Freeport School District #145
Approved Medical Reimbursement Plan (AMRP)

Northern Illinois Health Plan (NIHP) is pleased that we have been chosen to continue to provide district reimbursement administration services for the Freeport School District #145 and look forward to providing you with quality and responsive customer service.

2024 District Reimbursement

Effective January 1, 2024 you will be able to submit copies of your Explanation of Benefits (EOB's) or expense receipts to NIHP for reimbursement. Any balance left from 2023 will be rolled in to your 2024 account. Rollover balances will be assessed a monthly administrative fee of $5.95/month (or $17.85/qtr).

To ensure a timely reimbursement we ask that you enclose a completed reimbursement form (attached) along with your expense receipts or EOB's from your insurance carrier. These requests can be submitted to NIHP by one of the following methods:

Email:	**Mail:**	**Fax:**
NIHPCustomerService@nihp.com Subject: FSD AMRP Deductible Reimbursement	Northern Illinois Health Plan P.O. Box 880 Freeport, IL 61032	(815) 599-7059 Attn: FSD AMRP Deductible Reimbursement

NEW: Consumer Portal

1. Visit www.nihp.com
2. In the middle of the page, on the bottom, under "WEX Health Card Flexible Spending Access", click "Access your account at WEX Health Card" (*although this is NOT a flexible spending account, you may still gain access by clicking on this link).*
3. On the right hand side, under "New User?" click "Create your username and password"
4. Once you've created your login information and are logged in, on the left hand side click on "Banking" and enter your account information for reimbursements to be sent to.
5. Going forward, you can submit claims right from your login!

NEW: Mobile App

On your iOS (iPhone, iPad) or Android-powered device, search for NIHP FSA (*although this is NOT a flexible spending account, you may still gain access by searching and downloading this app)*. You'll be able to check balances and account details or submit claims for reimbursement.

Direct Deposit Available

Direct Deposit is now available for your reimbursements! Please complete the attached form if you'd like to receive reimbursements directly to your account, instead of via paper check.

QUESTIONS

If at any time you have questions about your benefits, coverage, or claims, please do not hesitate to contact your Human Resources Department or the Northern Illinois Health Plan Customer Service Department at (815) 599-7050, toll-free at (800) 723-0202, or via email at NIHPCustomerService@nihp.com. NIHP's normal business hours are 8:00 a.m. to 4:30 p.m. Monday thru Friday. Messages may be left on our confidential voicemail after hours. Messages left after hours will be returned the next business day.

Freeport School District #145
Approved Medical Reimbursement Plan (AMRP)
2024

Eligible members will be reimbursed for applicable medical expenses that the IRS determines are eligible under the qualified medical expenses discussed in Section 213(d) of the Internal Revenue Service tax code. You have been enrolled in this program as per terms of the collective bargaining agreement.

In order to obtain reimbursement benefits, it is necessary for you to submit an entire copy of your Explanation of Benefits (EOBs) or eligible receipt to NIHP.

Reimbursements will be mailed by the end of the month on a monthly basis. All reimbursement checks will be made payable to the eligible employee, regardless of whether the medical expense is for the employee or an eligible dependent.

To be considered, all requests for reimbursement must be submitted by March 31, 2025. District reimbursement requests should be sent to:

Northern Illinois Health Plan
P.O. Box 880
Freeport, IL 61032
NIHPCustomerService@nihp.com
Phone: (815) 599-7050
Fax: (815) 599-7059

FREEPORT SCHOOL DISTRICT 145
APPROVED MEDICAL REIMBURSEMENT PLAN
CLAIM FORM & FILING INSTRUCTIONS

On the reverse side of this page is a claim form. Please feel free to copy this form. After you fax a request and receipts, please do not follow-up with a hard copy in the mail. *Keep a copy of all expenses claimed for your records. The validity of AMRP expenses is your responsibility in the event of an IRS audit*

Mail ! Fax ! Email requests for reimbursements to:
Mailing Address: PO Box 880, Freeport, IL 61032
Fax: (815) 599-7059
E-Mail: NIHPCustomerservice@nihp.com

When filing your claim, you must attach copies of the receipts. According to the Internal Revenue Code, the Approved Medical Reimbursement Plan may reimburse an expense if the participant provides:

- A written statement, receipt or bill from an independent third party stating the expense(s) has been incurred;
- The amount of such expense(s);
- A signed statement that the expense has not been reimbursed or is not reimbursable under any other health plan coverage or a Flexible Spending Account.

