WageWorks
www.wageworks.com

RETIREE HEALTH CARE ACCOUNT (RHCA) —ASSETS AT MERRILL LYNCH

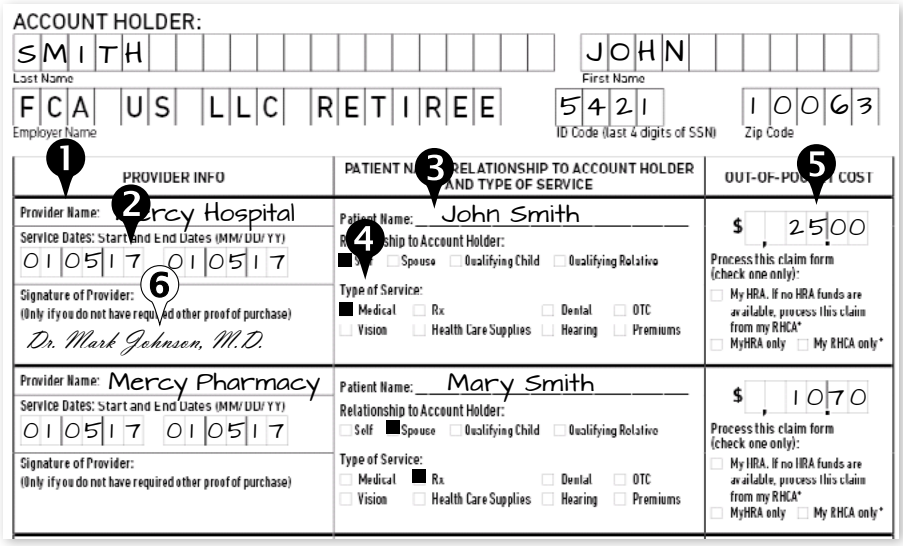
FCA HEALTH CARE RETIREMENT ACCOUNT (HRA) —POST 65-RETIREES

Claim Filing Options:

- **File claim online for faster processing:** Log in to your account at **participant.wageworks.com** to submit your claim electronically. You can also set up direct deposit for faster reimbursement.
- **File claim via fax or mail:** Claim details may be entered online and a completed form may be printed and faxed or mailed with documentation. **Fax:** 877-353-9236, **US Mail:** CLAIMS ADMINISTRATOR, P.O. Box 14053, Lexington, KY, 40512

Instructions to fill out this form:

- Complete ALL account holder information.
- Provide your employer name without abbreviation.
- Use your documentation to complete each section of the form, including the following:
  - ① **Provider Name**
  - ② **Service Date(s)**
  - ③ **Patient Name and Relationship to Account Holder**
  - ④ **Type of Service**
  - ⑤ **Patient Responsibility**
  - ⑥ **Provider Signature is not required, but can replace need for other proof of service**



Tips For Claim Submission

- An eligible dependent is defined as a spouse, qualifying child, or qualifying relative.
  - A qualifying child is defined as a dependent child up to age 26 or any age if permanently disabled.
  - A qualifying relative is someone who resides with you for more than half of the year.
  - Qualifying children and relatives must not provide more than half of his/her own support.
  - For spousal HRA claims—must have been legal spouse *prior* to retirement.
- For information to claim orthodontia expenses, refer to the guide located at: https://www.wageworks.com/employees/support-center/important-forms.aspx.
- For a complete list of eligible expenses specific to your plan, log in to your account at wageworks.com and select "Eligible Expense" from the left side of the screen. Only submit claims for eligible expenses.
- A letter of medical necessity is required for any expense listed as "Yes (Letter)" on the eligible expense list to establish medical necessity. Cosmetic surgery or procedures, e.g., teeth whitening, are not eligible expenses unless deemed as medically necessary by a licensed physician. A letter of medical necessity form can be obtained at: https://www.wageworks.com/employees/support-center/important-forms.aspx.
- For spousal RHCA claims—may submit for a spouse which you legally married *prior to or after* retirement.

Tip For Annual Claim Submission

- In order to do so, you need to complete a claim form indicating the dates for the entire year (i.e. 01/01/18 - 12/31/18) and the annual premium amount.
- You must provide Proof of Coverage and Proof of Payment for one month. See below for acceptable proof.
- WageWorks will enter the claim with the dates of service for the entire year and the annual amount. Claims are then prorated on a monthly basis based on the service dates going forward from the month documentation is received for proof of coverage and proof of payment. Payment is made at the beginning of each month automatically once the annual claim has been established.
- Please note—the above listed instructions are for annual claims submission when completed late December and/or the beginning of January of a new calendar year.
- For participants submitting claims any other month of the year—we require showing proof of coverage and proof of payment for each month past up to and including the current month. The remainder of the year will pay out monthly.

Tip for Over-the-Counter Expenses

- A prescription is required for any over-the-counter expense listed as "Yes (Rx)" on the eligible expense list. As a result of the Health Care Reform Law, in addition to the required detailed receipt, an actual prescription written by a doctor (on a prescription pad or form) dated on or before the date the expense was incurred is required to verify that the over-the-counter medicine is prescribed for a known medical condition.

Tips For Documentation

- Ensure that the documentation is legible.
- Cancelled or copies of checks and credit card receipts do not contain all required pieces of information needed to approve your expense, and are not acceptable for submission.
- Explanation of Benefits (EOBs) are recommended, especially if your insurance covered a portion of the expense.
- The use of a highlighter causes items to not be legible on the documentation; highlighter use is not recommended.
- Send only photocopies of your claim form and documentation—keep the originals for your records if submitting via US Mail.
- Your provider may sign the form confirming the date of services, charges and other service or product information in lieu of providing separate documentation or other proof of service.

