SCC of SDA SECTION 105 CLAIM FORM - 2024 Plan Year Specialty Plan

| Reimburse via Check Reimburse via Direct Deposit (enter Banking Information below BANKING INFORMATION: Routing #: Account #: | Address: | | | | | |
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| BANKING INFORMATION: Routing #: | Email address: | | | Phone Number: | | |
| Reimbursement Types: 1. Marriage & family counseling: 80% up to \$3,600 annually for Out-of-Pocket costs not covered by A from Anthem showing the visits and their costs required for reimbursement. 2. Dental Implants: After the Dental Plan processes and pays the claim per the plan contract, SCC reim Reasonable and Customary In-Network, 50% Out of Network. Up to \$3,000 Annually. 3. NEWSTART health & wellness management program: \$2,500 or 50% of treatment cost, whichever approval for reimbursement must be obtained from HR before starting treatment The undersigned participant in the Plan requests reimbursement in the amounts shown below: REQUIRED: Participants must submit an Explanation of Benefits (EOB) from Anthem or Visit states proof of payment with this claim form to secure reimbursement from this account. EXPENSE DETAIL: Primary Service Covered Account holder Counseling, Implants, or Date(s) Member or dependent? Health/Wellness program? Compared the contraction of the sufficiency and the submit and the | Reimburse v | via Check | Reimburse via Dir | ect Deposit (enter Banking Info | ormation below) | |
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| Primary Service Covered Account holder Counseling, Implants, or Date(s) Member or dependent? Health/Wellness program? Co \$ TOTAL: \$ READ CAREFULLY The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by sub form, were incurred (i.e., services were provided) during a period while the undersigned was covered under the Cafeteria to such expenses and that such expenses have not been reimbursed, or are not reimbursable, under any other health plan cundersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all info to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is clexpense under the Plan, the undersigned may be liable for the payment of all related taxes including federal, state or city amounts | The undersigned | participant in the Plan | requests reimbursement | in the amounts shown below: | | |
| Date(s) Member or dependent? Health/Wellness program? Comparison of the comparison o | proof of paymer | nt with this claim for | m to secure reimbursen EXPENSE : Primary | nent from this account. DETAIL: | or visit statements with | |
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| credit is permitted for amounts for which reimbursement is made. | form, were incurred to such expenses and undersigned fully up to this claim which expense under the amounts paid from the Plan | d (i.e., services were pro- nd that such expenses had understands that he or sho is provided by the under Plan, the undersigned man which relate to such exp | tifies that all expenses for wivided) during a period while ve not been reimbursed, or e alone is fully responsible rigned, and that unless and ay be liable for the payment tense. The undersigned furth | which reimbursement or payment is the the undersigned was covered und are not reimbursable, under any of for the sufficiency, accuracy and we expense for which payment or reint of all related taxes including fede | der the Cafeteria Plan with respect ther health plan coverage. The veracity of all information relating and the property of th | |
| Date | | | | Date | | |

Peter C. Foy and Associates, attn: Flex Dept.
6200 Canoga Ave, Suite 325, Woodland Hills, CA 91367 or fax to (818) 703-0935
Email forms to flex@pcfoy.com

For questions contact the Reimbursement Dept. at (818) 703-8057