Chadwick-Milledgeville CUSD #399
District Reimbursement

Greetings from Northern Illinois Health Plan (NIHP)! We are pleased to be continuing to provide district reimbursement administration services for the Chadwick-Milledgeville CUSD #399 and look forward to continuing to provide you with quality and responsive customer service.

2021 District Reimbursement
Continuing January 1, 2021 you will submit copies of your Explanation of Benefits (EOB's) with a service date of 01/01/2021 or after directly to NIHP for reimbursement. To ensure a timely reimbursement we ask that you enclose a completed reimbursement form along with your EOB's from your insurance carrier (*see below). These requests can be submitted to NIHP by one of the following methods
:

Mail:
Northern Illinois Health Plan
P.O. Box 880
Freeport, IL 61032

Fax:
(815) 599-7059 Attn: Deductible Reimbursement

Email:
NIHPCustomerService@nihp.com
Subject: Deductible Reimbursement

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 5:00 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.

*Q: How do I obtain an EOB:
A: The following are available methods to obtain an EOB
1) These are mailed out to members after claims are processed.
2) BlueCross BlueShield members can view them online by logging onto www.bcbsil.com.com

773 W. Lincoln Blvd., Suite 402, Freeport, IL 61032
(815) 599-7050 or (800) 723-0202
NIHPCustomerService@nihp.com

Chadwick-Milledgeville CUSD 399
PPO In-network Deductible Reimbursement Benefit
Calendar Year 2021

Active Employees, COBRA participants, Retirees and their enrolled family members will be reimbursed for medical costs applied towards In-Network deductibles that exceed $1,000 per insured individual during the calendar year. A maximum benefit of $1,000 per individual or $3,000 per family per calendar year will be provided.

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

EOB's should be submitted by the second Tuesday of the month in order to be approved at the monthly board meeting. Reimbursements will be mailed by the end of the month. All reimbursement checks will be made payable to the insured employee, regardless if the deductible expense is for an insured dependent.

The reimbursement expense request must be for a minimum of $25. If the amount is less than $25, the EOB will be retained until additional deductible expenses are submitted for the plan year. However, if following the 90-day run-out period at the end of the calendar year of December 31, 2021, your reimbursement amount owed remains less than $25, a check will be issued by March 31, 2022.

Coordination of Benefits (COB) applies when you have health care coverage through more than one group program. Before the district reimbursement can occur, a copy of the other carrier's EOB must also be submitted.

To be considered, all requests for reimbursement must be submitted by March 31, 2022. District reimbursement requests should be sent to:

Northern Illinois Health Plan
P.O. Box 880
Freeport, IL 61032
NIHPCustomerService@nihp.com
Phone: (800) 723-0202
Fax: (815) 599-7059

Reimbursement Claim Form : Chadwick-Milledgeville CUSD #399

EMPLOYEE NAME: ______________________________ EMPLOYEE SSN: ______________________

ADDRESS: ______________________________ CITY: ______________ ST: _____ ZIP: __________

Does the patient have secondary coverage? Yes / No
If yes, please provide the name of the carrier:____

MEDICAL/PRESCRIPTION EXPENSES - ATTACH A COPY OF EOB TO CLAIM FORM

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

To the best of my knowledge and belief, my statements in the Request of Reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year for my eligible dependents and myself. I certify that these expenses have not been and will not be reimbursed under any other employer sponsored benefit plan (including any HSA) and will not be claimed as an income tax deduction. In addition, I certify that these expenses have not been previously reimbursed under this plan. I understand and authorize that my plan account will be reduced by the amount of the requested reimbursement.

______________________________ ______________________________

Employee Signature* Date*

*Note: Form must be signed and dated in order to process this claim. **MINIMUM CHECK AMOUNT $25.00**

Reminders: Provide complete and proper documentation for all expenses submitted. Keep copies of everything submitted for reimbursement. All rejected claims must be resubmitted with proper documentation

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