearly renewal.** Monthly reimbursements will stop on December 31<sup>st</sup> of each year (or when your account is depleted). **IMPORTANT:** To avoid a break in reimbursements, you must submit a new request for Automatic Reimbursement by December 15<sup>th</sup> of each year.

OR

- **One-Time Reimbursement:** Requests for all other types of eligible expenses that do not qualify for Automatic Reimbursement. **One-Time reimbursement claims 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 in to the online portal (using the website provided on the front cover of this guide) to submit your claim online; attach all supporting documentation to the online portal. The retiree and eligible dependents or spouse must submit individual claims in their own RRA portal in order to access their individual subsidy funds (see Step 4 for instructions).

**OR**

- **Submit using paper forms.** Paper claim requests must be completed by the individual RRA subsidy holder. The retiree, eligible dependent and or spouse must correctly complete and sign their own individual claim form. Submit claim forms via mail, email or fax. Be sure to include copies of required supporting documentation with your claim forms submission.

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 RRA 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/comcastnbcu>
2. To log in to your online RRA 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.

**PERSONAL INFO**

Personal Info | Add Dependent | **Direct Deposit** | Change Password | Change Email

**DIRECT DEPOSIT INFORMATION**

Enable Direct Deposit  This box MUST be checked for direct deposit to occur

Bank Name

Account Name

ABA-Routing Number

Account Number

Account Type

Attach Void Check

**AGREED & ACKNOWLEDGED**: Checking this box and hitting submit constitutes my electronic signature pursuant to the Electronic Signatures in Global and National Commerce Act and the Uniform Electronic Transactions Act.

### 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, email or fax form and voided check to:

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

**Optional Direct Deposit Form**  
FOR QUALIFIED MEDICAL EXPENSES

MERCER MARKETPLACE  
EMPOWERING BENEFITS 365

**IMPORTANT INFORMATION**  
To allow payments for eligible medical expenses and/or premium reimbursements under your HRA Retiree Account 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 (received) 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).

**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 account. 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 of the termination in such form and to

Please provide the following information regarding the bank account to receive deposits for your eligible medical expenses from your HRA Retiree Account:

Name(s) on Account: \_\_\_\_\_  
Bank Name: \_\_\_\_\_  
Bank City and State: \_\_\_\_\_  
Routing/Transit Number: \_\_\_\_\_  
Account Number: \_\_\_\_\_

John Doe  
123 Your Street  
Youtown, AA 12345

PAY TO THE ORDER OF \_\_\_\_\_

Your Bank  
Anywhere USA

109800033 333562222 3333

Mercer Health & Benefits Administration, ATTN: Claims Dept., P.O. Box 14401, Des Moines, IA 50306-3401  
857.434.1144 (Res) • 857.362.2999 (Bus) • [hra@mercer.com](mailto:hra@mercer.com)

# STEP 2

## TYPE OF CLAIM YOU ARE SUBMITTING

There are two types of claim requests as described below:

### **AUTOMATIC REIMBURSEMENT REQUESTS:**

- Only monthly premiums paid through select insurance carrier plan(s) contracted with and purchased through Mercer Marketplace 365 and Medicare Part B Premiums 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. Comcast NBCUniversal's plan rules will determine the monthly payout date, 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 15<sup>th</sup> of each year, you can avoid a delay in reimbursement. Automatic monthly reimbursements are set up until December 31<sup>st</sup> 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 auto reimbursement.

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

# 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	<ul style="list-style-type: none"> <li><b>Welcome letter from carrier or yearly premium notification. Must contain:</b> <ul style="list-style-type: none"> <li>- name of insurance carrier</li> <li>- policy holder's name(s)</li> <li>- monthly plan premium</li> <li>- proof of payment <b>not</b> needed</li> </ul> </li> <li><b>OR</b></li> <li><b>Monthly Premium Bill</b> <ul style="list-style-type: none"> <li>- name of health insurance carrier</li> <li>- policy holder's name(s)</li> <li>- effective date of the policy</li> <li>- monthly plan premium</li> <li>- proof of payment <b>not</b> needed</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li><b>Welcome letter from carrier, monthly bill or yearly premium notification. Must contain:</b> <ul style="list-style-type: none"> <li>- name of insurance carrier</li> <li>- policy holder's name(s)</li> <li>- effective date of the policy</li> <li>- monthly plan premium</li> </ul> </li> <li><b>AND</b></li> <li><b>Proof of payment for each one-time claim submission</b> (copy of bank statement, or copy of check, or credit card statement, or monthly premium bill showing the previous month's payment was received.)</li> </ul>
Medicare Part B Premium	<ul style="list-style-type: none"> <li><b>Social Security cost of living statement</b> – showing the <b>Part B</b> monthly premium deduction</li> </ul>	<ul style="list-style-type: none"> <li><b>Social Security quarterly billing statement</b> – showing billing period and amount owed</li> <li><b>AND</b></li> <li><b>Proof of Payment</b> (copy of bank statement, or copy of check front &amp; back, or credit card statement)</li> </ul>



