



# Retiree HRA

Understanding your retirement benefit



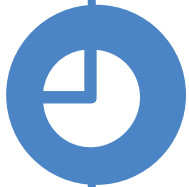
# Retiree HRA 101



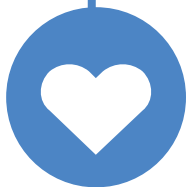
Interest-bearing account in your name



Employer deposits money



Money invested in a fixed-annuity, currently guaranteeing a 1.3% interest rate through 2022\*

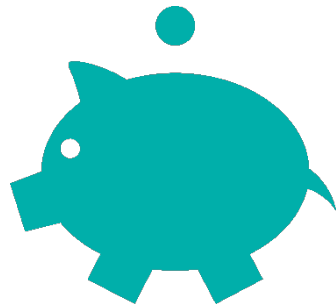


Use for medical expenses and premiums to offset your out-of-pocket costs

Guarantees are subject to the claims paying ability of American United Life Insurance Company.

\* American United Life Insurance Company's unallocated group Fixed Annuity. Not FDIC insured. Based on the claims-paying ability of the investment provider.

# Why use an **HRA**?



**Contributions  
are not taxed.**



**Distributions  
are not taxed.**



**Interest is  
not taxed.**

# HRA: Your Rainy Day Fund



- If you need it, it's there
- If you don't need it, it rolls over every year
- And grows tax-free
- Expenses do not expire—you can submit expenses that were incurred after you retired or separated from service at any time

# Who can benefit from your HRA?



## Individuals who qualify for reimbursement:

- You
- Your spouse
- Qualifying dependents
- Surviving spouse and qualifying dependents
- Beneficiary(s)
  - Funds first made available to surviving spouse and surviving qualifying dependents. If no surviving spouse and no surviving eligible dependents, funds made available to beneficiary
  - Reimbursements are taxable to the beneficiary
  - Can elect a beneficiary online through the participant portal

# Eligible Medical Expenses

- Physician visits
- Prescription medication
- Dental Care
- OTC Medications (per CARES Act 2020)
- Eye care
- Co-pays or deductibles
- Medical insurance premiums
- Etc.



# Qualifying Insurance Premiums

- Health, Dental, Vision, and Long-Term Care Insurance
- Medicare Part B, Part C, and Part D and Medicare Supplements
- Individual Policies on and off the Exchange
- Employer-Sponsored Group Health Coverage (as long as not paid with pre-tax payroll deductions)



# Claim Submission Options

## ONLINE



Submit claim securely online through the MidAmerica Journey Participant Portal

## APP



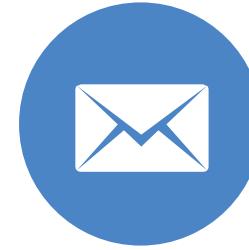
Submit claim securely through the Journey mobile app

## CARD



Pay for claims at the point-of-sale with the Journey Benefits Card

## MAIL



Mail claim form to:  
PO Box 24927  
Lakeland, FL  
33802



# Accessing Your **Online Account**

Logging into **MidAmerica Journey** for the first time



Go to [www.myMidAmericaJourney.com](http://www.myMidAmericaJourney.com).

