







MERS Health Care Savings Program

Wayne County Retirees



2024 Stipend Amounts

\$145.72

 Retirees whose health insurance benefits were established and modified by the 1990 Wayne County Health and Welfare Plan

\$140.72

All other retirees



Payment & Reimbursement Options



Online/Mobile



Reoccurring reimbursement form



Debit Card

Direct Payment to Provider



Most Common Expenses

- Insurance Premiums
 - Medicare Part B
 - Medicare Advantage
 - Medigap
 - Dental
 - Vision
 - Long-term Care
- Medical Expenses
 - Prescriptions
 - Co-pays
 - Office visits
 - Medical equipment



Keeping It Simple

Reimbursement of your Medicare B payment is the simplest way to utilize your stipend.

DOCUMENTATION REQUIRED:

For Medicare Part B: Annual Social Security Statement.

Can't locate this? Visit ssa.gov for instructions or call them at: 800.772.1213.

The full list of expenses can be found in IRS Publication 502 by visiting: https://www.irs.gov/publications/p502



2024 Medicare Premiums

https://www.cms.gov/newsroom/fact-sheets/2024-medicare-parts-b-premiums-and-deductibles

Full Part B Coverage					
Beneficiaries who file individual tax returns with modified adjusted gross income:	Beneficiaries who file joint tax returns with modified adjusted gross income:	Income-Related Monthly Adjustment Amount	Total Monthly Premium Amount		
Less than or equal to \$103,000	Less than or equal to \$206,000	\$0.00	\$174.70		
Greater than \$103,000 and less than or equal to \$129,000	Greater than \$206,000 and less than or equal to \$258,000	\$69.90	\$244.60		



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All other retirees



Reimbursement Form



Alerus Retirement and Benefits PO Box 64535 • St. Paul, MN 55164-0535

Wayne County Health Care Savings Program Reimbursement Claim

Please print clearly • See attached guide for details • Retain a copy for your records

This form is used to request reimbursement using a paper form. For the most secure and quickest method of reimbursement, consider managing your request electronically. If you need assistance in setting up a myMERS account, contact MERS at 800 767 6377

- This form can be used for a one-time reimbursement or to set up a recurring payment.
- · For participants who receive a monthly stipend that is less than the recurring amount, be sure to note if you we is equal to your stipend, or for the full amount of the premium. Otherwise, if the premium claim exceeds your the time of processing, you will receive partial reimbursement the following month.

For example;

John Smith receives a stipend amount of \$145 and his insurance premium is \$170.10. Since his premium is m stipend amount he receives monthly, the remaining \$24.90 will be reimbursed the following month out of the st deposited the next month. If John wants to only receive his full stipend amount (i.e. \$145), John should write in amount, not the premium amount.

Submit Your Reimbursement Electronically

- 1. Upload your Reimbursement Claim Form to the Claims Management Portal in your myMERS a
- 2. Download the Alerus Health Benefits app and attach your receipt using your mobile device's ca

1. Information about you Last name Mailing address* Be sure to keep your address information up to date by logging into your myMERS account; processing delays will occur if the information

Wayne County - Municipality #8261; Plan # 301675

2. Reimbursement/payment election

One-Time Reimbursement

Use this section to indicate any one-time reimbursement details by listing each in a separate line item in the ta the third-party receipt showing payment and the associated bill or statement detailing the expense incurred ar must be provided to complete processing. Expenses may not be those covered by insurance.

Date(s) Provided	Expense (Co-pays, Rx, Dentist, etc.)	Provided to (Name, relationship)

