



# Montebello Teachers Association Retiree Supplemental Health Plan

Administered by Coast Benefits, Inc.

## Claim for Reimbursement

### Participant Information:

---

Name Telephone Number Social Security Number

---



---

Address City State Zip Code

---

**Covered Expense Claims** - Attach appropriate receipt(s) for each expense listed below when submitting this form. Each claim for reimbursement must have supporting documentation and proof of payment by you in order for the Trust Office to issue a reimbursement. Please see the "Claim and Reimbursement Procedures" section of this form for more details. **Requests for reimbursement must total a minimum of \$25.00.**

Date you received the service	Service Provider	Expense Description	Person for whom Expense Incurred	Expense Amount
				\$
				\$
				\$
				\$
				\$
				\$
<b>Total</b>				<b>\$</b>

### Participant Authorization

By signing below, I certify that all services for which reimbursement is requested on this form were provided while I was eligible for coverage under the Montebello Teachers Association Retiree Supplemental Health Plan (the "Plan") and were for me or my eligible dependents, as defined by the Plan. Further, I certify that the eligible expenses: 1) have not been otherwise reimbursed, nor will they otherwise be reimbursed, through any other source; 2) have not been paid or are not eligible for payment on a pre-tax basis; and 3) have not been taken, nor intend to be taken, as a tax deduction. I understand that the Internal Revenue Service Code permits reimbursement only for eligible health care expenses. I understand that I alone am fully responsible for the sufficiency, accuracy, and truthfulness of all information relating to the claims on this form and that I am liable for payment of expenses. Further, I understand that if an expense is not eligible for reimbursement under the Plan, I am liable for payment of all related taxes on amounts paid by the Plan that relate to these expenses.

---

Participant's Signature Date

Mail, Email or Fax Completed form and any required documentation to:  
**Coast Benefits, Inc.**  
**3530 Camino Del Rio North, Suite 110**  
**San Diego, California 92108**  
**Telephone: (800) 886-7559 • Fax: (619) 501-3250 • [mtarshp@coastbenefits.com](mailto:mtarshp@coastbenefits.com)**

## Claim and Reimbursement Procedures

To receive reimbursement for eligible expenses you have already incurred, you must submit this written claim form, with the required supporting documentation, to the Plan in accordance with the Plan's claim procedures. The Plan Document and Summary Plan Description for Retired Employees (SPD) explain the claim procedures and benefits (including Covered Expenses) in more detail.

The Plan only reimburses Participants and their Dependents for out-of-pocket costs incurred by Participants for Covered Expenses (such as copayments and coinsurance for doctor's appointments, hospital stays, or prescription drugs), up to a Participant's **Allocated Amount**. The Plan does not reimburse Covered Expenses that have been paid, or will be paid, by another party or for which another party (such as a health plan or insurance company) is liable. **The IRS only allows reimbursement payments paid directly to you and only after you have provided the Plan with proof of payment made to your providers.**

**This claim form with all required documentation supporting the claim, must be submitted by the annual claims deadline, which is three (3) months after the end of the calendar year in which you paid the Covered Expense (i.e., no later than March 31st, for expenses you paid during the prior calendar year).**

**Claims submitted after this March 31st deadline (i.e., more than 3 months after the end of the calendar year in which you paid the Covered Expense), will not be eligible for reimbursement.**

*There is one exception to the claims deadline described above. By March 31, 2026, you may submit fully documented claims for reimbursement of Covered Expenses that you paid during the 2024 or 2025 calendar year (i.e., from January 1, 2024-December 31, 2025) while you were a Covered Retiree.*

While you can submit requests for reimbursement at any time, **the Plan requires that any requests for reimbursement be for a minimum of \$25.00.** Therefore, you will have to hold your requests for reimbursement until you have at least \$25.00 in eligible expenses. In addition, the amount reimbursed for any eligible expense will not exceed your Allocated Amount at the time reimbursement is requested.

The Plan requires specific supporting documentation, which depends on which of the following you are seeking reimbursement. (*See SPD, Article 5, section 5.A-D*):

- Covered Expenses (Other Than Premiums for Insurance or Medicare)
- Monthly Insurance Premium Payments
- Medicare Premiums Deducted from Social Security Payments
- Annual Premium Payments

The Plan's SPD in *Article 5 - Section 5. Documentation Needed to Support Claims for Covered Expenses* (specifically, subsections A through D on pages 24-27) describes the required documentation that must be submitted with this form for each of the categories above. You are responsible for submitting the required documentation and are encouraged to review the SPD before submitting this form, to prevent delays or denials of claims. The Trust Offices may request additional documentation, as applicable.

Along with this form, you must provide any of the following, as applicable:

1. An itemized receipt from the service provider that includes the name of the person incurring the charges, date of service, description of services, name of provider, and amount of charge.
2. An Explanation of Benefits (EOB) from any coverage (including any EOB issued by the MTA- RHSP when requesting reimbursement of the balance of charges for which coverage is available plus original receipts verifying payment.

3. Prescriptions for medication and glasses.
4. Any additional documentation requested by Coast Benefits
5. A copy of both the front and back of a “canceled check” will be accepted as proof of payment along with an itemized receipt of services.
6. Copy of bank statements or credit card statements will be accepted as proof of payment along with an itemized receipt of services.

Please note, it is always a good idea to make a copy of all materials you submit for your records. Materials you submit will not be returned to you.