# American Benefits Group is Administering Johnson Financial Group's Retiree Medical Savings Account (RMSA) Claims

American Benefits Group is a national third party administrator of Consumer Directed Benefit Accounts based in Northampton Massachusetts with a well established reputation for customer centric service delivery.

Claims are processed on a semi-monthly calendar cycle. Claims that are received by the 15th of the month will be paid on or about the 30th of the month. **We encourage you to sign up for convenient Direct Deposit Reimbursement (form enclosed) to expedite your reimbursement. Direct Deposit claims will post to your account by the next business day after processing**. By contrast, USPS mailed checks can take up to 7 days to arrive. If you choose the Direct Deposit method of reimbursement, you will receive an Advice of Deposit informing you of each reimbursement deposit, and the Advice of Deposit will include a detailed reconciliation of your claims.

**CLAIM FOR REIMBURSEMENT FORM** – The Claim for Reimbursement Form is to be used for mailing claims and supporting documentation to American Benefits Group. Instructions for filling out your claim form, including a description of the information that must be included on a copy of your receipt or invoice (or other statement that accompanies your claim form) in order to satisfy the IRS documentation requirement are located on the reverse side of the claim form.

***If you have monthly recurring non group health premiums such as Medicare Part B that you wish to pay through the RMSA, you may use the Recurring Premium Expense Claim Form provided by American Benefits. Please see the "Submitting Claims" section on page 5 for exclusions relevant to the Affordable Care Act (ACA) marketplace.***

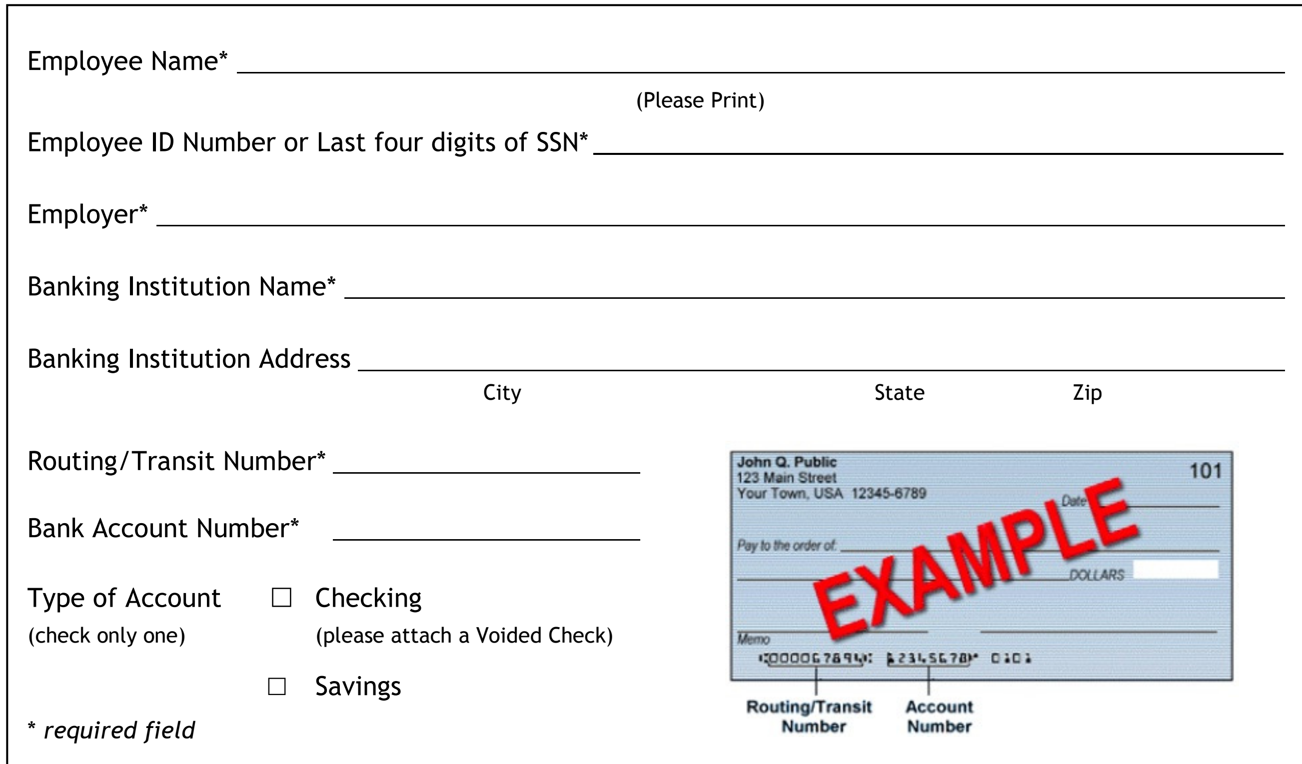
All reimbursement requests for eligible medical expenses should be submitted to American Benefits Group at the following address:

