MissionSquare RETIREMENT

Understanding Your MissionSquare Retirement Health Savings Plan Reimbursement Process

Congratulations on becoming eligible to claim your benefits!

Before you begin submitting for reimbursement of your eligible medical expenses, it is important that you understand how the MissionSquare Retirement Health Savings (RHS) plan reimbursement process works.

Please follow these steps to help ensure a smooth claims reimbursement experience:

1. Now that you've met the eligibility criteria, because you have retired or as defined by your employer, your employer notifies MissionSquare by submitting your benefit eligibility date to us.
2. This creates a file with your mailing information, which is provided to Meritain Health (Meritain), the third-party RHS claims administrator. They will automatically generate and mail a Welcome Packet to you, and it will include the following attachments:
   - *Welcome Letter*
   - *MissionSquare RHS Plan Employee Benefit Eligibility Form* (for initial claim only)
   - *MissionSquare RHS Plan Benefits Reimbursement Request Form*
   - *MissionSquare RHS Plan Direct Deposit Authorization Form* (if applicable)
   - *Necessary Documentation In Good Order (IGO) Submissions*
3. You may submit a claim online or by completing the required forms, listed above, and returning them along with your supporting documents to Meritain.
4. Meritain reviews the claim request to confirm the following: your benefit eligibility date, the requested reimbursement is covered based on your RHS account balance, and the expense is allowed by your RHS plan. If these conditions are met, the claim is processed and paid within 10 days. Claims received in good order are typically paid sooner.

If you have questions related to claims, please contact **Meritain at 888-587-9441.** For all other questions, please contact **MissionSquare**. If you need additional forms, you may obtain them through **Meritain** or **MissionSquare**.

MissionSquare Retirement Health Savings Plan

Eligibility Date: «Effective_date»

«Full_Name»
«Address_Line_1»
«Address_Line_2»
«City_State_ZIP_Code»

November 11, 2021

RE: Plan Number «Plan_Number»
MissionSquare Retirement Reference Code: «Reference_code»

SAMPLE

Dear «Full_Name»,

Congratulations! You are eligible to begin submitting claims* for reimbursement in accordance with the provisions of your employer's MissionSquare Retirement Health Savings (RHS) Plan.

In order to effectively process your claim requests, MissionSquare Retirement has selected Meritain Health (Meritain) to adjudicate all claims under your employer's RHS program. MissionSquare Retirement will continue to administer your RHS account. Meritain, however, will process your RHS claim reimbursements.

If you have an email address on file, you will receive email notices regarding your benefit from Meritain. You will also have access to Meritain's online claims portal to manage your RHS claims.

Two ways to submit claims:

- **Online** – You can use the online claims portal to submit claims, update information such as spouse and dependent(s), set up direct deposit, and much more. To use the portal, you will need to log in to your account through MissionSquare Retirement's Account Access (www.missionsq.org), select your plan number referenced above, then select "Claims" to be directed to Meritain's claim portal. Questions regarding claims or the claims portal should be directed to Meritain at 888-587-9441.

- **Form** – You can complete the enclosed form(s) to fulfill your RHS claim reimbursement needs. Note that Social Security numbers no longer appear on the enclosed forms. Instead, please use the MissionSquare Retirement reference code found at the top of this letter to complete the following forms:

  MissionSquare RHS Plan Employee Benefit Eligibility Form: If you have a spouse or eligible dependent(s) and have not already provided their information to Meritain, please complete this form. Meritain must have your spouse and dependent information on file before claims can be processed for them.

  MissionSquare RHS Plan Benefits Reimbursement Request Form: Complete and return this form to Meritain each time you have a reimbursement or would like to establish a recurring payment.

  MissionSquare RHS Plan Direct Deposit Authorization Form: Direct deposit is the fast and reliable way to receive your reimbursements. Complete this form to have your reimbursements deposited directly into your bank account. Remember to attach a voided check for checking accounts or deposit slip for savings accounts, and return the form to Meritain.

SAMPLE

Our goal is to provide you with world-class customer service. If you have suggestions on how we may improve our service, please let us know. We extend our warmest welcome to you and look forward to serving you.