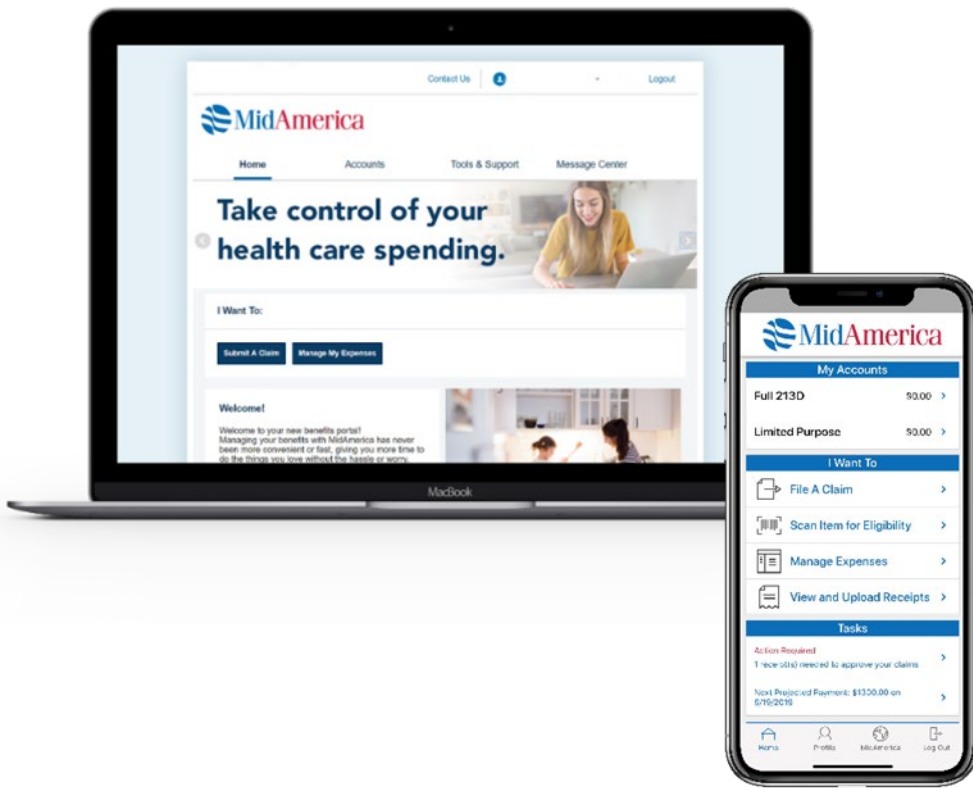


Select **Create Your New Username and Password**.



Enter your identifying details, establish your security questions and choose a username and password.

# MidAmerica Journey Portal Resources




- 24/7 Account Access
- Online Claims Submission
- Debit Card Management
- Journey mobile app
- Manage personal information and communication options (Manage direct deposit, sign up for text and email communications)
- \$1.00/mo. Platform Fee

# Debit Card: Documentation



- Eliminates need for claim forms and out-of-pocket payments at the point-of-sale
- Can be used anywhere from a doctor's office to a local pharmacy for eligible medical expenses
- **Supporting documentation may still be required** to substantiate debit card purchases/adjudicate a claim
- Balances and transactions accessible via MidAmerica Journey or via the Journey mobile app

# Submitting Paper Claims



## HRA/FSA Consolidated Claim Form

Return this completed form to:  
 Mail: MidAmerica Administrative & Retirement Solutions  
 Attn: PO Box 24927, Lakeland, FL 33802  
 Fax: (863) 577-4460 | Phone: (855) 329-0095

**STEP 1 Participant Information**

Employer:  Date of Birth (mm/dd/yyyy):

First Name:  Last Name:  M.I.:  Social Security Number:

Mailing Address:  City:  State:  Zip:  Telephone:

Email Address:  Check if permanent address change:  Actively employed with employer?  If no, separation date?

**STEP 2 Claim Information**

NOTE: Choose one or both options.

**Option 1 One-Time Expenses** NOTE: Choose one.  HRA Only  FSA Only  FSA then HRA\*

Approved claims are processed within 7–10 business days. Be sure to attach acceptable documentation as outlined in the [instructions](#). Failure to provide the requested information or acceptable documentation may delay your request. Applicable distribution fees will be deducted from the total eligible claim amount (per IRS guidelines). For PSERS Retirees: If you are receiving PSERS monthly premium assistance, you must reduce your medical premium reimbursement request by this amount.

Date of Expense	Name of Service Provider	Name of Covered Participant, Spouse, or Eligible Dependent	Service Provided	Payable to: (Set, Provider)	Amount to Reimburse
*FSA funds used until exhausted, followed by HRA funds.					Total One-Time Claim Expenses:

- Claim Form
- Include receipts or other documentation
- Mail or fax
- 10 business days for reimbursement
- \$5 fee for each reimbursement request not submitted through the Journey portal or Journey mobile app

# Documentation: Good vs. Bad

FORWARD SERVICE REQUESTED

For Billing Inquiries Call:

Sample Medical Care Provider  
(800) 000-0000

Sample Participant  
1234 ABC Street  
Somewhere, State 12345

Messages:

- PAYMENT DUE DATE: 30 DAYS FROM THE STATEMENT DATE
- You may now access your account online

Statement Detail Statement Date: 2017-12-17 Account No. 1234

Claim No.	Visit Date	Activity Date	Description of Service	Charges	Payments	Balance
12345	2017-01-01	2017-01-01	8297 Sample Testing	150.00		
12345	2017-01-01	2017-01-01	8237 Sample Testing	75.00		
12345	2017-01-01	2017-01-01	2347 Sample Testing	207.00		
12345	2017-01-01	2017-01-01	Patient Payment		45.00	
12345	2017-01-01	2017-01-01	Sample Insurance Payment		150.00	
12345	2017-01-01	2017-01-01	Sample Insurance Adjustment		125.00	
12345	2017-01-01	2017-01-01	Your Balance Due on These Services			112.00

Payment Due
112.00

## Good!

- ✓ Itemized statement (left), Explanation of Benefits (EOB), Co-Pay receipts, or invoices if no insurance
- ✓ Contains date of service, type of service, service amount and participant name\*

\*identifying details have been removed from example.

# Documentation: Good vs. Bad

Sample Doctor's Office  
1234 ABC Street  
Somewhere, State 12345

01/01/01 08:20:35  
Merchant ID: \*\*\*\*\*0000  
Device ID: 0000  
Terminal ID: ABCD

CREDIT SALE:

Transaction #: 8  
Card Type: VISA  
Account: 0000  
Entry: Swiped

AMOUNT: \$50.00

Auth Code: 0000  
Response: AUTH

CUSTOMER COPY

\*\*\*\*\*

## Bad.

- x Only includes total amount paid
- x Doesn't include breakdown of services

\*identifying details have been removed from example.

