THE NELSON TRUST

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Health Reimbursement Arrangement (HRA) Claim Form

(Please see the reverse side for instructions in preparing and submitting this form)

Section 1 Participant Information

SS # □□□-□□-□□□□	Phone # □□□-□□□-□□□□
Last Name	First Name Middle Initial
Address (☐ check if address is new)	Apt. #
Address	
City	State ZIP Code

IN ORDER TO RECEIVE REIMBURSEMENT, SECTION 2 MUST BE COMPLETED IN ITS ENTIRETY

Section 2 Information Regarding Your Premium Payment(s)

I am requesting reimbursement of premium payments for: ○ Myself ○ My Spouse ○ Myself + My Spouse

I would like to: ○ File a new claim ○ Make change to my existing claim

Date of Service or Premium Month(s)	Type of Service (e.g. Medical Service, Premium payment)	Name of Carrier or Provider	Amount Paid	Requested Reimbursement Amount
			$	$
			$	$
			$	$
			TOTAL REIMBURSEMENT FROM HRA	**$**

☐ **Check here to sign up for monthly automatic reimbursement of premium payments** (You are required to notify the Trust Office if your coverage and/or premium cost changes.)

***** *Indicate if premium is for: Medicare Advantage, Part B, Part D, or Supplemental Insurance (Medigap) OR other medical/dental premiums.*

***** *Attach supporting documentation*

Section 3 Retiree Certification and Signature

- I certify the attached information represents actual retiree medical plan premiums and expenses for me or my dependent.
- I understand that any person who knowingly, and with intent to defraud or deceive, 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.
- I have attached to this claim supporting documentation as required above to validate all premium reimbursement requests.

Signature	Date

PMB #116 • 5331 S Macadam Avenue • Suite 258 • Portland, OR 97239
(503) 222-7696 (800) 811-8853 Fax (503) 228-0149
WWW.NELSONBENEFITS.ORG

Your Retiree Reimbursement Account can be used for:

- Medicare Advantage premiums
- Medicare Part B premiums
- Medicare Part D premiums
- Premiums for a Medicare Supplement (Medigap) Insurance plan
- Other supplemental medical coverage
- Out of Pocket Claim Expenses (e.g. copay, deductible, coinsurance)

Your 2016 Health Reimbursement Arrangement (HRA)

Any unused balance from 2015 will rollover to the 2016 Plan year; provided you remain an eligible participant. Although you are not required, you are encouraged to file a claim at least once per year.

Each eligible Medicare retiree and/or Medicare eligible dependent who enrolled in an individual Medicare plan effective April 1, 2013 (or upon Medicare eligibility, if later), will continue to receive the following monthly deposit into their individual HRA if replacement coverage is continued in 2016;

$90 Per Medicare retiree plan enrollee who replaced Nelson Trust medical and prescription drug coverage, or
$40 Per Medicare retiree plan enrollee who replaced Nelson Trust prescription drug coverage only

How Do I Receive Reimbursement?

If you would like to be automatically reimbursed each month, you can simply sign up for recurring monthly reimbursement. Check the "**Monthly Automatic Reimbursement**" box located on the enclosed claim form. You will be automatically reimbursed each month via check or direct deposit for amounts that do not exceed your account balance.

1. **Direct Deposit**
   If you were not previously enrolled in direct deposit and would like to have your reimbursement directly deposited into your checking or savings account, please complete the attached enrollment form included or enroll online by visiting the secure online portal www.nelsonbenefits.org

2. **Check**
   If you are not enrolled in direct deposit, a check will be mailed to your home within 30 business days upon filing a paper or online claim.

3. **Benny Prepaid VISA Benefits Card**
   Each participant received a Benny Prepaid VISA benefits card that may be used to pay for prescription drug co-pays. You can swipe the card for an amount up to your available account balance.

Claim Submission Requirements

- ***For Medicare Advantage, Part B and Part D premiums***
  If requesting reimbursement, enclose a copy of your monthly premium deduction amount shown on your annual Social Security Administration Benefits letter along with the attached claim form.

- ***For Medicare Supplement (Medigap) Insurance plan or other medical coverage***
  Enclose a copy of the invoice for the premium (or other documentation for a spouse's employer's plan) along with the attached claim form.
  - The supporting document(s) must include the following information:
    - ✓ Covered participant's name
    - ✓ Name of the health insurance carrier
    - ✓ Coverage date(s)
    - ✓ Description of coverage (e.g., Medigap)
    - ✓ Certification of payment amount (e.g. a premium statement or other certification from your health insurance carrier indicating your premium amount).

NOTE: When submitting a claim for your premium the coverage period start date should be used as the date of service, not the date of payment. For example, if you are requesting reimbursement for April, May and June premiums, use April 1st as the service date.

- ***Out of Pocket Claims*** **(e.g. copayment, deductible, coinsurance)**
  If requesting reimbursement for out of pocket expenses, enclose a copy of proper supporting documentation.
  - The supporting document(s) must include the following information:
    - Explanation of Benefits (EOB) from your health insurance carrier will typically include all of the required information. If the receipt is handwritten, it must include the service provider's signature.
      - If an EOB is not available, supporting documentation must include the following from the provider:
        - ✓ Name of the provider
        - ✓ Description of the service or product
        - ✓ Date of service or purchase
        - ✓ Patient name
        - ✓ Amount paid or owed after insurance
        - ✓ If the receipt is handwritten, it must include the service provider's signature.

How to File Your Claim

- ***Online Claims Submission***
  You can file claims electronically via the Nelson Trust secure online portal. You have 24/7 access to view information, check status of your claim and manage your HRA.

  - Go to www.nelsonbenefits.org

- ***File a Claim using the New Mobile App!***
  Download the mobile app to access your account balance and file claims. Search for A&I Benefits Mobile at the Apple App Store or Google Play Android Market.

- ***Submit a Paper Claim***
  A claim form is enclosed for your convenience. You can also obtain claim forms by visiting the Nelson Trust secure online portal, www.nelsonbenefits.org or by calling BeneSys at 1-800-811-8853.

  Submit the completed claim form **along with** copies of your supporting documentation

  MAIL the form and required documentation to:

  The Nelson Trust HRA
  Claims 5331 S Macadam
  Avenue Suite 258, PMB# 116
  Portland, OR 97239

  OR

  FAX the completed form and required documentation to: **1-503-228-0149**

Important Reminders

- ✓ Please allow 30 business days for claims processing.
- ✓ Amounts that are not used in one year can be carried over to the following year, provided you remain an eligible participant.
- ✓ You must meet the Plan's eligibility requirements to remain eligible for the HRA benefit
- ✓ You will not be taxed on the value of your HRA account or on the reimbursements you receive from your HRA account.