Sincerely,

Benefits Administrator
Meritain Health

**Eligible claim expense(s) for reimbursement must be incurred on or after your eligibility date shown on the front of this letter. Generally, claims should be submitted within two years from the date of the expense, but this limit may vary among plans. If you have questions regarding this limit or your claims, please contact Meritain at 888-587-9441 or MissionSquare@meritain.com.*

MissionSquare RETIREMENT

MissionSquare Retirement Health Savings (RHS) Plan

Employee Benefit Eligibility Form Instructions

Once your employer has indicated you are eligible for benefits and you submit this completed form, you will be able to request payment for benefits covered by your employer's RHS plan. This form is used by the claims administrator (Meritain Health, Inc.) to set up your account and process claims.

In order for us to efficiently process your benefits, you must fully complete this form and submit it to Meritain Health, Inc. Please be sure to keep a copy of all forms and documentation you submit for your records. **Alternatively, you may update or add your spouse and dependent information online.** To ensure your information is current on both systems, first log on to Account Access (www.missionsq.org) to review/update your information. Then remain in your RHS plan and select Claims to get to the Meritain Health claims portal to complete your spouse and dependent information on the Meritain side.Accuracy and completeness of the information you submit will expedite your claims.

After a claim you have submitted has been processed, always review your Explanation of Benefits from Meritain Health, Inc. to confirm the accuracy of your benefit eligibility and enrollment information. If you discover a discrepancy, contact Meritain Health, Inc. at 888-587-9441 as soon as possible.

Note: *If you are able to access funds from your RHS plan in the same year in which you contribute to your Health Savings Account (HSA) administered through another provider, please consult your tax advisor prior to submitting reimbursement to your RHS account. There are specific rules governing HSAs when an employee is also enrolled in a Health Reimbursement Arrangement (HRA), like the RHS plan, that may affect the tax treatment of the HSA contributions.*

SAMPLE

Instructions:

1. **Participant Information**

   Please complete this section carefully. The information will be used to set up your account for benefit payments. You will receive your reimbursements and Explanations of Benefits at the address you list. The employer plan number is available from your employer or MissionSquare Retirement's Participant Services staff at 800-669-7400. For privacy and security reasons, MissionSquare removed Social Security Number as an identifier on this form. Please provide your MissionSquare Reference Code instead of your Social Security Number. If you do not know your Reference Code, it is available through Account Access (www.icmarc.org/login) on the My Profile tab and on your MissionSquare statements.

2. **Spouse and Dependent Information**

   An eligible dependent is (a) the Participant's lawful spouse, (b) the Participant's child under the age of 27, as defined by IRC Section 152(f)(1) and Internal Revenue Service Notice 2010-38, or (c) any other individual who is a person described in IRC Section 152(a), as clarified by Internal Revenue Service Notice 2004-79. In general, dependents consist of your spouse and those who meet each of the following three criteria:

   A. The person is related to you OR lived with you for the entire year as a member of your household; and

   B. The person was a U.S. citizen or resident (or resident of Canada or Mexico) for some part of the calendar year; and

   C. You provided over half of the person's total support for the year.

   See IRS Publication 502, Medical and Dental Expenses, for more information.

   For your spouse and each dependent, please indicate the full name, birth date, and relationship to you.

   If you need to add or delete eligible spouse or dependents, contact Meritain Health, Inc. at 888-587-9441.

3. **Participant's Signature**

   Once you have completed this form, sign it, retain a copy for your records and submit it to Meritain Health, Inc.

   Your signature on the form certifies all information provided is accurate, and all dependents meet the IRS criteria outlined in the instructions for Section 2.

   Please Note: *Your employer must also submit your benefit eligibility date to MissionSquare via EZLink before benefits can be paid. Check with your employer to be sure this notification has occurred prior to submitting claims to Meritain Health, Inc.*

MissionSquare RETIREMENT

MissionSquare Retirement Health Savings (RHS) Plan

Employee Benefit Eligibility Form

- Complete this form once you become eligible to receive benefits in your employer's RHS Plan. Please print legibly in blue or black ink.
- Read instructions on the back before completing this form.
- Return this form to: **MissionSquare RHS Plan, c/o Meritain Health, Inc., P.O. Box 30136, Lansing, MI 48909-7611**.