Procedures for submitting claims that will help to ensure prompt and efficient processing:

- Date of service,
- Description of services provided,
- Patient name,
- Provider name and address,
- Total amount of payment for which you are seeking reimbursement,
- An Explanation of Benefits (EOB) from an insurance company, if applicable, must also be submitted.
- Over the counter drugs (Only eligible with a physician's prescription) and items must have a receipt that contains the date purchased, name and cost of item. If the receipt does not provide a name, then a box top or box side should be submitted that contains the name and cost of item that corresponds to the receipt.

YOU MUST SIGN AND DATE THE CLAIM FORM WHEN SUBMITTING FOR REIMBURSEMENT.

CLAIM FORM – FSD 145 AMRP

EMPLOYEE NAME: **EMPLOYEE SSN:**

ADDRESS: **CITY:** **ST: ZIP:**

THIS IS A CHANGE OF ADDRESS / NEW ADDRESS: YES NO

MEDICAL/DENTAL/VISION EXPENSES - ATTACH BILLS, RECEIPTS, OR EOB TO CLAIM FORM

Item	Patient Name	Date (s) of Service	Provider (Person or Business)	Reimbursement Required
1				
2				
3				
4				
5				
6				
7				
8				

I hereby certify that:

- The information given on this reimbursement form is complete and accurate.
- I have not previously received reimbursement for these expenses from this Flex account or any other source.
- All heath expenses listed above comply with the requirements and guidelines listed in the Flexible Spending Reimbursement guidelines and meet the definition of a medical expense as defined in Code Section 213 and ruling and Treasury Regulations thereunder.

_____ _____

Employee Signature* Date*

**Note: Form must be signed and dated in order to process this claim.*

MINIMUM CHECK AMOUNT $25.00

****KEEP A COPY FOR YOUR FILES ****

Mail / Fax / Email requests for reimbursements to:
Mailing Address: PO Box 880, Freeport, IL 61032
Fax: (815) 599-7059
E-Mail: NIHPCustomerservice@nihp.com

DIRECT DEPOSIT FORM

NORTHERN ILLINOIS HEALTH PLAN

Freeport School District - AMRP

INSTRUCTIONS:

1. Print Clearly
2. Complete ALL information
3. Attach an entire VOIDED CHECK or ENCODED SAVINGS DEPOSIT TICKET
4. Sign and date application
5. Return by Email, mail or fax to: Northern Illinois Health Plan
   ATTN: Customer Service
   773 W. Lincoln Blvd., Suite 402
   Freepor t, IL 61032
   Fax: 815-599-7059
   Email: NIHPCustomerservice@nihp.com

NAME OF EMPLOYER **Freeport School District (AMRP)** _____

EMPLOYEE NAME _____ Social Security Number _____

☐ YES - I would like to receive notification of Direct Deposit electronically and my email address is:

PLEASE DEPOSIT MY REIMBURSEMENTS INTO THE BANK ACCOUNT INDICATED BELOW:

BANK NAME ROUTING # _____

Check only one account type:

CHECKING – attach a voided check below Checking account number_____

SAVINGS – Obtain an encoded deposit ticket from your bank and attach it below. A non-encoded savings deposit slip is not sufficient. Savings account number _____

I hereby authorize Northern Illinois Health Plan (hereinafter (NIHP) to deposit any amounts owed me by initialing credit entries to my account at the financial institution (hereinafter BANK) indicated above. Further, I authorize BANK to accept and to credit any credit entries indicated by NIHP to my account. In the event that NIHP deposits funds erroneously into my account, I authorize NIHP to debit my account for an amount not to exceed the original amount of the erroneous credit. This authorization is to remain in full force and affect until NIHP and BANK have received written notice from me of its termination in such time and in such manner as to afford NIHP and BANK a reasonable opportunity to act on it.

EMPLOYEE SIGNATURE DATE _____

If you have any questions concerning this form, please contact the Northern Illinois Health Plan Customer Service Department at 815-599-7050 or NIHPCustomerService@nihp.com.

********REQUIRED: ATTACH VOIDED CHECK OR ENCODED DEPOSIT SLIP********