

**Dennis-Yarmouth Regional Schools- Health Reimbursement Arrangement (HRA)
Claim Voucher ~ JULY 1, 2023 TO JUNE 30, 2024**

Cafeteria Plan Advisors
An Alera Group Company
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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.

Medical Expense	<input type="checkbox"/> Blue Cross <input type="checkbox"/> Harvard Pilgrim	<u>Reimbursable Co-pay Amount</u>	Quantity #	Dates of Services	Total Reimbursement <small>(Qty. # x Reim. Amt.)</small>
Office Visit	\$20.00 copay	\$10.00 per visit			
Office Surgery Level 1 <i>*incl. physical therapy</i>	\$20.00 copay	\$10.00 per visit			
Office Surgery Level 2	\$45.00 copay	\$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, 2024)****