1 PARTICIPANT INFORMATION

EMPLOYER PLAN NUMBER:	EMPLOYER PLAN NAME:			STATE:
PARTICIPANT FULL NAME: *LAST, FIRST, MI*				
REFERENCE CODE:	DATE OF BIRTH: *MM/DD/YYYY*	PREFERRED PHONE NUMBER:	GENDER: ☐ Female ☐ Male	MARITAL STATUS: ☐ Married ☐ Single
MAILING ADDRESS: *STREET*	*CITY*	*STATE*	*ZIP*	

2 SPOUSE AND DEPENDENT INFORMATION *(COMPLETE THIS SECTION IF YOU HAVE A SPOUSE AND/OR ELIGIBLE DEPENDENTS. SEE INSTRUCTIONS.)*

FULL NAMES OF SPOUSE AND ELIGIBLE DEPENDENTS	DATE OF BIRTH: *MM/DD/YYYY*	RELATIONSHIP
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

SAMPLE

3 PARTICIPANT SIGNATURE

I certify the information provided on this form is accurate and all listed dependents are eligible to receive benefits under the RHS Plan *(see instructions)*:

Participant Signature: ____________________ Date: *MM/DD/YYYY* ____________

Important Note: Your employer must also submit your eligibility information into the EZLink system to establish your benefit eligibility. Please confirm notification has occurred prior to submitting claims to Meritain Health, Inc.

PLEASE RETAIN A COPY FOR YOUR RECORDS.

MissionSquare Retirement Health Savings (RHS) Plan
c/o Meritain Health, Inc.
P.O. Box 30136
Lansing, MI 48909-7611

888-587-9441 ■ Fax: 888-665-8495

MissionSquare Retirement Health Savings (RHS) Plan

Benefits Reimbursement Request Form

- Complete this form and send with supporting documentation to **MissionSquare RHS Plan, c/o Meritain Health, Inc., P.O. Box 30136, Lansing, MI 48909-7611** or fax to 888-665-8495 for processing. Alternatively, you may submit reimbursements and documentation by logging in to Account Access at www.missionsq.org. Select your RHS plan and then Claims to get to the Meritain Health claims portal.
- For privacy and security reasons, MissionSquare Retirement removed Social Security Number as an identifier on this form. Please provide your MissionSquare Reference Code instead of your Social Security Number. If you do not know your Reference Code, it is available through Account Access on the My Profile tab and on your MissionSquare statements.
- Each form of documentation must contain the date(s) of service, provider name, provider address, description of treatment, service or supply, amount charged, insurance payments, as well as the name of the claimant. ***Supporting documentation may consist of: Itemized Bills, Explanation of Benefits, Premium Notices, Itemized Receipts.***
- Eligible claim expense(s) for reimbursement must be incurred on or after your eligibility date. Generally, claims should be submitted within two years from the date of the expense, but this limit may vary among plans. If you have questions regarding this limit or your claims, please contact Meritain at 888-587-9441.

SAMPLE

PLEASE NOTE – SIGNATURE IS REQUIRED FOR PROCESSING: ***Do not*** submit claims for charges eligible under your insurance or Medicare. A medical care expense may not be reimbursed from a Flexible Spending Account (FSA) if the expense has been reimbursed or is reimbursable under any other accident or health plan. If a medical care expense is eligible for coverage by both a Health Reimbursement Arrangement (HRA) and a health FSA, amounts available under a HRA must be exhausted before reimbursement may be made from a health FSA. This requirement does not apply to medical care expenses which are reimbursed from a health FSA but are not reimbursable by the HRA. In no case may a participant be reimbursed for the same medical care expense by both a HRA and a health FSA. ***Do not*** submit claims for services provided prior to your benefit eligibility date. Claims are processed upon receipt of documents in good order.

If you are able to access funds from your RHS plan in the same year in which you contribute to your Health Savings Account (HSA) administered through another provider, please consult your tax advisor prior to submitting reimbursement to your RHS account. There are specific rules governing HSAs when an employee is also enrolled in a HRA, like the RHS plan, that may affect the tax treatment of the HSA contributions.

PART A PLAN AND PARTICIPANT INFORMATION

EMPLOYER PLAN NUMBER:	EMPLOYER PLAN NAME:	STATE:
FULL NAME: *LAST, FIRST, MI*		
REFERENCE CODE:	PREFERRED PHONE NUMBER:	EMAIL ADDRESS:
MAILING ADDRESS: *STREET* *CITY* *STATE* *ZIP*		

NOTE: If this is a new address, please contact MissionSquare at 800-669-7400 to update your address. Your check will be mailed to the address on file with MissionSquare.

