2026

AssuredPartners

O'Fallon CCSD#90

Section 105 Employer Provided Deductible Reimbursement Plan

Reimbursement Request

Employee's Name:	**Last 4 Numbers of Social Security:**
Mailing Address:_____	**Telephone No. or Email Address:** _____

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 (March 31st) or within 90 days after your termination in this plan.
- You are responsible for the first **$500** of deductible expenses per covered individual. Your employer will provide reimbursement up to the next **$2,000** per covered individual. You are responsible for the remaining **$500** of deductible expenses per covered individual.
- You are responsible for the first **$800** of coinsurance expenses per covered individual. Your employer will provide reimbursement up to **$1,200** per covered individual.
- Your maximum out of pocket is **$1,800** per individual / **$3,600** per family.

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
			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 _____

Email, Fax or Mail to:

AssuredPartners, Admin Department
12645 Olive Blvd, Suite 300
St. Louis, MO 63141
Phone – 314.373.2930 / Fax – 314.373.2931
APCS-STLTPA@assuredpartners.com
Secure Consumer Portal: https://cigpart.lh1ondemand.com