# STEP 4

## SUBMITTING YOUR CLAIM

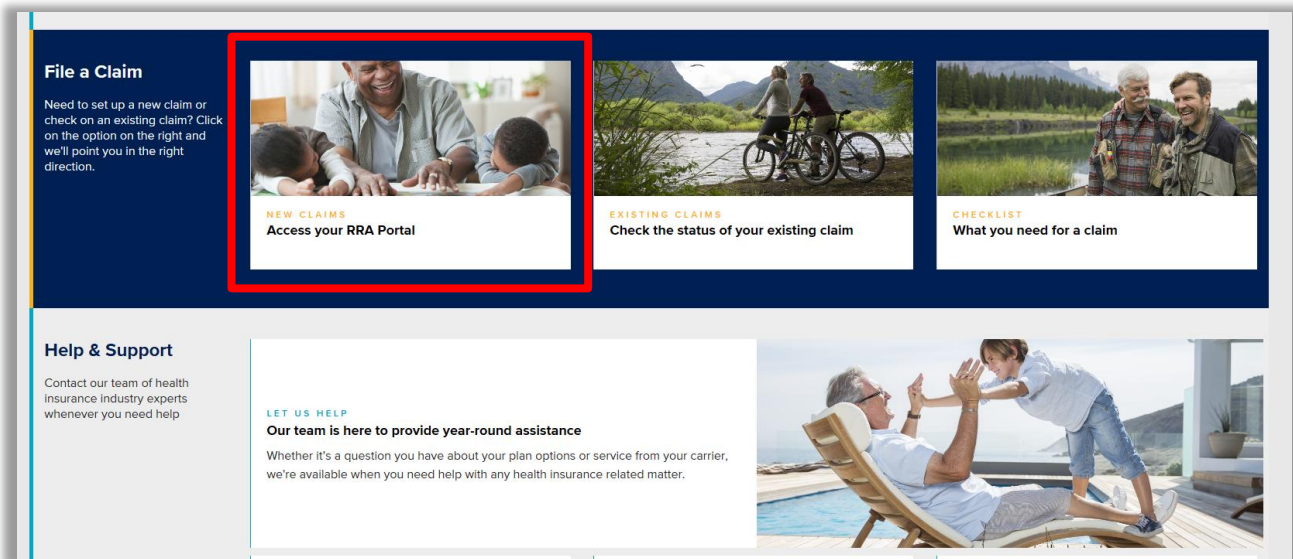
### TWO WAYS TO SUBMIT YOUR CLAIM FOR REIMBURSEMENT

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

### SUBMITTING THROUGH THE ONLINE PORTAL

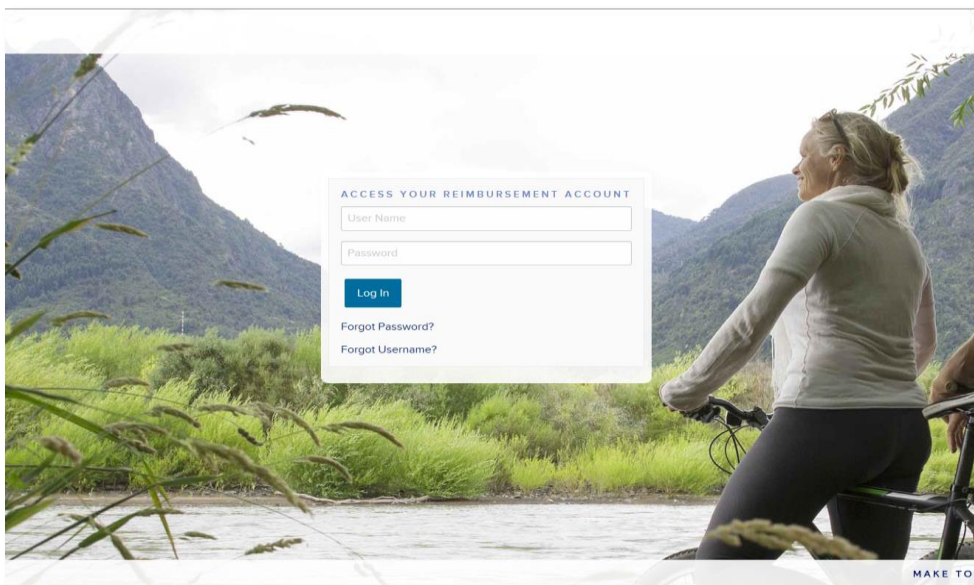
Let's first make sure you feel familiar with the **online portal**: how to find it, how to log in, how to submit a claim and how to take advantage of the other features you will find helpful to manage your RRA.

