120 LONGWATER DRIVE * SUITE 102 NORWELL MA 02061 * 781-848-9848

Town of Ipswich

Health Reimbursement Plan

July 1, 2023 to June 30, 2024

As a part of efforts to keep your medical benefit costs as affordable as possible, the Town of Ipswich is pleased to sponsor a Health Reimbursement Arrangement (HRA).

We are pleased to announce the addition of a second HRA Plan (HRA#2) that will be available until the budgeted funds are exhausted. The plan year runs from July 1, 2023 to June 30, 2024.

Eligible expenses must be incurred within the plan year. The Plan provides eligible retiree or active employees and family members participating in the Network Blue New England HMO or the Blue Care Elect PPO Health Plans the opportunity to be reimbursed for the following expenses:

HRA #1

- **HOSPITAL ADMISSION / IN-STAY COPAY - $300 or $700**

HRA #2

- **AMBULATORY OUTPATIENT DAY SURGICAL COPAY - $150**
- **EMERGENCY ROOM COPAY - $100**
- **HIGH TECH IMAGING (MRI, PET, CT, Nuclear Cardiac Scans) COPAYS - $100**
- **MENTAL HEALTH HOSPITAL & SUBSTANCE ABUSE FACILITY COPAY - $200**

Once you have incurred an eligible expense, submit a copy of your Explanation of Benefits / Claim Summary from the insurance company and a completed claim form, to Cafeteria Plan Advisors, Inc. at the address below. All payments will be made directly to the participant. All expenses must be submitted no later than **30** days after plan year ends. ***However, it is recommended you submit expenses for the HRA#2 plan immediately since it is funded by a budget.***

As the Administrator for this Plan, should you have any questions please contact us at:

Cafeteria Plan Advisors
An Alera Group Company
120 Longwater Drive, Suite 102
Norwell, MA 02061
Phone: 781-848-9848 Fax: 781-848-8477 www.cpa125.com

TOWN OF IPSWICH
Health Reimbursement Account (HRA) Claim Form
Plan Year: July 1, 2023 – June 30, 2024

Cafeteria Plan Advisors
An Alera Group Company
120 Longwater Drive, Suite 102
Norwell, MA 02061
(781) 848-9848 (Phone)
(781) 848-8477 (Fax)
info@cpa125.com (Email)

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

MAILING ADDRESS: _____ **CITY:** _____

STATE: _____ **ZIP:** _____ **DAY TIME PHONE: ( )** _____

EMAIL: _____

HRA Reimbursement for eligible retirees or active employees & family members enrolled in the Network Blue New England HMO or Blue Care Elect PPO Health Plans for the following expenses:

HRA #1
- HOSPITAL ADMISSION / IN-STAY COPAY - $300 or $700

HRA #2
- AMBULATORY OUTPATIENT DAY SURGICAL COPAY - $150
- EMERGENCY ROOM COPAY - $100
- HIGH TECH IMAGING (MRI, PET, CT, Nuclear Cardiac Scans) COPAYS - $100
- MENTAL HEALTH HOSPITAL & SUBSTANCE ABUSE FACILITY COPAY - $200

Date of Service:	Name of Eligible Member Incurring Expense:	Type of Service (Hospital Copay or High Tech Imaging):	Amount to be Reimbursed:
_____	_____	_____	$_____
_____	_____	_____	$_____
		TOTAL:	$_____

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 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 Summary from the insurance company detailing the expense. All payments are paid to the participant. Expenses must be submitted no later than **30** days after the plan year ends (July 31). However, expenses incurred under the HRA#2 reimbursements are available only until the budgeted funds are exhausted.

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