PART B REQUEST FOR REIMBURSEMENT OF NON-RECURRING EXPENSES

Use this section to request a reimbursement of non-recurring expenses *(e.g., co-payments, medications, out-of-pocket expenses).*

Summary of Healthcare Expenses

Incurred Date*	**Applicant's Full Name** *(last, first, middle initial)*	**Provider** *(e.g., doctor name/ pharmacy name)*	**Claim for** *(self, spouse, dependent child, other dependent)*	**Description of Service**	**Amount to be Reimbursed**
					$
					$
					$
				Total reimbursement request:	**$**

**Incurred date is the date of service, not the billing or payment date.*

PARTICIPANT NAME: *LAST, FIRST, MI*	REFERENCE CODE:

PART B REQUEST FOR REIMBURSEMENT OF NON-RECURRING EXPENSES *(CONTINUED)*

READ CAREFULLY AND SIGN BELOW FOR PROCESSING.

The undersigned certifies all expenses for which reimbursement or payment is claimed by submission of this form were incurred by the participant, the participant's spouse, or the participant's eligible dependents while the undersigned was eligible to receive benefits under the RHS Plan. The undersigned also certifies as follows:

- The medical expenses have not been reimbursed and are not reimbursable under any other health/dental plan or Medicare.
- The undersigned is responsible for requesting cessation of automated reimbursement of recurring expenses when the expense is no longer being incurred, and will retain sufficient documentation for all recurring expenses. Meritain Health, Inc. reserves the right to periodically request documentation for all automated payment requests.

The undersigned understands he/she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim. The undersigned understands he/she will be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan for non-qualifying expenses.

Signature: ______________________________ Date: *MM/DD/YYYY* ______________

SAMPLE

USE THIS SECTION TO REQUEST AUTOMATED REIMBURSEMENT OF RECURRING EXPENSES (e.g., insurance premiums).

Note: *Payment must be made to the account holder. Payment will not be made directly to an insurance company or other third party.*

You are responsible for ensuring automated reimbursements are for qualifying medical expenses. You are also responsible for ensuring automated reimbursements are stopped if you are no longer incurring the expense(s). You must provide documentation of the recurring expense with this request, and you must retain sufficient documentation for all recurring expenses. Supporting documentati on must show the premium is paid with after-tax funds and include the following: (i) Insurance Carrier; (ii) Type of Insurance; (iii) Policy Holder's Name; (iv) Amount; and (v) Coverage Period. Meritain Health, Inc. reserves the right to periodically request documentation for all automated payment requests.

1. ☐ **BEGIN** recurring reimbursement of $______________
   Beginning Date – insert date you wish payments to begin: *MM/DD/YYYY* ______________
   Frequency *(Check one)*: ☐ Annual ☐ Quarterly ☐ Monthly
   Ending Date – insert date of last payment: *MM/DD/YYYY* ______________
2. ☐ **CHANGE** recurring payment amount from $______________ to $______________
   Effective date of change: *MM/DD/YYYY* ______________
3. ☐ **END** recurring payment of $______________
   Ending Date: Insert date of last payment: *MM/DD/YYYY* ______________

Note: *Payments will continue until your account is depleted, unless an ending date is provided. Any changes to your payment must be received by Meritain Health at least 10 business days prior to next payment. Otherwise the change will take effect on the next scheduled reimbursement.*

PARTICIPANT NAME: *LAST, FIRST, MI*	REFERENCE CODE:

PART B REQUEST FOR REIMBURSEMENT OF NON-RECURRING EXPENSES *(CONTINUED)*

READ CAREFULLY AND SIGN BELOW FOR PROCESSING.

The undersigned certifies all expenses for which reimbursement or payment is claimed by submission of this form were incurred by the participant, the participant's spouse, or the participant's eligible dependents while the undersigned was eligible to receive benefits under the RHS Plan. The undersigned also certifies as follows:

- The medical expenses have not been reimbursed and are not reimbursable under any other health/dental plan or Medicare.
- The undersigned is responsible for requesting cessation of automated reimbursement of recurring expenses when the expense is no longer being incurred, and will retain sufficient documentation for all recurring expenses. Meritain Health, Inc. reserves the right to periodically request documentation for all automated payment requests.