**American Benefits Group**
**RMSA Claims**
**PO Box 1209**
**Northampton, MA 01061-1209**

**Claims can also be emailed to RMSAclaims@amben.com or faxed to 877-723-0147.**

**For questions regarding your claim, contact your Customer Support Specialists at RMSAclaims@amben.com or 855-482-5246. Johnson Financial Group's Customer Support Specialists Elizabeth Bonney, Alan Taylor and Marguerite Rock.**

# REIMBURSEMENT ACCOUNT
# DIRECT DEPOSIT AUTHORIZATION AGREEMENT



Employee Name* ______________________________________________

(Please Print)

Employee ID Number or Last four digits of SSN* ______________________________

Employer* ______________________________________________

Banking Institution Name* ______________________________________________

Banking Institution Address ______________________________________________

City State Zip

Routing/Transit Number* ______________________

Bank Account Number* ______________________

Type of Account (check only one) ☐ Checking (please attach a Voided Check)

☐ Savings

** required field*

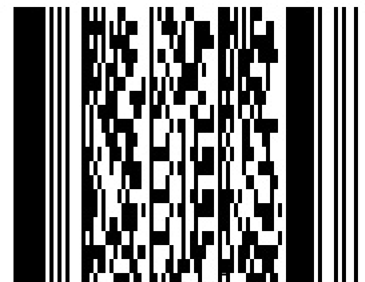


I hereby request and authorize American Benefits Group to remit by direct deposit to my bank named above any reimbursement payments. I also request and authorize the Banking Institution to accept such deposits initiated by American Benefits Group and to direct such deposits to the designated account without responsibility for the correctness of the amount.

It is understood that this agreement may be terminated at anytime by written notification by me to American Benefits Group. Any such notification to American Benefits Group shall be effective only with respect to entries initiated by American Benefits Group after receipt of such notification and within a reasonable opportunity to act on it. Any such notification to the Banking Institution by the participant is unacceptable. The Banking Institution may terminate this agreement by written notice to the participant for Just Cause.

Signature ______________________________________________ Date ______________________

**Fax: 877-723-0147 • Email: RMSAclaims@amben.com**
Mail: American Benefits Group • RMSA Claims • PO Box 1209, Northampton, MA 01061-1209
Tel: 855-482-5246 (855-48-CLAIM)



# AMERICAN BENEFITS GROUP

## RECURRING PREMIUM REIMBURSEMENT REQUEST FORM

Participant Name: ____________________________________________ Last Four Digits of SNN: _________

Participant Address: ______________________________________________________________Change? ☐ yes ☐ no

Phone Number: ______________________________________ Email Address:________________________Change? ☐ yes ☐ no

Employer Name: _________________________________________________________________________

The person named above is a participant in the Retiree Medical Savings Account (RMSA) plan. Through this plan, recurring medical premium payments may be reimbursed on a tax-qualified basis. You need to provide proof of the insurance premiums and a completed *Recurring Premium Reimbursement Request Form*. American Benefits Group (ABG) will automatically reimburse your recurring payment for the entire plan year.

The participant hereby directs ABG to deduct the amount below from his/her RMSA each period until one or more of the following occur.

- The RMSA funds that are available to the participant for reimbursement are depleted
- The participant drops/adds/modifies existing expense and the participant provides written direction to ABG to cease such recurring payments
- The end of the plan year

I understand that plan distributions will be based on the amount available in my plan account and the expenses submitted for reimbursement. I understand that it is my responsibility to inform ABG, the plan administrator, if my premium changes, as compared to the amount shown above. I understand I must provide written documentation if the periodic amount to be reimbursed changes. I accept full liability for timely notification of any changes.

The automatic payment process does not extend beyond one year from the beginning month. You will need to complete a new *Recurring Premium Reimbursement Request Form* along with proper documentation for the new plan year.

