Dennis-Yarmouth Regional Schools- Health Reimbursement Arrangement (HRA)
Claim Voucher ~ JULY 1, 2022 TO JUNE 30, 2023

Cafeteria Plan Advisors
An Alera Group Company
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Norwell, MA 02061

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(781) 848-8477 (Fax)
info@cpa125.com (Email)

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.

Medical Expense	☐ Blue Cross ☐ Harvard Pilgrim	**Reimbursable Co-pay Amount**	Quantity #	Dates of Services	Total Reimbursement *(Qty. # x Reim. Amt.)*
Office Visit Office Surgery Level 1 **incl. physical therapy* Office Surgery Level 2	$20.00 copay $20.00 copay $45.00 copay	**$10.00 per visit** **$10.00 per visit** **$22.50 per visit**			
Office visit – Specialist	$45 co-pay	**$22.50 per visit**			
Emergency Room (not admitted)	$100 co-pay	**$50 per visit**			
High Tech Imaging (MRI/CAT/PET)	$100 co-pay	**$50 per visit**			
In-Patient Admission	$500 co-pay	**$250 per visit**			
Same-day Surgery (per incident)	$250 co-pay (waived for all colonoscopies)	**$125 per incident**			
Prescription drug – Retail Co-pays	Tier 2 - $30 Tier 3 - $65	**$15.00** **$32.50**			
Prescription drug – Mail Order Co-pays	Tier 1 - $25 Tier 2 - $75 Tier 3 - $165	**$12.50** **$37.50** **$82.50**			
Plan Year Deductible	$300 Individual plan $600 Single Parent/Child $900 Family plan	**$125 max per plan year** **$250 max per plan year** **$375 max per plan year**			

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 both the date of service & description of the expense.*

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

*****All expenses must be submitted no later than 30 days after the plan ends (July 30, 2023)*****

*Rev 9.1.22**