Same form for One Time Payment OR Recurring Reimbursements

Wayne County Health Care Savings Program Reimbursement Claim				
Last name* (please print clearly)	Social Security Number*			
Recurring Expense				
To schedule reimbursement for a recurring expense that is paid monthly (suci grid below. Each month should be itemized on its own line below. If the amou following month's deposit will be used to make up for any difference. To redu the the amount of your stipend.	unt entered below exceeds the acc	ount balance, the		
Coverage Type Provided to (Madical, Dental, Medicare, etc.) (Name, relationship)	Month of coverage (12 months max)	Monthly Amount		
		\$		
A different reimbursement form should be completed for each type		\$		
of premium. For example, if you have monthly premiums for dental		\$		
and medical, complete separate forms for each.		\$		
Recurring expenses may only run for 12 months, after that time a		\$		
new form will be required.		\$		
DOCUMENTATION REQUIRED:		\$		
For Medicare Part B; Annual Social Security Statement.		\$		
Can't locate this? Visit ssa.gov for instructions or call them at:		\$		
800.772.1213.		\$		
		\$		
		\$		
3. Payment direct to provider				
Skip this section if reimbursement is being directed to you. Please complete all recresult in delays in processing this form.	quired information - incomplete sub	omissions may		
Provider name*	Provider account number*			
Provider address line 1* Provider address	is line 2			
Provider city*	Provider state*	Provider zip*		
4. Claimant's certification and signature				
I certify that all expenses for which reimbursement of payment is claimed by s by my dependent(s).	submission of this form were incurre	ed either by me or		
 I certify that the medical expenses incurred by me or by my dependent(s) are Revenue Code, Section 213(d). I understand that if these medical expenses a 				



Recurring Expense Reimbursement Page 2 ~ Medicare Example

Wayne County Health Care Savings Program Reimbursement Claim

Last name* (please print clearly)

Social Security Number*

Devember

SMITH

123-45-6789

Recurring Expense

To schedule reimbursement for a recurring expense that is paid monthly (such as insurance premiums or Medicare Part B), use the grid below. Each month should be itemized on its own line below. If the amount entered below exceeds the account balance, the following month's deposit will be used to make up for any difference. To reduce confusion, enter the amount below that is equal to the the amount of your stipend.

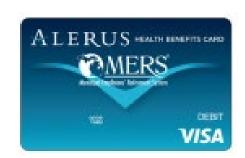
the the amount of your superio.						
Coverage Type (Medical, Dental, Medicare, etc.)	Provided to (Name, relationship)	Month of coverage (12 months max)	Monthly Amount			
MEDICARE	NAME, Self OR Spouse	January	\$140.00			
A different reimbursement form should be completed for each type of premium. For example, if you have monthly premiums for dental and medical, complete separate forms for each.		February	\$140.00			
		March	\$140.00			
		April	\$140.00			
Recurring expenses may only run for 12 months, after that time a new form will be required.		May	\$140.00			
		June	\$140.00			
DOCUMENTATION REQUIRED:		July	\$140.00			
		August	\$140.00			
	Annual Social Security Statement.	September	\$140.00			
Can't locate this? Visit s 800.772.1213.	ssa.gov for instructions or call them at:	October	\$140.00			
		November	\$140.00			



\$ 140.00

Health Benefits Debit Card

- Two cards per account
- Great for point-of-service expenses such as prescriptions and co-pays

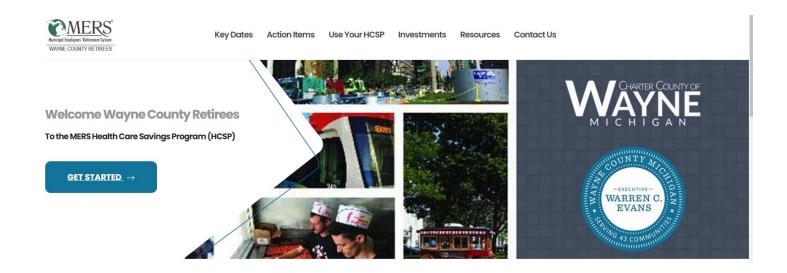


- Best for those who:
 - Are not getting insurance premium reimbursements
 - Have coverage through a spouse
 - Have unused funds in their account
- Do not use your debit card if:
 - You do not have excess funds in your account
 - You get reimbursed each month for your insurance or Medicare Part B premium



Resources

www.mersofmich.com/WayneCounty is a website for Wayne County retirees only to get necessary resources for using your MERS HCSP account





Customer Service Contacts

 Contact MERS for assistance with myMERS access and making changes such as contact information, beneficiaries, or investment changes weekdays from 8:30 a.m. – 5:00 p.m. EST at 800-767-MERS (6377)

 Contact Alerus to set up direct deposit, pay-to-provider, or have claims questions at 866-808-7823 option 3