# Documentation: Premiums



Premium Notice from your insurance company that includes:

- Type of Premium
- Premium Amount
- Effective Date of Coverage
- Name of insured – you, your spouse, or another qualifying dependent
- Name of provider/employer



MidAmerica will reimburse premiums one month in advance, but **no more than one month in advance**

- Exception: Long-Term Care premiums must be paid before reimbursement and proof of payment must be included with supporting documentation.



Recurring premium reimbursement policies remain in effect for the earlier of 12 months or when your premiums change\*

*\*New claim form or online submission with required documentation must be submitted to renew recurring claim after 12 months*

# Recurring Premium Claims

- **Step One** – decide how to pay your insurance premiums directly to providers/employer in retirement
  - Automatic payments from your personal checking or savings account?
- **Step Two** – set up Recurring Premium Claim with MidAmerica
  - Set up Recurring Premium Claim online at [www.myMidAmericaJourney.com](http://www.myMidAmericaJourney.com), through the MidAmerica Journey mobile app, or complete a paper claim form. Supporting documentation is required when using any method and **supporting documentation is critical!**
  - Once you set up your recurring premium claim, MidAmerica will send you a monthly payment each month for up to the next 12 months
  - Monthly payments will be sent to you one month in advance
  - MidAmerica can send funds to you via direct deposit to the same checking/savings account you use to pay your insurance premiums as outlined in Step One
- **Step Three** – **After 12-months, payments will cease until you submit a new Recurring Premium Claim and supporting documentation!**



# Documentation Example: Premium Notice

Your TPA  
2913 Administration Lane  
Your Town, MN 98765

5/31/2020

Ms. Sally Test  
4321 Front Street  
Happy Valley, USA

Dear Ms. Sally Test,

We are confirming your monthly premium due for the ABC Area Schools retiree coverage(s) as of 7/1/2020.

Your monthly premiums and coverages are as noted below:

Plan Name	Coverage Level	Premium Amount
Medical High Plan	EE Only	\$804.51
Dental	EE Only	\$29.40
<b>Total Premium Amount</b>		<b>\$833.91</b>

Here is a monthly listing of the next 12 monthly premium amounts due for your retiree coverage(s).

Premium Due Date	Total Amount Owed
7/1/2020	\$833.91
8/1/2020	\$833.91
9/1/2020	\$833.91
10/1/2020	\$833.91
11/1/2020	\$833.91
12/1/2020	\$833.91
1/1/2021	\$833.91
2/1/2021	\$833.91
3/1/2021	\$833.91
4/1/2021	\$833.91
5/1/2021	\$833.91
6/1/2021	\$833.91

- Provided by Retiree Billing/COBRA TPA
- Contains:
  - Coverage period
  - Name of covered individual
  - Premium amount
  - Coverage type
  - Name of insurance provider

\*Identifying details have been removed from example.

# Documentation Example: Premium Invoice

ABC Benefits Administration 7805 Benefits Blvd. Your Town, MN 98765		<b>Invoice</b>	
		Invoice Date	Invoice
		09/10/2020	1002500
		Terms and Conditions	
		Please review this invoice carefully and notify us of any discrepancies. As a reminder, please pay your invoice as billed. Any changes will be reflected on your next invoice.	
Bill To: <span style="border: 1px solid black; padding: 5px;">Doe, John 1234 Main Avenue Happy Valley, USA</span>		Please note, premium credits will only be allowed 90 days back from the date of this invoice. Thank you.	
		Due Date	Invoice Amount
		09/25/2020	\$1,637.24
Make Check Payable To:	Send Payments To:	Biller Contact:	
ABC Benefits - Or pay online at <a href="http://www.abc.biz">www.abc.biz</a>	ABC Benefits Administration 7805 Benefits Blvd. Your Town MN 98765	Jane Doe 800-555-XXXX	
<b>Charge Summary</b>			
Date	Product	Coverage	Amount
10/01/2020	Med Adv Value BCBS	Emp. + Spouse	\$1,637.24
Total			\$1,637.24

- Provided by insurance provider
- Contains:
  - Coverage period
  - Name of covered individual
  - Premium amount
  - Coverage type
  - Name of insurance provider

\*Identifying details have been removed from example.

# Questions?

## Participant Service Hours

Monday through Thursday,  
8:30 a.m. – 8 p.m. ET  
Friday, 8:30 a.m. – 6 p.m. ET

## Send All Forms To:

MidAmerica Administrative &  
Retirement Solutions  
Attn: HRA Dept.  
PO Box 24927  
Lakeland, FL 33802

Fax: 863.577.4460



Online Inquiry through [myMidAmerica.com](https://myMidAmerica.com)



[healthaccountservices@myMidAmerica.com](mailto:healthaccountservices@myMidAmerica.com)



Call (855) 329-0095

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# Thank you!