The undersigned understands he/she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim. The undersigned understands he/she will be liable for payment of all related taxes, including federal, state, or local income tax on amounts paid from the Plan for non-qualifying expenses.

Signature: ______________________________ Date: *MM/DD/YYYY* ____________________

SAMPLE

PLEASE RETAIN A COPY FOR YOUR RECORDS.

Send completed form to:

MissionSquare Retirement Health Savings (RHS) Plan
c/o Meritain Health, Inc.
P.O. Box 30136
Lansing, MI 48909-7611

888-587-9441

MissionSquare
RETIREMENT

MissionSquare Retirement Health Savings (RHS) Plan

Direct Deposit Authorization Form

Terms and Conditions for Participating in RHS Direct Deposit

Participants in the RHS reimbursement program have the option of having authorized reimbursements deposited directly into their bank accounts at their financial institution rather than receiving the payment by check. The following are the terms and conditions for participating in the RHS Direct Deposit program. You do not have to participate in the RHS Direct Deposit Program in order to have an RHS account. For privacy and security reasons, MissionSquare Retirement removed Social Security Number as an identifier on this form. Please provide your MissionSquare Reference Code instead of your Social Security Number. If you do not know your Reference Code, it is available by logging in to Account Access at www.missionsq.org on the My Profile tab and on your MissionSquare statements.

1. In order to take advantage of the RHS Direct Deposit program, the RHS reimbursement program participant's financial institution must be a member of an Automated Clearing House (ACH).
2. Participants must complete this authorization form to enroll in the RHS Direct Deposit Program. A signed and dated form is required for processing. If participants have a joint account, both parties must sign the form. Once your form is received by Meritain, there may be up to a four-week administrative processing period before implementation of the RHS Direct Deposit Program. Participants will receive checks for any reimbursement claims paid during this processing period.
3. Meritain will mail participants a direct deposit statement each time an electronic transfer is made to the participant's account. The receipt will show information on the claim being paid, as well as year-to-date information on the participant's MissionSquare RHS accounts. The standard turnaround time for deposit into your account could be up to 72 hours from the time Meritain transmits the reimbursements. Participants should verify that the deposit has been made into his/her account before attempting to withdraw funds.
4. If an electronic transfer is returned to Meritain or for any reason cannot be made to a participant's account, Meritain will investigate the cause and if needed, will issue and mail a reimbursement check to the participant. Until the problem is corrected, the participant will continue to receive reimbursement checks in the mail.
5. It is the participant's responsibility to notify Meritain immediately of any changes in the status of the bank account, such as a bank account closure or a change in the bank account number. Complete this form indicating the action is a change, and provide the new information. There may be up to a four (4) week processing period before the change is effective. If there is interruption in the direct deposit service, the participant will receive checks for any reimbursement claims paid during that time.
6. Participants may cancel direct deposit at any time by completing this form and checking CANCELLATION. The cancellation will take effect as of the date the participant indicates, or as soon as the form is received and processed by Meritain.
7. Meritain reserves the right to automatically cancel a participant's direct deposit services upon termination of employment or termination of a participant's MissionSquare RHS account.
8. When a participant re-enrolls in an RHS in subsequent years, direct deposit services will remain in effect from one plan year to the next until the participant cancels the direct deposit services.

If you have any questions regarding this form, call Meritain at 888-587-9441.

SAMPLE

MissionSquare RETIREMENT

MissionSquare Retirement Health Savings (RHS) Plan

Direct Deposit Authorization Form

To set up Direct Deposit for your MissionSquare RHS account, please read the bottom of this form and fill in the information requested in SECTION 1 and SECTION 2. The completed form must be returned to **Meritain Health, MissionSquare RHS Department, PO Box 30136, Lansing MI 48909-7611.** Alternatively, you may set up or update direct deposit via Account Access (www.missionsq.org). Select your RHS plan and then Claims to get to the Meritain Health claims portal.