**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 below, click "NEW CLAIMS - Access Your RRA 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 below for username/password reset options.



**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

## WELCOME TO YOUR

**DASHBOARD:** The RRA portal was designed to provide online 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 former 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.

**AUTOMATIC CLAIM SUBMISSION**

Plan Information: Plan Name, Address, Contact, Start Date, End Date, Monthly Premium, Service Period

**SUPPORTING DOCUMENTS**

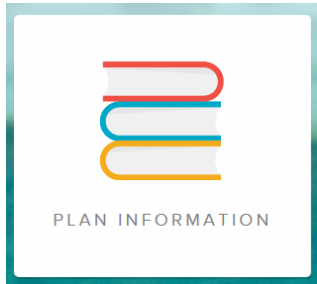
Upload Document

Read Statement

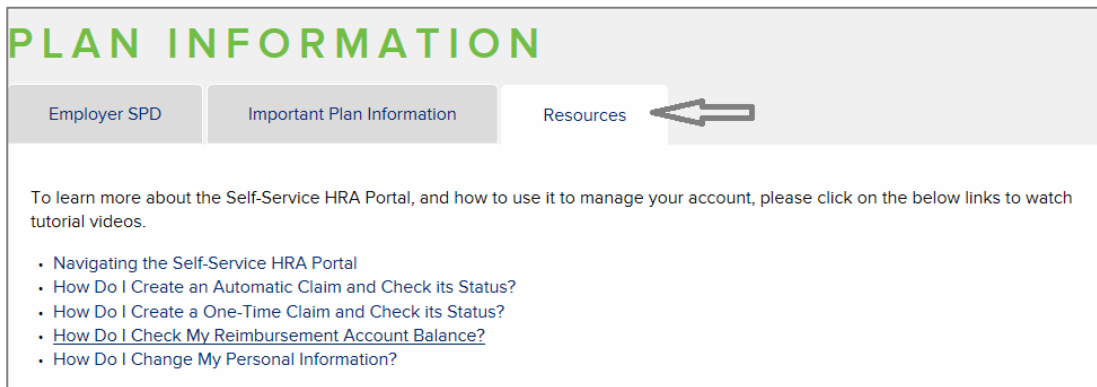
Submit Claim

## 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 available to provide additional support.

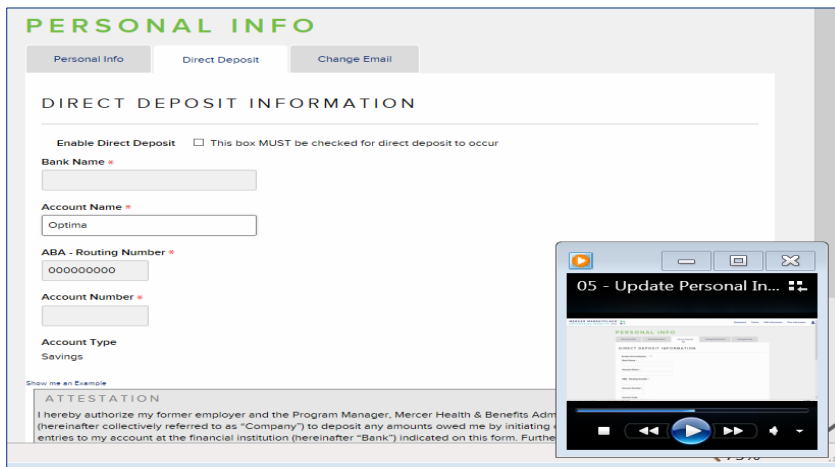
## ONLINE VIDEO TUTORIAL EXAMPLES

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.