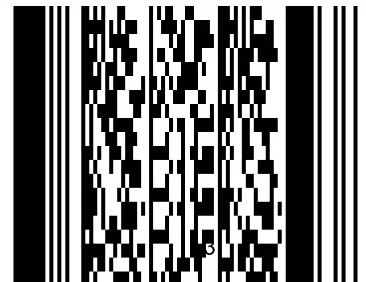
### Recurring Premium

| Description | Period | Beginning (month/year) | Ending (month/year) | Amount |
|---|---|---|---|---|
| | ☐ quarterly ☐ monthly | | | |
| | ☐ quarterly ☐ monthly | | | |
| | ☐ quarterly ☐ monthly | | | |
| | ☐ quarterly ☐ monthly | | | |
| | | | Total Premiums | |

I have read the above and understand, and verify that, as a participant in the RMSA plan, I incur recurring premium expenses.

Participant Signature: ________________________________________ Date: _________________

**Fax: 877-723-0147 • Email: RMSAclaims@amben.com**
Mail: American Benefits Group • RMSA Claims • PO Box 1209, Northampton, MA 01061-1209
Tel: 855-482-5246 (855-48-CLAIM)



# AMERICAN BENEFITS GROUP

## RMSA CLAIM FOR REIMBURSEMENT

Participant's Name: ______________________ Last Four Digits of SNN: __________

Participant's Address: ______________________ Change? ☐ yes ☐ no

Phone Number: ______________________ Email Address: ______________________ Change? ☐ yes ☐ no

Former Employer: ______________________

### Unreimbursed Medical Expense Claims

| | Date Expense Incurred (Dates of Service) | Name of Service Provider | Detailed Description of Expense | Person for Whom Expense was Incurred (Self, Spouse, etc.)* | Expense Amount Claimed |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |
| 5 | | | | | |
| 6 | | | | | |
| 7 | | | | | |
| 8 | | | | | |
| 9 | | | | | |
| 10 | | | | | |
| 11 | | | | | |
| 12 | | | | | |
| | | | | Total Claims | |

* Claims can only be submitted for covered individuals.
  Please refer to your HRA Plan Document to determine who qualifies as a covered individual.

**READ CAREFULLY**
In order to have expenses reimbursed from your Retiree Medical Savings Account (RMSA), you must provide American Benefits Group with the IRS required substantiation to verify that the expense is a covered, unreimbursed medical, dental or vision expense as defined under IRC Section 213(d). **The substantiation must state the medical services or items received, and the cost paid by you. It must also show the dates of service, the provider's name and the recipient's name.** These documents should be mailed or faxed along with this form to the address or fax number below. Please make sure this form has been completed and signed.

The undersigned participant in the plan certifies that all expenses being submitted for reimbursement on this claim form were incurred during a period when the undersigned was covered under the Company's RMSA Plan. In addition the undersigned certifies that the medical expenses have not been previously reimbursed and are not reimbursable under any other health plan coverage. The undersigned acknowledges that he or she is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim, and that, the undersigned may be liable for repayment of any and all improperly claimed expenses.

Participant Signature: ______________________ Date: ______________

Please submit this claim form along with substantiating statements of services received.

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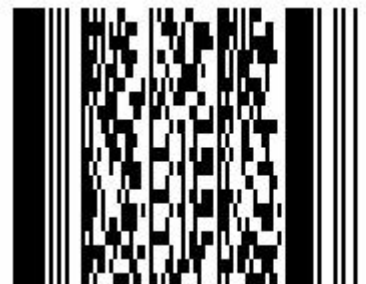
Mail: American Benefits Group • RMSA Claims • PO Box 1209, Northampton, MA 01061-1209
Tel: 855-482-5246 (855-48-CLAIM)



## Submitting Claims

**Examples of eligible expenses** include co-payments, deductibles, unreimbursed medical, dental, and vision expenses, therapy you receive as medical treatment, prescription drugs, and designated over-the-counter items. Categories of eligible expenses are listed in IRS Publication 502, pages 5-17 www.irs.gov/pub/irs-pdf/p502.pdf. However, if you enroll in the Affordable Care Act (ACA) marketplace and receive a subsidy from the government for that health premium, you cannot make a claim against your RMSA account for the plan year.

