Aetna

Retiree Reimbursement Account (RRA) Reimbursement

Mail or fax completed form and documentation to:
AETNA INC., PO Box 4000
Richmond, KY 40476-4000
Fax to: 1-888-238-3539 (1-888-AET-FLEX)
Customer Service: 1-800-356-6285, press retiree prompt #1
For the hearing impaired, call 1-877-703-5572 TDD/TTY

Note: Eligibility for reimbursement from the Retiree Reimbursement Account (RRA) is determined by your plan. Allowable expenses are also determined by your plan.

*** **You must sign and date this form to avoid claim payment delay.** ***

*** **Refer to Instructions on reverse side.** ***

1. Participant Information

Participant's RRA Identification Number	Participant's Last Name	First	MI	Daytime Telephone Number
W				( )
Street Address	City	State	Zip Code	

2. Employer Information

Employer Name	RRA Control Number
Owens Corning	658270

3. Expense Information – Refer to instructions for plans that allow reimbursement of premiums, which are to be listed here.

Patient's First Name	Relationship to Retiree	Date of Birth *(MM/DD/YYYY)*
	☐ Retiree ☐ Spouse ☐ Dependent	/ /
Date(s) of Service *(MM/DD/YYYY)* From / /	Thru / /	**Total Amount Submitted $**

Patient's First Name	Relationship to Retiree	Date of Birth *(MM/DD/YYYY)*
	☐ Retiree ☐ Spouse ☐ Dependent	/ /
Date(s) of Service *(MM/DD/YYYY)* From / /	Thru / /	**Total Amount Submitted $**

Patient's First Name	Relationship to Retiree	Date of Birth *(MM/DD/YYYY)*
	☐ Retiree ☐ Spouse ☐ Dependent	/ /
Date(s) of Service *(MM/DD/YYYY)* From / /	Thru / /	**Total Amount Submitted $**

Patient's First Name	Relationship to Retiree	Date of Birth *(MM/DD/YYYY)*
	☐ Retiree ☐ Spouse ☐ Dependent	/ /
Date(s) of Service *(MM/DD/YYYY)* From / /	Thru / /	**Total Amount Submitted $**

4. Coordination of Benefits (COB)

Are you or any family members for whom you are requesting reimbursement eligible to receive benefits under any medical, dental, prescription or vision plan other than your primary coverage?

☐ Yes – You must include copies of your EOBs. ☐ No

5. Certification

I certify that the expenses for which I am seeking reimbursement from the Retiree Reimbursement Account have been incurred by me, or (if covered under this plan) by an individual who qualifies as my spouse or my dependent under IRS guidelines. I further certify that these expenses have not been reimbursed, nor shall reimbursement be sought, from any other health plan coverage, including a Health Savings Account (HSA). I also certify that I have not, and will not, claim a tax deduction or credit for these expenses on my federal income tax return, or on my state or local tax returns in violation of state or local law. I agree to submit and retain sufficient documentation for any expense for which I seek reimbursement.

Any person who knowingly and with intent to defraud files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime.

Sign Here ► Signature ______________________________ **Date** ______________

SUBMITTING YOUR CLAIM & PREPARING YOUR CLAIM FORM

- Retain copies for your files. Claim information cannot be returned.
- Do not highlight the form or enclosed documentation. Highlighting makes scanned and faxed documents difficult to read.
- Refer to **www.aetnanavigator.com** for additional claim tips. Once in Navigator, click on the Claims & Balances link and then click on Claims. On the left side of the screen, click on Forms. Scroll down to Flexible Spending Account (FSA) and scroll to the Reimbursement section. Click on the link for Health Care and Dependent Care claim submission guidelines.

SECTION 1 – Participant Information

RRA Identification Number – As a participant with the RRA, you have been assigned a unique participant number. Your RRA ID Number is a 9-digit number preceded with a "W". If you do not know your W#, you can locate it from any one of the following sources:

- Explanation of Payment (EOP) – Paper EOPs always display your W#.
- Activity Statement – As an Aetna RRA participant, you may receive an activity statement at least once a year; refer to this statement for your W#.
- Aetna Medical ID Card – If you have Aetna medical coverage, the W# displayed on your ID card is also used for your RRA.
- Member Services – Call Member Services to inquire about your W#.

NOTE: If you prefer, you can use your Social Security Number in this field.

Retiree's Address – Report an address change to your employer. To avoid misdirected claim payments, your employer must notify Aetna of your new address.

SECTION 2 – Employer Information

RRA Control Number – Your employer has been assigned a unique RRA plan number. If this form does not have that number pre-printed, you can locate this number from any one of the sources (with the exception of the Aetna Medical ID card) listed above in Section 1.

SECTION 3 – Expense Information

List and separate expenses* by individual family members. **Attach the appropriate documentation for each claim.**
NOTE*: A canceled check is not adequate documentation.*

- **If you have insurance:**

  Submit the Explanation of Benefits (EOB) with your completed claim form. If the claim was denied entirely by insurance, submit the EOB *and* the itemized receipt or statement (as listed below). If insurance covered at least part of the expense, you do not need to submit any other documentation with the EOB. **Note**: If a receipt indicates that insurance is pending, this claim will be denied until the EOB is submitted.

- **If you do not have insurance:**
  Submit the itemized receipt or statement from the doctor/dentist/health care professional. This itemized receipt or statement must include:
  - Name & address of doctor/dentist/health care professional
  - Patient's name
  - Date(s) of service
  - Type of service
  - Dollar amount charged

  NOTE: Receipt from doctor/dentist/health care professional must clearly document the patient's financial responsibility.

- **If the RRA allows for reimbursement of healthcare premiums* you must include the following required information:**
  - **Medicare Part B –** The first time you are requesting reimbursement of premiums, enclose a copy of your "Notice of Medical Insurance Enrollment and Premium Deduction" from the Department of Health & Human Services. Each time thereafter, you need only complete this form.
  - **Medicare Part D, Medigap or other medical coverage –** Include a copy of the invoice for premium.

  NOTE: ***Premiums paid with pre-tax salary deferrals cannot be reimbursed from an RRA.*** *The appropriate documentation for premiums paid on a* ***post tax*** *basis must show evidence that the payments were made post tax, e.g., pay stubs should indicate wording such as Post Tax or After Tax. A statement on company letterhead that is signed by a company official to attest that the payments are post tax is also acceptable.*

* Refer to your plan documents for a list of eligible expenses.

SECTION 4 – Coordination of Benefits (COB)

When an expense is covered under more than one health plan (including Medicare), all EOBs for the expense must be submitted in order to process the reimbursement.

SECTION 5 – Certification

You must sign and date this form to avoid claim payment delays.