The Ohio PERS
Retiree Medical Account

Send Completed Form To: **Aetna, Inc.**
PO Box 4000
Richmond, KY 40476-4000
Fax to: 1-888-238-3539

For questions regarding your account balance, the status of claim payments, eligible expenses, or how to complete this form, call Aetna at 1-888-672-9136.

Section 1	
Account Holder's Name	Control Number **876832**
Telephone Number	Identification Number/Social Security
Address ☐ Check here if address is new	*Street* *City* *State* *ZIP Code*

Section 2 — *Complete this section if you are requesting payments for premiums or claims.*

Please ensure you have submitted all required documentation with this claim.

☐ **Self *(Please check this box if retiree is deceased and you are an eligible spouse or dependent.)***

Note: When completing the "Amount of Claim" section please use the full amount of the claim you are submitting and not your present balance as that amount may be subject to change. Your claim will be processed to the available balance at the time the claim is received. **Example: Total of claim is $250, your balance at the time you submit is $230, you should complete the "Amount of Claim" section using the full amount of the claim, $250, and Aetna will reimburse what is available at the time the claim is processed.**

Requesting reimbursement for expenses incurred (Check all that apply.):	**Name of Person**	
☐ Self ☐ Spouse ☐ Dependent		
Date(s) of Service From / / Thru / /	Type ☐ Claim ☐ Premium	Amount of Claim **$**
Requesting reimbursement for expenses incurred (Check all that apply.): ☐ Self ☐ Spouse ☐ Dependent	**Name of Person**	
Date(s) of Service From / / Thru / /	Type ☐ Claim ☐ Premium	Amount of Claim **$**
Requesting reimbursement for expenses incurred (Check all that apply.): ☐ Self ☐ Spouse ☐ Dependent	**Name of Person**	
Date(s) of Service From / / Thru / /	Type ☐ Claim ☐ Premium	Amount of Claim **$**
Requesting reimbursement for expenses incurred (Check all that apply.): ☐ Self ☐ Spouse ☐ Dependent	**Name of Person**	
Date(s) of Service From / / Thru / /	Type ☐ Claim ☐ Premium	Amount of Claim **$**

I authorize Aetna to process my payment in the full amount of my claim at the time it is received. I understand my claim will be processed up to my available balance at the time of submission. I certify that the medical expenses for which I am seeking reimbursement from the Retiree Medical Account have been incurred by the Account Holder, or by an individual who qualifies as the Account Holder's spouse or dependent under IRS guidelines. I further certify that these expenses have not been reimbursed, nor shall reimbursement be sought, from any other health plan coverage, including a Health Savings Account. I also certify that these expenses have not, and will not, be claimed as a tax deduction or credit on any federal income tax return, or on any state or local tax returns in violation of state or local law. Any person who, knowingly and with intent to defraud or deceive any insurance company, files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be liable for substantial civil penalties.

Signature of **Account Holder** or **Account Holder's Authorized Representative**	Date
Signature of **Power of Attorney**	Date

You can use your Medical Savings Account – Retiree Medical Account to reimburse yourself for:

- **Deductibles and copayments under Medicare, or a Medigap insurance plan, any employer-sponsored or individual health plan, including your Ohio PERS medical, dental and vision plans.**

  You must enclose an Explanation of Benefits or other proof of payment from the insurer and all other required documentation, i.e., invoice from physician, copayment receipt, etc.

- **Medicare Part B premiums except the amount for which Ohio PERS reimburses you, premiums for a Medigap Insurance plan, or other supplemental medical coverage such as your medical, dental and vision coverage provided by Ohio PERS.**

  You must submit/attach the following required documentation:

  Medicare Part B premiums — The first time you are requesting reimbursement for Medicare Part B Premiums, **enclose a copy of your *Notice of Medical Insurance Enrollment and Premium Deduction*** from the Department of Health and Human Services. Each time thereafter, you need only complete the front of this form.

  Medigap insurance plan or other medical coverage — Complete the front of this form and enclose a **copy of the invoice for the premium** (or check stub for a spouse's employer's plan) each time you submit a claim.

- **Other eligible health care expenses not covered by Medicare, Medigap plans, or other insurance policies. A listing of expenses eligible for reimbursement can be found in IRS Publication 502 as well as in www.aetna.com/fsa, Medical and Dental Expenses available from your local IRS Department.**

  You must submit/attach the following required documentation:

  To be reimbursed for an eligible expense you have paid, you must file a claim, accompanied by an itemized bill. The itemized bill should include a description of the service (doctor's visit, surgery, eye exam, etc.), the service provider's name, and address, and the claim amount.

  Change Effective 1/1/2011: All Over the Counter Medicines will now require a prescription with each submission to be covered under your RMA. For a complete list of covered expenses please visit www.aetna.com/fsa.

  Reimbursements will occur when the Claim amount reaches a minimum of $15.

  As claim administrator, Aetna has sole discretion to determine if an expense is eligible for reimbursement and the documentation of a claim is complete. If you have any questions about Aetna's determination, call Aetna at 1-888-672-9136 for claim appeal procedures.