SCC of SDA
SECTION 105
CLAIM FORM - 2026 Plan Year
Deductible Reimbursement

Employee Name: _____ Final 4 Digits of SSN: XXX-XX-_____

Address: _____

City, State, Zip_____

Email address: _____

Phone Number: _____

☐ Reimburse via Check ☐ Reimburse via Direct Deposit (enter Banking Information below)

BANKING INFORMATION: Routing #: _____ Account #: _____

Single: Employee pays first $300 of $5,500 deductible. Employer will then reimburse the next $3,575 of deductible. Employee pays remaining $1,625 of deductible. Total OOPM is $6,650 less Deductible of $5,500 leaves $1,150 of OOPM. OOPM.
Employee pays first $390 of OOPM. ER pays remaining $760 of OOPM.
EE's maximum responsibility is $2,315 and ER's maximum reimbursement is $4,335.00

Family: Employee pays first $600 of $11,000 deductible. Employer will then reimburse the next $7,150 of deductible. Employee pays remaining $3,250 of deductible. Total OOPM is $13,300 less $11,000 deductible.
TOTAL OOPM is $13,300 less Deductible of $11,000 leaves $2,300 OOPM.
Employee pays first $780 of OOPM, ER pays remaining $1,520 of OOPM.
EE's maximum responsibility is $4,630 and ER's maximum reimbursement is $8,670.

EE Employee
ER Employer
HSA Health Savings Acct
OOPM Out-of-Pocket Maximum

The undersigned participant in the Plan requests reimbursement.

REQUIRED: Participants must submit an Explanation of Benefits (EOB) showing Deductible and OOP Accumulators from Blue Shield with this claim form to secure reimbursement from this account. No other forms of documentations will be accepted.

READ CAREFULLY

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred (i.e., services were provided) during a period while the undersigned was covered under the Cafeteria Plan with respect to such expenses and that such expenses have not been reimbursed, or are not reimbursable, under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the Plan which relate to such expense. The undersigned further understands that no medical expense tax deduction or credit is permitted for amounts for which reimbursement is made.

_____ _____
Employee's signature Date

Please submit all claim forms and documentation to:
Trucordia Insurance Services, LLC
21300 Victory Blvd Suite 700, Woodland Hills, CA 91367
or fax to (818) 703-0935
Email forms to flex.10003@trucordia.com
For questions contact the Reimbursements Dept. at (818) 703-8057

NO CLAIMS FOR 2025 WILL BE ACCEPTED AFTER MARCH 31, 2027