



TOWN OF SCITUATE

Health Reimbursement Plan

JULY 1, 2010 – JUNE 30, 2011 (FY11)

The Town of Scituate will sponsor a Health Reimbursement Arrangement (HRA) for FY11. This plan runs from July 1, 2010 to June 30, 2011 (concurrent with the medical plan year). Eligible expenses must be incurred within the plan year. Plans are administered on a year-by-year basis. Future plan specifics will be subject to action by Mayflower Municipal Health Group (MMHG).

The Plan provides each eligible employee (**only those participating in Network Blue HMO, or Harvard Pilgrim Health Care HMO**) with the opportunity to be reimbursed only for the increase portion of the co-pays that was voted by Mayflower Municipal Health Group.

Medical expenses eligible for reimbursement, and the amounts include:

	<u>Network Blue (HMO)</u>	<u>HPHC (HMO)</u>
Office visits	\$10.00	\$5.00
ER	\$50.00	\$25.00
Retail Prescriptions Tier 1	n/a	\$5.00
Retail Prescriptions Tier 2	n/a	\$5.00
Mail Order Prescriptions Tier 1	\$10.00	\$15.00
Mail Order Prescriptions Tier 2	\$20.00	\$25.00
Mail Order Prescriptions Tier 3	\$35.00	\$70.00

Once you have incurred an eligible expense for yourself, your spouse, or your dependents, simply submit a copy of your co-pay receipt or bill along with a claim form, a copy of which is attached, 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 **90** days after the plan year ends on 6/30/11. As the Administrator for this Plan, please contact us directly with questions at:

Cafeteria Plan Advisors, Inc.

420 Washington Street, Suite 100

Braintree MA 02184

Phone: 781-848-9848 Fax: 781-848-8477

Town of Scituate Health Reimbursement Arrangement (HRA)

Claim Voucher

JULY 1, 2010 TO JUNE 30, 2011

CPA, INC.
420 Washington Street, Suite 100
Braintree, MA 02184

(781) 848-9848 (Phone)
(781) 848-8477 (Fax)

EMPLOYEE: _____ SS#: _____ - _____ - _____

ADDRESS: _____ CITY: _____

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

HEALTH PLAN (check one): Network Blue HMO HPHC HMO

Reimbursement for subscriber and family members enrolled in either Network Blue HMO or HPHC HMO health plans. ALL EXPENSES MUST BE INCURRED BETWEEN JULY 1, 2010 TO JUNE 30, 2011

Type of Medical Care COPAY Expenses	Reimbursable Amount	Reimbursable Amount	Number of visits, admissions, incidents, or prescriptions	Total Reimbursement (Number times reimbursable amount)
	Network BLUE	HPHC HMO		
<i>Example: Office Visit Co-pay</i>	<i>\$10.00 per visit</i>	<i>\$10.00 per visit</i>	<i>3</i>	<i>\$30</i>
Office Visit Copays Subject to the Primary Care Co-pay	\$10 per visit	\$5 per visit		
Emergency Room visit (no admission)	\$50 per visit	\$25 per visit		
Retail Prescription Tier 1	n/a	\$5.00		
Retail Prescription Tier 2	n/a	\$5.00		
Mail Order Prescription Tier 1	\$10.00	\$15.00		
Mail Order Prescription Tier 2	\$20.00	\$25.00		
Mail Order Prescription Tier 3	\$35.00	\$70.00		

TOTAL CLAIM AMOUNT: \$ _____

This is to certify that I have incurred the expenses listed above that qualify for reimbursement under the Town of Scituate 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 original invoices or receipts.**

PARTICIPANT'S SIGNATURE: _____ DATE: _____