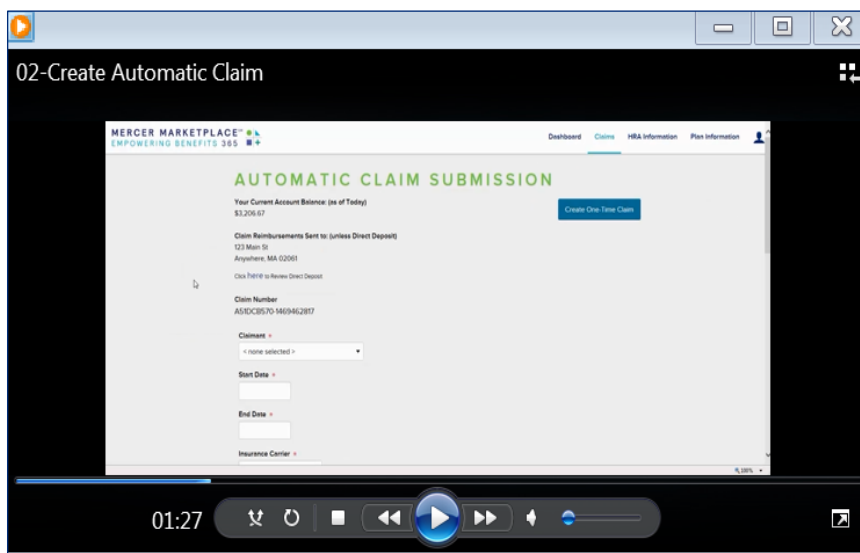
This video icon that will show up on your toolbar when you click on the video link.

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



**Submitting claims online through your RRA 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 Supplemental 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*

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EMPOWERING BENEFITS 365

**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 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	INSURANCE COMPANY	AMOUNT OF EXPENSE
WILLIAM WORKER	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 any coverage ends or my monthly premium amount changes from the amount shown above. I accept full liability for timely notification of any changes.

**Participant Information**  
I have read this document and understand and confirm that as a Participant in the Plan, premiums insured above for myself and any eligible dependents will be deducted from my HRA Account and reimbursed to me directly every month beginning 1/1/2019 (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.

**Participant (Account Holder) Name:** William Worker  
**Signature:** *William Worker*  
**Date:** 12/15/2017

Mercer Health & Benefits Administration, ATTN: Claims Dept., PO Box 14401, Des Moines, IA 50395-3401  
(866) 638-4810 (toll free) • (515) 262-2999 (local) • <http://vdice.mercomarketplace.com/ide/health> • [hra@mercer.com](mailto:hra@mercer.com)

### Automatic Reimbursement online submission on 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 37038  
Claim Ref# to Review: Direct Deposit

Claim Number: ASDCE970-4499166735

Claimant:

Start Date:

End Date:

Insurance Carrier:

Monthly Premium: \$ 0.00

Expense Incurred:

**SUPPORTING DOCUMENTS**

Upload Document:  [Browse...](#) [Add to List](#)  
(Use jpeg, png, bmp, tiff or pdf files, max 10mb 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 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 March 08, 2017  
10 Sunshine Av  
Clarksville NM 12345

Dear Mr. Worker,

policy # 123465200ABC


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

**Notification of enrollment 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 notify you of any changes in your plan.

Due Date	Amount Due
April, 2017	\$175.70
May, 2017	\$175.70
June, 2017	\$175.70
July, 2017	\$175.70
August, 2017	\$175.70
September, 2017	\$175.70
October, 2017	\$175.70
November, 2017	\$175.70
December, 2017	\$175.70

**ABC** Supplemental and Personal Health

**Prescription Drug /welcome letter  
proof of premium/coverage**



**XYZ Part D Insurance**

William Worker Rx-ID 000345678X  
10 Sunshine Av  
Clarksville NM 12345

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 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

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PARTICIPANT (ACCOUNT HOLDER) NAME Wanda Worker      SSN xxx-xx-1234      Please retain a completed copy of this form for your records.

ADDRESS 13 Sunrise Lane

CITY Seaside      STATE FL      ZIP CODE 02300

---

**LIST ONE CLAIMER 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.

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

**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 800-885-6399**

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**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 (toll) • <http://refree.mercermarketplace.com/refreehealth> • [hr@mercer.com](mailto:hr@mercer.com)

ONE-TIME CLAIM SUBMISSION

Your Current Account Balance: (as of Today)  
\$4,930.40

[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  
AS1DCB570-1499228197

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](#)

Use JPEG, PNG, BMP, GIF or PDF files (less than 10MB)

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 reimbursements. **Acceptable supporting documentation is outlined in detail during Step 3 of this guide.** These forms are mailed directly to you from your insurance company after enrollment. Below are examples of an insurance company invoice with policy holder 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**

**AND**

**Bank Statement  
PROOF OF PAYMENT**

**Blue Health Insurance**  
Statement Date: 1/1/2017

Blue Health Monthly Billing Statement

Policy holder: Wanda Worker  
Account #000000  
Effective Date: 1/1/2017

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

DATE:	DESCRIPTION:	AMOUNT:
1/28/2017	Previous Balance	\$ 500.00
	Jan 1 <sup>st</sup> Payment Received	- \$ 500.00
		\$ 0.00
2/28/2017	Current Balance payment due Feb 1st	Pay This Amount \$ 500.00