Type of Transaction: ☐ New ☐ Change ☐ Cancellation

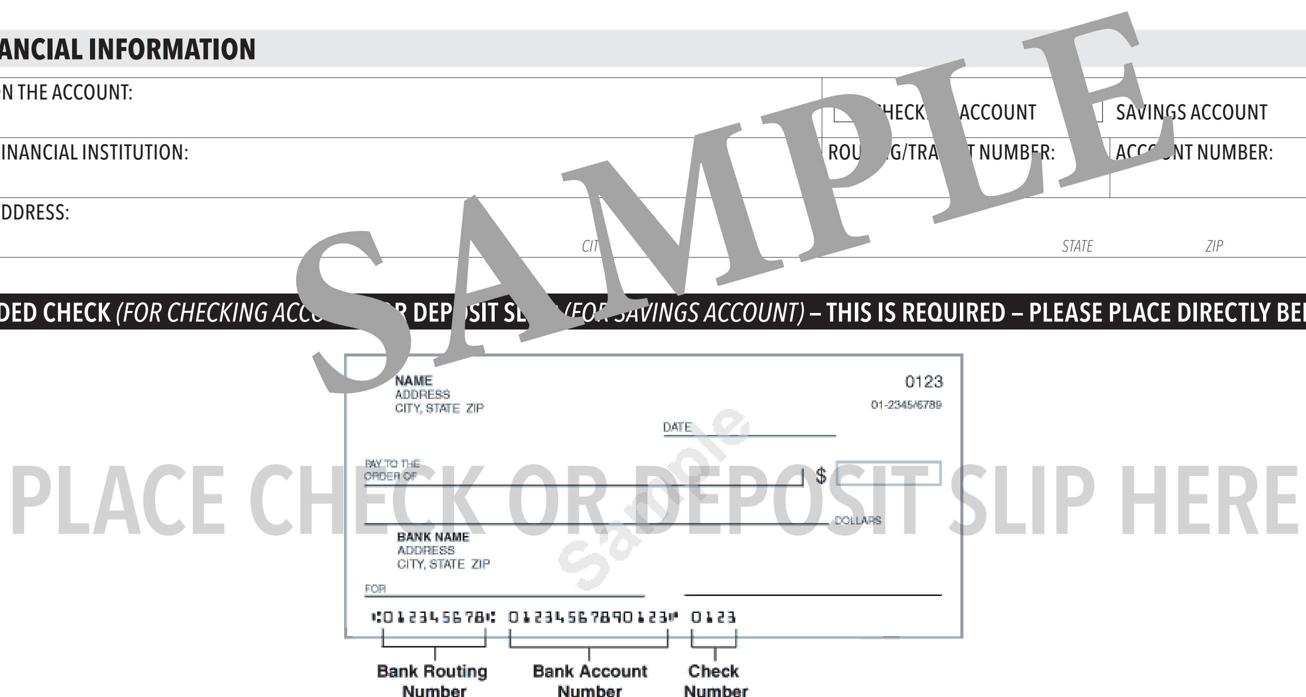
1 DEPOSITOR INFORMATION

EMPLOYER PLAN NUMBER:	REFERENCE CODE:	PREFERRED PHONE NUMBER:	EMAIL ADDRESS:
FULL NAME: *LAST, FIRST, MI*			
MAILING ADDRESS: *STREET*	*CITY*	*STATE*	*ZIP*

2 FINANCIAL INFORMATION

NAME(S) ON THE ACCOUNT:	☐ CHECKING ACCOUNT	☐ SAVINGS ACCOUNT
BANK OR FINANCIAL INSTITUTION:	ROUTING/TRANSIT NUMBER:	ACCOUNT NUMBER:
MAILING ADDRESS: *STREET* *CITY*	*STATE*	*ZIP*

VOIDED CHECK *(FOR CHECKING ACCOUNT)* **OR DEPOSIT SLIP** *(FOR SAVINGS ACCOUNT)* **– THIS IS REQUIRED – PLEASE PLACE DIRECTLY BELOW**



**If the savings deposit slip does not contain a routing number maintained by your bank, you will need to submit a bank form, or statement on bank letterhead that verifies the account and routing numbers of your savings account.*

DEPOSITOR CERTIFICATION

I certify that I have read and understand the terms at the bottom of this form. By signing this form, I authorize my MissionSquare RHS account reimbursements to be sent to the financial institution named above and to be deposited in the designated account.

