Mission Regional Medical Center

Catilize Health

Introducing a Medical Expense Reimbursement Plan ("MERP") as part of your benefits package.

The MERP offers **up to 100% coverage** to eligible employees who have access to alternate group medical and prescription drug coverage. You will be reimbursed for ALL eligible co-pays, co-insurance and deductibles incurred through your alternate group medical plan up to $8,150/single and $16,300/family per year.

No premium contribution will be deducted from your paycheck.

Eligibility

- **Current employees as of December 31, 2021:** must be enrolled in their Prime Healthcare Medical Plan
- **Employees enrolled in the MERP in 2021:** You do not need to complete another Enrollment form or re-enroll online; however, *you **MUST** complete a new Attestation Form* and return it to your HR Department.
- **New employees:** Full-Time and Part-Time employees must satisfy eligibility requirements
- **Qualifying event or newly eligible:** marriage, birth of child, part time to full time, etc.

Opportunities for Enrollment

- Your annual open enrollment window
- Qualifying event: marriage, spouse's change in employment status, birth of child, Per Diem to Part-Time/Full-Time, etc.
- Spouse's annual open enrollment window
- New employee

IRS Rules

- You may be enrolled in an HRA or FSA. You **CANNOT** be reimbursed from both the MERP and your HRA or FSA.
- Employees are NOT eligible for the MERP if their Alternate Coverage is:
  - High Deductible Health Plan (HDHP) **with** active contributions to a Health Savings Account (HSA),
  - Medicare, Tricare or Medicaid
  - Healthcare Exchange Policy made available thru the Affordable Care Act
  - Individual policy
  - Limited Benefit Health Plan

Catilize Health

2605 NICHOLSON ROAD
SUITE 1140
SEWICKLEY PA 15143

PHONE: 877-872-4232
MERP@CATILIZEHEALTH.COM

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Enrollment

- Enroll in alternate group medical plan (usually your spouse's) and waive coverage on a Prime Healthcare medical plan.
- Enroll in the MERP on your online enrollment site.
- Complete Attestation Form and return it to your HR Department.

Claims

- MERP ID Card:
  - Present Alternate Coverage ID card
  - Present MERP ID card
  - Provider may bill Catilize Health directly
- Paper Claims:
  - Present Alternate Coverage ID card
  - Complete MERP claim form and sign
  - Send completed and signed claim form to Catilize Health with the following:
    - Office visit co-pay, co-insurance or deductible: Explanation of Benefits (EOB) from Alternate Coverage
    - Prescriptions: "Tab" from pharmacy that includes name of drug, date filled, patient's name and patient responsibility amount

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ATTESTATION FORM

Employee Name:_____ Work Phone:_____

☐ New MERP election. I am also submitting a MERP Enrollment Form to HR with this Attestation Form.
☐ 2022 MERP re-election. I am electing to continue MERP for the 2022 plan year. No additional forms are required.

Facility/Hospital:_____ E-mail Address:_____

This form applies to individuals who participate in the MERP and who waive coverage in the Prime Healthcare group medical plan.

By signing below, I certify that:

Prime Healthcare has offered me and my eligible dependents a group medical plan that does not consist solely of "excepted benefits" under the Affordable Care Act of 2010 ("ACA").

I, and/or my dependents are enrolled in a group health plan of another employer (such as my spouse's employer) (my Alternate Group Health Plan) that does not consist solely of "excepted benefits" under ACA (such as limited-scope dental or vision coverage), nor does it consist solely of a "health reimbursement arrangement" (reimbursement of health care expenses up to a dollar limit). For confirmation that the other plan meets the IRS's definition of minimum value and does not consist solely of an HRA, please contact the benefits coordinator at the other employer.

-- I understand that by enrolling in this MERP, I am waiving participation for the MERP participants in the Prime Healthcare group medical plan for my covered MERP enrollees as follows:

_____ _____
Name Name

_____ _____
Name Name

Attach a separate sheet if space is needed for additional participants

I further certify that my alternate coverage is not a:

- High Deductible Health Plan (HDHP) with active contributions to a Health Savings Account (HSA)
- Medicaid, Medicare or Tricare
- Healthcare Exchange Policy made available thru the Affordable Care Act
- Individual policy
- Limited Benefit Health Plan

I understand that my spouse is not eligible for the MERP if (s)he is offered medical coverage through his/her employer. If I am including my spouse in the enrollment choice above, I further attest that the alternate coverage is provided through a secondary employer of my own.

_____ _____
Employee Signature Date

_____ _____
Spouse's Signature Date

For more information, please contact Catilize Health at 877-872-4232

PLEASE COMPLETE THIS FORM AND SUBMIT TO HUMAN RESOURCES

TO BE COMPLETED BY HUMAN RESOURCES	
☐ MERP Eligibility is confirmed.	☐ BenAdmin System has been updated.
☐ If applicable, dependents have been verified.	☐ Form(s) submitted to Catilize Health on __/__/__
Signature of HR Administrative Contact X	Date (mm/dd/yyyy)

Catilize Health

MERP Enrollment Form

Mission Regional Medical Center

EMPLOYER INFORMATION

Employer Name: Mission Regional Medical Center

Please mail, e-mail or fax completed form to:

Catilize Health
2605 Nicholson Road, Suite 1140
Sewickley, PA 15143

Email: merp@catilizehealth.com
Telephone: 877-872-4232
Toll Free Fax: 877-599-3724

I am enrolling in the MERP for (Please check one): ☐Self Only ☐Self & Child(ren) ☐Child(ren) Only ☐Spouse Only ☐Self & Spouse ☐Self & Family ☐Spouse & Child(ren)

I understand that my spouse is not eligible for the MERP if (s)he is offered medical coverage through his/her employer. If I am including my spouse in the enrollment choice above, I further attest that the alternate coverage is provided through a secondary employer of my own.

