

Spousal Parity Reimbursement Program

The District does not allow spouses/partners to be covered under the D155 medical insurance if he or she is eligible for coverage through their employer. In order to participate in the Spousal Parity Reimbursement Program you must have a D155 family medical plan in force along with the family medical plan deduction. Under your family plan only you and/or your children may only be covered.

**Dental and vision are not eligible for this reimbursement plan.*

If a spouse/partner is eligible for medical coverage at his/her place of work, you will need to submit a copy of their employer's **medical benefit summary, rate sheet showing the different plans they are offered and the most recent pay stub clearly showing the deduction of single medical coverage only. Along with the completed Affidavit.**

Once all paperwork is received you will be enrolled in this program and receive reimbursement for your spouse/partners medical deduction each month.

The plan may reimburse in-network deductibles, coinsurance and copays based on District #155's in-network benefits you are enrolled in. You will need to complete the reimbursement form and include the EOB for the claims that you are wanting to be reimbursed for along with any bills that you have received. Claims are reimbursed twice a month. You can email this information to the address listed on your claim form or you can set up an online account at www.groupadministrators.com our Third Party Administrator, Group Administrators.

Should there be a change in your spouse's/ partner's employment, insurance company, medical benefits and/or contributions, it is your responsibility to notify the District within 31 days. Failure to notify D155 of any changes may result in removal from the program.

If you have any questions, please contact Marnie Lalor, Benefits Coordinator at (815) 455-8500 ext. 1021.

AFFIDAVIT OF INSURANCE COVERAGE

For your spouse, civil union or domestic partner to be eligible for District's 155's Medical Reimbursement Program, you must complete this affidavit and return it to the HR office within **31 days of your effective date on the district medical plan**. With this affidavit you MUST include the following paperwork from your spouse/partner. **A copy of the benefit summary, the rate sheet showing the different plans they are offered and the most recent pay stub clearly showing the single cost of medical coverage only.** (Dental and vision are not reimbursed under this plan).

Should there be a change in your spouse's/partner's employment, insurance company, medical benefits and/or contributions, you must notify the district within 31 days. At that time you will need to complete a new affidavit of coverage for current members found on your benefit website.

Please complete the following in detail.

Employee Name _____ SSN# _____ DOB _____

Sp/Civil Union Partner Name _____ SSN# _____ DOB _____

Employee Home Address _____

Spouse/Civil Union Partner's Employer Name _____

Address _____ Phone Number _____

What D155 medical plan are you enrolled in ☐ HDHP ☐ PPO ☐ HMO

Spouse/Partner's name of Medical Insurance Company _____ Effective
date of Change _____

Spouse/Partner cost of single medical coverage (you must indicate # of payrolls below) \$ _____

☐ Weekly ☐ Bi –Weekly (26 payrolls) ☐ Twice a Month (24 payrolls) ☐ Monthly

What medical plan is your spouse/partner currently enrolled in or eligible for:

☐ HMO ☐ PPO ☐ HDHP/HSA

If your spouse/partner participates in a High Deductible Plan, does the spouse/partner's **employer** contribute to their Health Savings Account? If so how much annually do they contribute \$ _____

Please describe any other stipends and or reimbursement your spouse might receive related to their coverage _____



AFFIDAVIT IS DUE ASAP

YOU MUST COMPLETE THE FOLLOWING STEPS!

- ☐ Enroll in D155 family medical plan (not including your spouse/partner)
- ☐ Complete each step of the attached affidavit
- ☐ Provide a Summary of Health Benefits for your spouse/partners single medical coverage
- ☐ Provide an insurance rate sheet indicating the employer and employee contributions
- ☐ Provide a pay stub from your spouse/partner clearly indicating their single medical deduction
- ☐ Provide proof of any employer HSA contributions or any special reimbursements
- ☐ Sign and date below
- ☐ Initial the disclaimer

Failure to complete the steps above could cause a delay in your reimbursement. Employee

Signature _____ **Date** _____

Providing false information and/or failure to exclude a spouse, civil union or domestic partner from a D155 health insurance plan, who is eligible under his/her employer's health plan will be considered fraud and subject to retroactive termination of insurance coverage.

Please initial here that you have read and understand this disclaimer _____

Please return all of your documents to the HR Office - Attention Marnie Lalor

Cary Grove • Crystal Lake Central • Crystal Lake South • Prairie Ridge • Haber Oaks