Bond County CUSD #2

Section 105 Employer Provided Deductible Reimbursement Plan

Reimbursement Request

Employee's Name:	**Social Security No:**
Mailing Address:_____	_____ (Is this a new address? Yes ☐ No ☐)

Instructions:

- Complete the necessary information below for qualifying expenses incurred by you or your eligible dependents for which you request reimbursement.
- Expenses covered by your medical care plan must be submitted under that Plan first, even if it will be applied to the deductible or otherwise unpaid by the medical care plan, and **the resulting EOB must be submitted with your reimbursement request.**
- Claims incurred during a Plan Year may be filed up to 90 days after the end of the Plan Year or within 90 days after your termination in this plan.

UHC Platinum - $400 deductible

- **The employees and dependents will be responsible for the first $400 in deductible expenses. The District will reimburse the next $600 of deductible if incurred.**
- **After the deductible, the plan pays 85% coinsurance in-network and the member is responsible for 15% of charges. The District will NOT reimburse any coinsurance.**

UHC Gold - $600 deductible

- **The employees and dependents will be responsible for the first $600 in deductible expenses. The District will reimburse the next $400 of deductible if incurred.**
- **After the deductible, the plan pays 85% coinsurance in-network and the member is responsible for 15% of charges. The District will NOT reimburse any coinsurance.**

EXPENSE DETAIL: (or you may attach a spreadsheet)

Date expense incurred	Type of expense	Name and Relationship of Person Incurring Expense	Name of Provider	Amount Requested
	Deductible			
	Deductible			
	Deductible			
	Deductible			
			Total Requested	

I certify that the requested amounts are not reimbursable by any form of insurance or other benefit plan, and that I have not, nor will not, deduct these expenses on my personal income tax return. I further certify that I have read and understand the limitations on reimbursements as explained in the Summary Plan Description, and I have determined that the submitted expenses are eligible for reimbursement. I hereby agree to indemnify my Employer for any taxes, interest, or penalties imposed due to the failure of my requested expense reimbursements to qualify as eligible expenses under the Deductible Reimbursement Plan.

Signature _____ Date _____

Mail or Fax to:

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