

MEDICAL REIMBURSEMENT REQUESTS:

For CPEA Members, Administrators & Executive Assistants with insurance benefits as of 6/30/03 continuing on 7/1/03 (effective date of new plan), You may submit eligible EOB (explanation of benefits) forms until September 30, 2006 for reimbursement of 2006 out of pocket expenses.

**NOTE for the above groups only:
2006 reimbursements will only be made for expenses incurred prior to July 1, 2006.**

For OAPSE members with insurance on 9/30/04 continuing coverage on 10/1/04, You may submit eligible EOB (explanation of benefit) forms until March 31, 2007 for reimbursement of 2006 out of pocket expenses.

How is the reimbursement calculated?

Each "patient's responsibility" amount is totaled from the EOB's for each patient.

The old CCS plan out of pocket maximums are deducted from the total paid out of pocket. The difference is the amount that is eligible for reimbursement up to the limits specified. Out of pocket expenses can be incurred either through medical expenses or prescriptions.

	Canton City Schools "Old Plan"	Stark County Schools "New plan"	Difference in Out of Pocket Maximum equals reimbursement maximum:
Prescriptions Single	50		
Medical Maximum out of pocket	<u>250</u>		
Single Out of Pocket Maximum	300	600	300
Prescriptions Family	100		
Medical Maximum out of pocket	<u>500</u>		
Family Out of Pocket Maximum	600	1200	600

Please Note: Reimbursements are calculated for out of pocket expenses that occur above and beyond the old CCS plan maximum limits. Therefore, please retain your EOB forms and do not submit for reimbursement until you have met the total out of pocket amount. We will not process partial payments.

For Family reimbursements, there must be at least ONE other family member with claims in addition to the first patient's \$300. Maximum reimbursement per individual is \$300 up to a family maximum of \$600

Reimbursements can be made up of prescriptions that exceed the old plan; Physician's office visits up to \$100 per person; and Medical Claims that exceed the old plan. Any combination of these will be allowable for reimbursement.

YOU MUST SUBMIT EXPLANATION OF BENEFITS FORMS FROM THE INSURANCE CARRIER. THESE ARE THE FORMS THAT ARE SENT IN THE MAIL. PLEASE RETAIN A COPY AS WE WILL NOT RETURN THE FORMS TO YOU.

MEDICAL REIMBURSEMENT REQUEST FORM

EMPLOYEE NAME: _____

SOCIAL SECURITY # _____

DATE SUBMITTED: _____

INSURANCE COVERAGE (CHECK ONE):

AULTCARE _____ SUPERMED PLUS _____

EMPLOYEE SIGNATURE: _____

By signing, I attest that I have made a copy of this form for my reference. The enclosed EOB statements are for consideration of the \$300 / \$600 reimbursement. I am releasing this confidential medical information, protected under HIPAA regulations, to the Human Resources Department.

DEPENDENTS (SPOUSE & CHILDREN) INCLUDED IN EOB'S:

NAME: _____ SS# _____

NAME; _____ SS# _____

NAME: _____ SS# _____

(Attach additional sheet if necessary)

ATTACH EXPLANATION OF BENEFITS (EOB) FORMS.

We cannot accept prescription receipts, invoices or bills from doctors or hospitals.

You must have the EOB for each claim that you are submitting.

A MAXIMUM OF \$300 FOR SINGLE PLANS AND \$600 FOR FAMILY PLANS WILL BE REIMBURSED.

FAMILY REIMBURSEMENT MUST REPRESENT TWO OR MORE INDIVIDUALS.

SEE REVERSE SIDE FOR A MORE DETAILED EXPLANATION.

SUBMIT REQUESTS TO: HUMAN RESOURCES DEPARTMENT, ROOM 110

PAYMENTS WILL BE PROCESSED APPROXIMATELY ONE MONTH FROM DATE SUBMITTED.

NO PARTIAL PAYMENTS WILL BE PROCESSED.