Tips For Faxing

- Do not use a cover page when faxing the claim form and documentation.
- Submit only claims for your own account.

Tips for Viewing Claim Status

- Please allow 2 business days from receipt of your claim for processing.
- You will be notified via email of the status of your claim if we have a valid email address on file (to update your email address, please log in to your account at participant.wageworks.com and select "Profile" in the upper right corner of the screen).

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FCA HEALTH CARE RETIREMENT ACCOUNT (HRA) —POST 65-RETIREES

Pay Me Back Claim Form

- **File claim online for faster processing.** Log in to your account at **participant.wageworks.com** to file your claim electronically and upload your documentation. You can also set up direct deposit for faster reimbursement.
- **File claim via fax or mail:** Claim forms may also be filed either via fax or US Mail and sent to the following locations:
  Fax: 877-353-9236,
  US Mail: CLAIMS ADMINISTRATOR, P.O. Box 14053, Lexington, KY, 40512
- Claim processing time: Claims will be processed within 2 business days after receipt of the form. You may check the status of your claim by logging in to your account at **wageworks.com**.

ACCOUNT HOLDER:

Last Name: ____________________ First Name: ____________________

Employer Name: FCA US LLC RETIREE   ID Code (last 4 digits of SSN): ______   Zip Code: ______

PROVIDER INFO	PATIENT NAME, RELATIONSHIP TO ACCOUNT HOLDER AND TYPE OF SERVICE	OUT-OF-POCKET COST
Provider Name: Service Dates: Start and End Dates (MM/DD/YY) Signature of Provider: (Only if you do not have required other proof of purchase)	Patient Name: ____________ Relationship to Account Holder: ☐ Self ☐ Spouse ☐ Qualifying Child ☐ Qualifying Relative Type of Service: ☐ Medical ☐ Rx ☐ Dental ☐ OTC ☐ Vision ☐ Health Care Supplies ☐ Hearing ☐ Premiums	$ ______ Process this claim form (check one only): ☐ My HRA Only ☐ My RHCA Only* ☐ My HRA then My RHCA* (Once HRA funds are exhausted)
Provider Name: Service Dates: Start and End Dates (MM/DD/YY) Signature of Provider: (Only if you do not have required other proof of purchase)	Patient Name: ____________ Relationship to Account Holder: ☐ Self ☐ Spouse ☐ Qualifying Child ☐ Qualifying Relative Type of Service: ☐ Medical ☐ Rx ☐ Dental ☐ OTC ☐ Vision ☐ Health Care Supplies ☐ Hearing ☐ Premiums	$ ______ Process this claim form (check one only): ☐ My HRA Only ☐ My RHCA Only* ☐ My HRA then My RHCA* (Once HRA funds are exhausted)
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More expenses? Please complete another form.   **CLAIM FORM TOTAL:** $ 0.00

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* If I have requested to have any portion of this claim payable from my RHCA account, I am hereby requesting funds in my Institutional Money Market Portfolio II (Institutional) Fund managed by Merrill Lynch be frozen to pay this claim, should it be approved. If there are not currently sufficient funds in my Institutional Fund to cover RHCA claims, I understand that I am immediately responsible for moving funds from my other investment options to the Institutional Fund to enable my claims to be paid by contacting Merrill Lynch online at 1-800-483-7283 or online at www.benefits.ml.com. I acknowledge my RHCA claims will only be paid up to the amount available in the Institutional Fund when my claim is approved (less any amounts previously frozen for previously filed claims or premiums).

CERTIFICATION AND AUTHORIZATION: I certify that the information on this form is accurate and complete. I am requesting reimbursement for eligible deductible expenses incurred by myself or an eligible dependent while I was a participant in the plan. (Patient & Relationship is assumed to be Self unless otherwise indicated.) I have already received these products and services and confirm that by requesting reimbursement here that I have not and will not seek reimbursement of this expense from any other plan or party. I further certify that I have not previously received reimbursement for this expense from this plan or from any other plan. If I am covered under more than one healthcare account, reimbursement will be made according to the "Pay from Account" preference indicated on this form (or, if not indicated, according to the payment order designated by my employer). I understand that health care reimbursements are not eligible deductions on my individual tax return. Claim decisions will be made in accordance with the provisions of the plan. Use of this service indicates my acceptance of the WageWorks User Agreement at **wageworks.com** (available upon registration; enter username and password or click on Registration link).

IMPORTANT: If your Medicare Part B base premium of $109 is being auto-reimbursed but your total premium is more than $109, you may submit a claim to be reimbursed for the difference.

Example:

Your Medicare Part B Premium	$110
Base Medicare Part B Premium	$109 (*Auto-Reimbursed*)
Remainder	$1 (***submit a claim to be reimbursed the $1 difference only***).

In this particular scenario, you are being auto-reimbursed the base of $109, and should not submit a claim for $110 as this will result in overpayment. You should submit a claim for the $1 difference only.

NOTE: If you do not wish to be auto-reimbursed, you may contact WageWorks to discontinue or log in to your account to disable the feature under the Program Options button.

Also, if after your HRA is fully used, you wish to be reimbursed for the base of $109 (or your greater monthly amount) from your RHCA after your HRA is fully used, you must submit a claim for reimbursement from the RHCA and simultaneously disable the auto-reimbursement (AHPC) from the HRA. If you would like to activate or have questions about this option, please log in to your account or call WageWorks.

You may not submit claims for expenses incurred prior to your HRA effective date nor for any expenses previously reimbursed.

Signature of Account Holder_____ **Date** _____