Monticello Teachers' Association
Benefit Trust Fund
1970-2023

Benefit Trust Chairperson: **Rose Joyce-Turner** mtarjoyceturner@gmail.com

Member Benefits Facilitator: **Yesenia Kreeger** ykreeger@k12mcsd.net

Member Trustee/Secretary: **Cynthia Grant** cgrant@k12mcsd.net

Member Trustee/Treasurer: **Tyler Laufersweiler** mtatlauferweiler@gmail.com

Member Trustee: **Carolyn Strahan** cstrahan@k12mcsd.net

MONTICELLO TEACHERS' ASSOCIATION BENEFIT TRUST FUND

MEDICAL EXPENSE REIMBURSEMENT PLAN BENEFIT

Members of the Monticello Teachers Association Benefit Trust can receive up to $250 per unit member per plan year (July 1- June 30). The $250 benefit includes services provided to members, spouses, and eligible dependent children.

To receive this benefit, you must complete the Medical Expense Reimbursement claim form and attach the following:

1. Copies of itemized bills for the expenses that you are claiming.
2. Completed Claim form.

Covered Expenses Include:

1. Medical & Hospital Deductibles & Co-Payments.

2. Prescription Drug Deductibles or Co-Payments.

3. Charges for Health Care services covered by a member's existing coverage(s) that exceed the reimbursement received. This includes services covered under Monticello Teachers Association Benefit Trust Fund Plans.

4. *** NEW***Health and Fitness Memberships

Claim Submission & Status:

1. You may submit **one claim** totaling $250 of out-of-pocket expenses per benefit year. (July 1, 2023 - June 30, 2024)

2. If you do not have the $250 in out-of-pocket expenses then you can submit your eligible expenses at the end of the plan year. (June 30, 2023)

3. All claims submitted must be postmarked no later than June 30 of the plan year in which they are incurred. Example (Claims for charges incurred July 1, 2023, through June 30, 2024, must be postmarked by June 30, 2024.)

4. Claim forms can be downloaded at www.monticelloschools.net

5. Questions regarding claim status or coverage can be directed via email to ykreeger@k12mcsd.net.

IN ORDER TO QUALIFY FOR REIMBURSEMENT

THE OUT-OF-POCKET EXPENSE MUST MEET ALL OF THE FOLLOWING REQUIREMENTS

- ✓ It must be incurred on or after July 1, 2023.
- ✓ It must appear in the list of EXPENSES THAT CAN QUALIFY FOR REIMBURSEMENT.
- ✓ It must be documented by a detailed billing statement from the provider or from your bank statements including the name, address, telephone number. The nature of the medical services rendered and/or an explanation of benefits voucher from all other plans.
- ✓ Physical copies should be sent to Yesenia Kreeger @ KLR (Please do not send digital copies)

***PARTIAL LIST OF EXPENSES THAT CAN QUALIFY FOR REIMBURSEMENT

- MEDICAL, HOSPITAL DEDUCTIBLES AND CO-PAYMENTS
- PRESCRITION DRUG DEDUCTABLES
- AMBULANCE
- PSYCHIATRIC CARE
- HOSPITAL SERVICES
- PSYCHOANALYSIS
- PSYCHOLOGISTS
- THERAPY
- TRANSPLANTS
- NURSING SERVICES
- Fitness Memberships
- Health Membership
- HEARING AIDS
- ARTIFICIAL LIMB
- CHIROPRACTORS
- LABORATORY FEES
- MEDICAL SERVICES (not already covered by health plan)
- MEDICINES
- DENTAL TREATMENT (not already covered by our plan)
- WHEELCHAIR
- FITNESS CLASSES
- WHEELCHAIR

If you are not sure please just send an email to ykreeger@k12mcsd.net to verify the expenses qualifies.

MONTICELLO TEACHERS' ASSOCIATION BENEFIT TRUST FUND
MEDICAL EXPENSE REIMBURSEMENT CLAIM FORM

MEMBER INFORMATION

MEMBER NAME		DOB	DATE
ADDRESS	CITY	STATE	ZIPCODE
PHONE NUMBER		BUILDING CURRENTLY WORKING	

PATIENT(S) INFORMATION

PATIENT NAME	OUT OF POCKET CHARGES INCURRED
1.	
2.	
3.	
4.	
5.	
	TOTAL:

IMPORTANT NOTICE

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIAL FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERE TO, COMMITS A FRAUDULENT ACT, WHICH IS A CRIME PUNISHABLE BY FINE, IMPRISONMENT OR BOTH.

MEMBER SIGNATURE

I HEREBY CERTIFY THAT EXPENSES CLAIMED HAVE NOT BEEN REIMBURSED AND ARE NOT REIMBURSABLE UNDER ANY OTHER HEALTH PLAN COVERAGE. I HEREBY AUTHORIZE ANY INSURANCE COMPANY, PREPAYMENT ORGANIZATION, EMPLOYER, HOSPITAL, OR PROVIDER, TO RELEASE ALL INFORMATION WITH RESPECT TO MYSELF OR ANY OF MY DEPENDENTS WHICH MAY HAVE A BEARING ON THE BENEFITS PAYABLE UNDER THIS OR ANY OTHER PLAN PROVIDING BENEFITS OR SERVICES. I HEREBY CERTIFY THAT THE INFORMATION I HAVE PROVIDED IN SUPPORT OF THIS CLAIM IS COMPLETE, TRUE AND CORRECT AND THAT ALL CHARGES CLAIMED WAS THE AMOUNT BILLED. **REIMBURSEMENTS ARE PAYABLE TO MEMBERS ONLY**

_____ _____

SIGNATURE OF UNIT MEMBER DATE

(Please do not send digital copies)

Interoffice Physical Copies to: Yesenia Kreeger @ KLR

or Mail To:

Yesenia Kreeger

44 Echo Road

Bloomingburg, NY 12721