**To claim benefits under the plan, complete the *RMSA CLAIM FOR REIMBURSEMENT* form. Submit the claim form along with substantiating statements to:**

**Fax: 877-723-0147**
**Email: RMSAclaims@amben.com**
**Mail:** American Benefits Group • RMSA Claims • PO Box 1209, Northampton, MA 01061-1209

Eligible claims that are received by American Benefits Group (ABG) by the 15th of the month will be paid on or about the 30th of the month. Claims received by the 30th of the month will be paid on or about the 15th of the following month. It is important you make sure the documentation you submit to ABG is legible. If ABG is unable to read any of the following items because the quality of the image or the fax, the claim will be denied pending your resubmission of legible documentation.

The documentation must clearly identify:

1. **Person who incurred the expense**
2. **Detailed description of the expense or the nature of service**
3. **The date the service was incurred**
4. **The name of the provider**
5. **The amount of the expense**

To be eligible for reimbursement under the plan, you must provide verification or where and when the medical expenses were incurred. Please include a copy of an itemized statement from each service provider. Expenses are only eligible if they are incurred following your retirement/termination date. Expenses may be incurred by you, your spouse or other individuals who qualify as your eligible dependents under federal rules governing cafeteria plans.

You may use a single line on the claim form to claim multiple expenses which are identical in nature (i.e. office visit co-pays, RX co-pays, etc.) from the same provider. Use a range of dates (earliest to most recent) and the total cost to you. Please make sure to include documentation verifying each individual expense.

Please identify each piece of documentation with the corresponding line number form the claim form. Sign and date the claim form and submit it with the documentation substantiating the expenses. Forms that are not signed and dated will result in the denial of the claims. We suggest that you photocopy your form and documentation for your own records before submitting them.

If your claim is denied, in part or in full, you can file an appeal. You can find the appeal procedure in your ***Summary Plan Description.***

**You may download additional forms at www.amben.com/rmsa.html**

# IMPORTANT INFORMATION REGARDING YOUR RETIREE MEDICAL SAVINGS ACCOUNT PLAN

Dear RMSA Participant:

**Under IRS guidelines, you are not eligible to receive a government subsidy for coverage through the government marketplace (a.k.a. exchange) and have coverage under an employer's group health plan at the same time. The Johnson Financial Group, Inc. ("JFG") Retiree Medical Savings Account is considered a group health plan per government definition. Therefore, if you have a RMSA and receive (or intend to receive) a government subsidy for coverage you gain through the marketplace, you will need to "opt-out" of the RMSA for as long as you receive that subsidy. "Opt-out" means that you cannot receive any money from your RMSA account during that period. You will have the opportunity to opt-out following separation from employment, as well as annually thereafter. Each opt-out is valid through December 31 of each year.**

However, if you turn 65 during the year and had elected to opt-out of the RMSA, you may resume participation in the Plan at age 65, and would thereafter be eligible to file claims for reimbursement of expenses incurred after the subsidy was no longer in place. This is because the government does not provide premium subsidies for individuals who are eligible for Medicare.

Based on the above information, if you would like to opt out of the RMSA for any given plan year (or until you turn age 65 in in that plan year) please complete the "RMSA Opt-Out Form for Health Care Premium Subsidy" found on the next page and fax it to ABG at the fax number listed below.

American Benefits Group (ABG)
RMSA Claims
PO Box 1209
Northampton, MA 01061-1209

Fax: 877-723-0147
Email: RMSAclaims@amben.com

American Benefits Group will require a signed form every year you chose to opt out of the Plan, and an opt-out election will only be valid through December 31 of each year.

If you have any questions regarding this matter, please contact the JFG's benefits department at 262-619-2672 or email JFG at benefits@johnsonbank.com.

**Johnson Financial Group, Inc. (“JFG”)**
**Retiree Medical Savings Account Plan**

**RMSA Opt-Out Form for Health Care Premium Subsidy**
**Calendar Year _______**

Name: _________________________________ Last 4 digits of SSN: _________________

Address: ____________________________________________________________________

Phone: _________________________________

I am receiving or expect to receive a health care premium subsidy under the Affordable Care Act in the year 20___ and I request to opt-out of participating in the JFG Retiree Medical Savings Plan for the calendar year 20___. I understand this request will expire at the end of this year and I may not opt back into the plan during the current calendar year. However, if I am turning 65 this year, I wish to opt-out only until the first day of the month of my 65th birthday.

Participant Signature: _____________________________________ date: __________________

Submit to:

American Benefits Group
RMSA Claims
PO Box 1209
Northampton, MA 01061-1209

Fax: 877-723-0147
Email: RMSAclaims@amben.com