Dennis-Yarmouth Regional Schools- Health Reimbursement Arrangement (HRA)
Claim Voucher ~ **JULY 1, 2019 TO JUNE 30, 2020**
*****All expenses must be submitted no later than July 30, 2020.***

Cafeteria Plan Advisors, Inc.
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EMPLOYEE: _____ **SS#: XXX - XX -** _____

MAILING ADDRESS: _____**CITY:**_____

STATE: _____ **ZIP:** _____**DAYTIME PHONE: ( )** _____**E-MAIL:** _____

Expenses for subscriber and family members enrolled in the eligible health plans must be incurred within the plan year.

Type of Medical Expense	☐ Blue Cross ☐ Harvard Pilgrim	**Reimbursable Co-pay Amount**	Quantity #	Dates of Services	Total Reimbursement *(Quantity # x Reimbursement Amount)*
All office co-pays, physical therapy, chiropractic, & other office visits by the member's Primary Care Physician or Specialist	$20.00 per visit	**$10 per visit**			
Office visit – Specialist	$45 per visit	**$25 per visit**			
ER Copay (not admitted)	$100 per visit	**$25 per visit**			
In-patient Copay	$500 per admission	**$200 per admission**			
Same-day Surgery Copay	$250 incident (waived for all colonoscopies)	**$100 per incident**			
Prescription drug – Retail Co-pays	Tier 2 - $30 Tier 3 - $65 Non formulary	**$10 for each prescription with co-pay of $30 or more**			
Prescription drug – Mail Order Co-pays	Tier 1 - $25 Tier 2 - $75 Tier 3 - $165	**$20 each prescription**			
Plan Year Deductible	$300 Individual plan $600 Single Parent/Child $900 Family plan	**$125 max per plan** **$250 max per plan** **$375 max per plan**			

TOTAL CLAIM AMOUNT: $_____

This is to certify that I have incurred the expenses listed above that qualify for reimbursement under the Health Reimbursement Arrangement. I have not been reimbursed from any other source including insurance programs or other programs offered by my employer. 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 Summaries from your insurance company*** *showing the date of service & description of the expense.*

PARTICIPANT'S SIGNATURE: _____ **DATE**: _____