Town of North Attleboro
Health Reimbursement Arrangement (HRA)
Claim Form
Plan Year: July 1, 2020 – June 30, 2021

Cafeteria Plan Advisors, Inc.
420 Washington Street, Suite 100
Braintree, MA 02184

(781) 848-9848 (Phone)
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info@cpa125.com (Email)

EMPLOYEE: _____ **SS#: xxx -xx-** ___ ___ ___ ___

ADDRESS: _____ **CITY:** _____

STATE: MA **ZIP:** _____ **DAY TIME PHONE:** _____ **E-MAIL:** _____

HRA Reimbursement for subscribers participating in the Blue Care Elect Preferred (PPO); Network Blue New England (HMO); MEDEX II with Prescription Drug Plan (PDP); and Managed Blue for Seniors with PDP plans are eligible for the following reimbursement:

EXPENSES MUST BE INCURRED BETWEEN JULY 1, 2020 THROUGH JUNE 30, 2021

Type of Medical Care Expense	Reimbursable Copay Amount	# Co-pays	Dates of Service	Total Reimbursement
Example:		**2**	7/1+5/31	$70
Specialist Office Visit Copay $60	$35 per visit			0.00
Urgent Care $60 (No ER Co-payments)	$35 per visit			
In-patient Hospital Admission Copay	$275/$1500 Per admission			
Outpatient Day Surgical Copayment	$250 per incident			
High Tech Imaging Copayment (MRI, CT, PET) no X-Ray	$100 per incident			
Annual Deductible	Up to $300 per person/$900 family			

TOTAL CLAIM AMOUNT: $ 0.00

This is to certify that I have incurred the expenses listed above that qualify for reimbursement under my employer's Health Reimbursement Account Plan. **I have not been reimbursed for the amounts claimed from any other source including insurance programs or other programs offered by my employer, including the Flexible Spending Health Care Account.** None of these expenses have previously been submitted. I understand and agree that since these expenses are to be reimbursed they may not be claimed as deductions for income tax purposes. I hereby request reimbursement for these claims.

All medical claims submitted require copies of the Explanation of Benefits/Claim Summary from the insurance company detailing the expense. All payments are paid to the participant. Claims are paid within 30 days. Expenses must be submitted no later than 60 days after the plan year ends (August 31). *However, it is recommended that you submit expenses immediately since the program is funded by a budget. The funds are paid out on a first come, first served basis.*

Participant SIGNATURE: _____ **DATE**: _____

Revised 3/4/20 *PRINT FORM, SIGN and RETURN OR PRINT LAST NAME & LAST 4 SOCIAL TO EMAIL FORM ALONG WITH RECEIPTS*