**The Family Bank**  
STATEMENT DATE: 2/10/2017

Wanda Worker  
123 Sunshine Lane  
Mantown, PA 19260  
ACCOUNT # 20810917486279000

**CHECKING ACCOUNT HISTORY**

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

**Supporting documentation using COLA statement.** The form on the right is a Cost of Living Statement (COLA). The Social Security Administration sends this statement in December of each year. This statement can be used by Medicare-eligible participants as proof of premium to be reimbursed for a number of different premiums including Medicare Part B, Part D prescription drug plans and Medicare Advantage plans. 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**. This statement can also be used for reimbursement for Part B premiums reimbursement.

**SOCIAL SECURITY ADMINISTRATION**  
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  
MANTOWN, USA 11111-1111

What's Inside...  
Your Estimated Benefits..... 2  
Your Earnings Record..... 3  
Some Facts About Social Security..... 4  
If You Need More Information..... 4

**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 it 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** is **\$ 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 paper Direct Deposit form.

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*

# Automatic Reimbursement Request Form

## FOR QUALIFIED MEDICAL PREMIUM REIMBURSEMENTS

MERCER MARKETPLACE 365<sup>SM</sup>  
RETIREE

I participate in the Employer Sponsored Retiree Reimbursement subsidy Account (RRA), 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 subsidy 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.

<b>ACCOUNT HOLDER NAME</b> _____		<b>SSN</b> _____
EXPENSE	INSURANCE COMPANY	AMOUNT OF EXPENSE
MEDICAL		\$
PRESCRIPTION DRUG		\$
PART B		\$
DENTAL		\$
VISION		\$
<b>TOTAL MONTHLY RECURRING EXPENSE REIMBURSEMENT REQUEST</b>		<b>\$</b>

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.

\_\_\_\_\_  
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 RRA subsidy 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.

**[This page has been intentionally left blank]**

# One-Time Claim Form

## FOR QUALIFIED MEDICAL EXPENSES

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 866-435-5135

**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 \_\_\_\_\_

**[This page has been intentionally left blank]**

# Direct Deposit Form

FOR QUALIFIED MEDICAL EXPENSES

## IMPORTANT INFORMATION

To allow payments for eligible medical expenses and/or premium reimbursements under your RRA 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 RRA:

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







## Addendum to the Mercer Marketplace 365<sup>SM\*</sup> RRA Instructional Guide for Comcast NBCUniversal – December 2017

### Post-Tax Group Premiums

#### For retirees with a retirement date on or before 12/31/17

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Mercer Marketplace 365 will administer the RRA to allow for post-tax group premiums for all retirees eligible for an RRA. This will include any medical, dental and vision post-tax group premium, including non-Comcast NBCUniversal COBRA and group plans.

In addition to the documentation required, as outlined in Step 3 on page 8 of the RRA Instructional Guide, retirees submitting RRA claims for non-Comcast NBCUniversal COBRA and group plans will need to include a statement from the carrier or plan administrator stating that the premiums are post-tax payments.

#### For retirees with a retirement date on or after 1/1/18

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Post-tax group premiums will not be an eligible expense for the RRA. Mercer Marketplace 365 will administer the RRA to only allow for reimbursements for eligible individual plan premiums. This will include any medical, prescription drug, dental and vision individual premiums.

### RRA Eligibility for Plans Purchased Outside of Mercer Marketplace 365

#### For Pre-65 and Medicare-eligible retirees with a retirement date on or before 12/31/17

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Mercer Marketplace 365 will reimburse for eligible<sup>1</sup> medical, prescription drug, dental, vision and part B premiums purchased outside of Mercer Marketplace 365.

#### For Pre-65 retirees with a retirement date on or after 1/1/18

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Mercer Marketplace 365 will reimburse for eligible<sup>1</sup> individual medical, prescription drug, dental and vision purchased outside of Mercer Marketplace 365.

#### For retirees aging into Medicare after 1/1/18<sup>2</sup>

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- Mercer Marketplace 365 will only reimburse for medical, prescription drug, dental and vision premiums purchased through Mercer Marketplace 365.
- Part B premiums are eligible for reimbursement even if a retiree does not purchase a plan through Mercer Marketplace 365.

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<sup>1</sup>Eligible Pre-65 plans are ACA-compliant (metal tier) medical plans.

<sup>2</sup>Only applies to retirees who retired on or before December 31, 2017 and have maintained eligibility for the RRA.

\*Services provided by Mercer Health & Benefits Administration LLC.