CITY OF SALEM
HEALTH REIMBURSEMENT
PLAN YEAR: JULY 1, 2012 – JUNE 30, 2013

As part of the efforts to keep your medical costs as affordable as possible, the City of Salem is pleased to sponsor a Health Reimbursement Arrangement (HRA). The HRA runs with the Plan Year of July 1, 2012 – June 30, 2013. Eligible expenses must be incurred within the Plan Year. The HRA provides Benefit Eligible employees and retirees enrolled in Group Insurance Commission (GIC) plans with the City of Salem with the opportunity to be reimbursed for the following expenses:

SERVICE	REIMBURSEMENT
Outpatient Surgery Copayments	100%, max. of $250.00 per occurrence
Inpatient Hospital Admission Copayments	100%, max. of $750.00 per occurrence
High-Tech Imaging Copayments (MRI, PET & CT scans)	50%, max. of $50.00 per occurrence

Your actual copayment cost and reimbursement will depend upon the plan in which you are enrolled. Kindly refer to your GIC Benefit Decision Guide for the copay associated with your plan.

Once you have incurred an eligible expense, please submit a copy of your invoice with the attached 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 60 days after the Plan Year ends.

If you have any questions about this HRA, please do not hesitate to contact us at:

Cafeteria Plan Advisors, Inc.
420 Washington Street, Suite 100
Braintree, Massachusetts 02184
781-848-9848
781-848-8477
www.cpa125.com

HRA - Co-payment Reimbursement Voucher

CPA, INC.
420 Washington Street, Suite 100
Braintree, MA 02184
(781) 848-9848 (Direct)
(781) 848-8477 (Fax)

Go to www.cpa125.com for additional forms

EMPLOYER: CITY OF SALEM

EMPLOYEE: _____ SS#: XXX-XX-_____

ADDRESS: _____ CITY: _____

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

NAME OF MEMBER INCURRING THE CLAIM _____

REIMBURSEMENT: For Employee/Retiree Subscribers & Family Members enrolled in a GIC Plan with the City of Salem.

PROVIDER (Hospital)	Type of Service (Inpatient/Outpatient/High Tech Imaging)	Date of Service	AMOUNT
_____	_____	_____	$_____
_____	_____	_____	$_____
_____	_____	_____	$_____
_____	_____	_____	$_____
	TOTAL:		$_____

This is to certify that I have incurred the expenses listed above that qualify for reimbursement under my employer's Health Reimbursement 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 the reimbursed expenses 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 and proof of payment. Claims are processed twice a month. Please allow 3 business days to receive your check.

PARTICIPANT'S SIGNATURE: _____ DATE: _____