WageWorks
www.wageworks.com

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

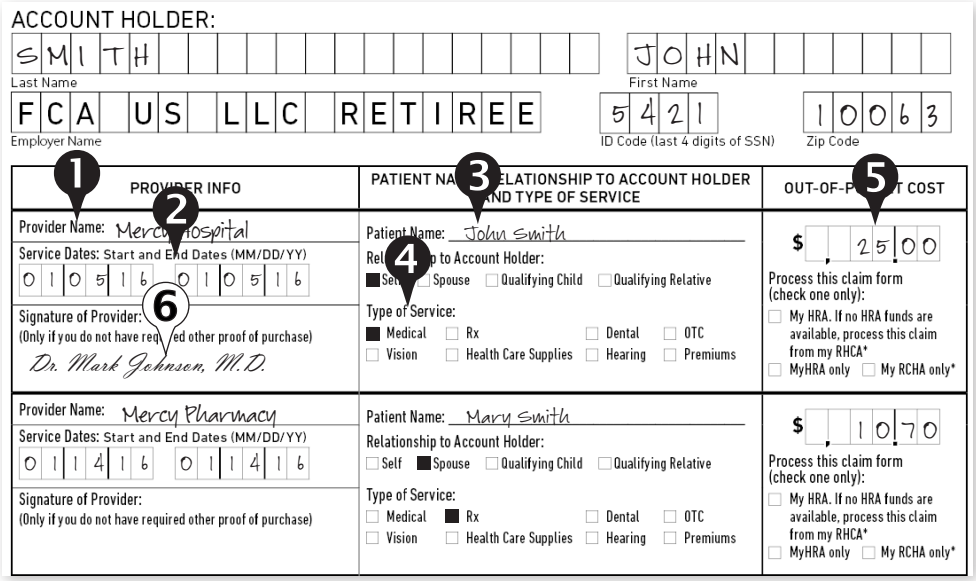
FCA HEALTH CARE RETIREMENT ACCOUNT (HRA) —POST 65-RETIREES

Claim Filing Options:

- **File claim online for faster processing:** Log in to your account at **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 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.**

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 **wageworks.com** and select "Profile" in the upper right corner of the screen).

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Pay Me Back Claim Form

- **File claim online for faster processing.** Log in to your account at **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 _______________

FCA US LLC RETIREE
Employer Name

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. If no HRA funds are available, process this claim from my RHCA* ☐ MyHRA only ☐ My RCHA only*
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. If no HRA funds are available, process this claim from my RHCA* ☐ MyHRA only ☐ My RCHA only*
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. If no HRA funds are available, process this claim from my RHCA* ☐ MyHRA only ☐ My RCHA only*

More expenses? Please complete another form. **CLAIM FORM TOTAL:** $ ___,___.__

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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 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. 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).

Signature of Account Holder _____ **Date** _____