PARTICIPANT INFORMATION

Employee Name:	Birthdate:	Hire Date:
Social Security No:	Gender: ☐M ☐F	MERP Effective Date:
Home Street Address:		
City:	State:	Zip Code:
Home Phone:	Work Phone:	Cell Phone:
Email Address:		

SPOUSE INFORMATION

Spouse Name:	Birthdate:	Gender: ☐M ☐F
Social Security No:	Spouse's Employer:	

*** If your spouse's plan has a High Deductible with a Health Savings Account (HSA), you are not eligible to participate in the MERP, unless the Employer allows your spouse to drop the HSA portion of the plan. Written documentation is required. Also, if your alternate medical coverage is through Medicare, Tricare or Medicaid, Healthcare Exchange, Limited Benefit Health Plan or an Individual Policy you are not eligible for the MERP.**

DEPENDENT INFORMATION: (Attach a separate sheet if additional space is needed for additional dependents)

Name:	Date of Birth:	Gender: ☐Male ☐Female
Social Security No:		
Name:	Date of Birth:	Gender: ☐Male ☐Female
Social Security No:		
Name:	Date of Birth:	Gender: ☐Male ☐Female
Social Security No:		

PARTICIPANT AUTHORIZATION

I hereby authorize my employer to enroll me into the employer sponsored MERP. I agree to comply with the terms and conditions of the plan. You may be prosecuted for fraud for knowingly using health insurance benefits for which you are not eligible. It is YOUR responsibility to know when you or a family member is no longer eligible for MERP benefits. The deductible, co-pay and co-insurance reimbursements will remain tax free. **I further understand that if any current contributions are made to a Health Savings Account (HSA) by my spouse or his/her Employer, I am *not eligible* to participate in the MERP offered through my employer.**

Employee Signature: **Date:**

MERP Claim Form

Mission Regional Medical Center

EMPLOYER INFORMATION

Employer Name: Mission Regional Medical Center

SEND THIS FORM, COPIES OF RECEIPTS, EXPLANATION OF BENEFITS & ANY OTHER CLAIM DOCUMENTATION TO:

Catilize Health
2605 Nicholson Road, Suite 1140
Sewickley, PA 15143

Email: merp@catilizehealth.com
Telephone: 877-872-4232
Toll Free Fax: 877-599-3724

PARTICIPANT INFORMATION

Employee Name:	Last 4 of Social Security No:	Date of Birth:

PRESCRIPTION REIMBURSEMENT INFORMATION:

Date:	Name of Drug:	Co-Pay Amount:
Date:	Name of Drug:	Co-Pay Amount:
Date:	Name of Drug:	Co-Pay Amount:
Date:	Name of Drug:	Co-Pay Amount:
Date:	Name of Drug:	Co-Pay Amount:
Date:	Name of Drug:	Co-Pay Amount:
Date:	Name of Drug:	Co-Pay Amount:
Date:	Name of Drug:	Co-Pay Amount:

PHYSICIAN OFFICE VISITS:

Date of Visit:	Co-Pay Amount:
Date of Visit:	Co-Pay Amount:
Date of Visit:	Co-Pay Amount:
Date of Visit:	Co-Pay Amount:

EXPLANATION OF BENEFITS: EOBs

Date of Service:	Amount Owed:
Date of Service:	Amount Owed:
Date of Service:	Amount Owed:
Date of Service:	Amount Owed:

Documentation submitted must include: Patient name, date of service, type of service or service code, drug name or Rx number if prescription.

Please Note: *All medical claims must be submitted first through your alternate coverage. You are required to include the following documentation: for co-pay, co-insurance or deductible, you will need to submit the Explanation of Benefits (EOB) from your alternate group health plan, and for prescriptions, submit the "tab" that includes the name of the drug, date filled, patient's name and co-pay amount. Do not submit a cash register or credit card receipt; these alone are not acceptable as per the IRS regulations.*

EMPLOYEE STATEMENT:

I hereby certify that the information contained on this Reimbursement Claim Form is to the best of my knowledge and belief true and correct and each item is eligible for reimbursement. I understand that any expenses reimbursed are NOT tax deductible on my individual or joint federal tax return. You may be prosecuted for fraud for knowingly using health insurance benefits for which you are not eligible. It is YOUR responsibility to know when you or a family member is no longer eligible for MERP benefits.

I certify that the amounts above have not been reimbursed under any other health care plan or program, federal, state, or government program, worker's compensation, or any other policy of health insurance, and that I will not seek reimbursement under any of the aforementioned plans, including an HSA, HRA or FSA account.

Employee Signature: _____ **Date:** _____

All 2022 claims must be received no later than 90 days after plan year ends or 90 days after termination.