Depositor's Signature: ______________________ Date: *MM/DD/YYYY* ______________

Joint Account Holder's Signature: ______________________ Date: *MM/DD/YYYY* ______________

Note: *Any joint account holder MUST sign this form in order to be reimbursed.*

PLEASE RETAIN A COPY FOR YOUR RECORDS

Necessary Documentation for In Good Order (IGO) Submissions

This information outlines the documentation necessary for Retirement Health Savings (RHS) reimbursement requests that are submitted to Meritain Health®, the third-party claims administrator. The qualifying medical expenses allowed for reimbursement varies by employer. Your RHS plan may allow reimbursement for all medical expenses, selected medical expenses, or limited to insurance premiums only. The eligible benefits are outlined in the RHS plan summary provided by your employer.

Insurance premiums. Documentation must indicate who is covered, the type of policy, the cost (premium) of the policy, and must confirm you were enrolled at the point that you are requesting reimbursement for. Examples include, but are not limited to: Itemized statements from the provider, retirement paystubs, enrollment confirmation letters, etc. Indemnity plans and medical cost sharing plans are not eligible.

Service-based medical, vision, and dental claims. Documentation must contain:

1. **Date of service.**
    a. We cannot approve any portion of a statement that is listed as a previous or prior balance.
    b. Date of payment is not necessarily the date of service.
2. **Patient name.**
3. **Service(s) rendered (brief description).** If it is a simple office copay, "copay" or "office visit" will suffice.
4. **Total amount charged.**
5. **Amount actually paid and/or adjusted by insurance**.
    a. Any statement showing insurance as pending, estimated, billed to, or expected will be denied.
    b. If the expense is a copay (an even $15/20/25, etc.), we do not need the insurance information.

We do not need proof of payment. We need to know what the final patient responsibility is. However, orthodontics is an exception (see Orthodontics below).

Credit card receipts and many statements do not provide the needed information. Either an Explanation of Benefits (EOB) from your insurance company (the itemized page[s], not a summary), or an itemized statement with actual insurance payments listed, will allow your claim to be paid. Most providers are able to provide an account history report (or ledger), if asked. This will usually detail all of the needed information as well.

Prescriptions. Please submit one of the following:

1. **Rx slip** with the fill date, pharmacy name, patient name, drug name, and cost.
2. **Cash Register receipt** with the date, pharmacy name, and full Rx number.
3. **Pharmacy ledger or history report:** a patient-specific spreadsheet printed out by the pharmacy.

Over-the-counter (OTC) items. Documentation must include:

1. **Name of store where purchased.**
2. **Date of purchase.**
3. **Item(s) purchased.**
    a. OTC medication (e.g., Motrin, Tylenol, etc).
    b. Medical supplies (thermometers, contact solution, bandages, etc) are eligible.
    c. Vitamins and supplements: We must have a Letter of Medical Necessity (LOMN) on file, stating the specific medical condition/diagnosis creating the need for each specific item. If the treatment is ongoing, have the letter include the duration of time that they will be necessary. The letter can be good for up to a year.
4. **Amount paid.**

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An Aetna Company

Orthodontics: Documentation must have:

1. A copy of the orthodontic contract, with the banding date (the date the braces were put on).
2. Proof of payment. If the payment coincides with the monthly payment amount on the contract, only a receipt is needed. If payment veers away from the payment plan at all, please provide a financial ledger of the account.

Common services requiring a Letter of Medical Necessity (LOMN): Anything that could serve a non-medical purpose, including, but not limited to: Massage Therapy, Vein treatment, Weight loss programs.

Common ineligible expenses: Vision warranty, late fees, services incurred outside of the eligible time period, teeth whitening, toothbrushes or paste, anything considered cosmetic, foods associated with a weight loss program.

Information on what constitutes a qualifying medical expense can be found in IRS Publication 502, Medical and Dental Expenses, available at **www.irs.gov/publications/p502**.

Questions?

Have any questions or need more information? We can help. Just reach out to Meritain Health Member Service at **1.888.587.9441**, weekdays 8:00 a.m.- 5:00 p.m. EST.

PROPRIETARY NOTICE

This information, provided by Meritain Health, is intended only for the use of the addressee and only for the purpose that it is being provided. The information shall not be distributed, disclosed or conveyed to any consultant, subcontractor, vendor or other third party. The addressee is required to use appropriate safeguards to protect the information from unauthorized disclosure. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received these documents in error, please notify the Meritain Health Privacy Officer immediately to arrange for their return at 1.800.831.1166.