CITY OF SALEM
HEALTH REIMBURSEMENT PLAN
PLAN YEAR: JULY 1, 2024 - JUNE 30, 2025

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, 2024- June 30, 2025. 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 $1500.00 per occurrence
High-Tech Imaging Copayments (MRI, PET & CT scans)	100%, max. of $100.00 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 the detailed Summary of Benefits or itemized receipts showing the insurance copay details, along with the 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 90 days after the Plan Year ends.

If you have any questions about this HRA.)., do not hesitate to contact Cafeteria Plan Advisors.

Cafeteria Plan Advisors, Inc.
120 Longwater Drive, Suite 102
Norwell, MA 02061
Telephone: 781-848-9848
Fax: 781-848-8477
Scan/Email to: info@cpa125.com
www.cpa125.com

City of Salem Health Reimbursement Arrangement (HRA) Claim Voucher

PLAN YEAR: JULY 1, 2024 - JUNE 30, 2025.

Cafeteria Plan Advisors, Inc.
120 Longwater Drive, Suite 102
Norwell, MA 02061
Tel: (781) 848-9848

Fax Claims to: (781) 848-8477
Email claims to: info@cpa125.com

EMPLOYEE: _____ **SS#:** **XXX** - **XX** _____

ADDRESS:_____ **CITY:**_____

STATE: ____ **ZIP:**_____ **PHONE:** _____ **E-MAIL:**_____

Reimbursements are for subscribers and family members enrolled in health plans through the City of Salem.

All expenses must be incurred between July 1, 2024 - June 30, 2025, and claims submitted no later than 90 days after the plan year ends. All claims require a copy of the Summary of Benefits or itemized receipts showing the insurance copay details.

Type of Medical Care COPAY Expenses		**Reimbursable Amount**	**Date(s) of admissions, surgery, or imaging**	**Total Reimbursement** (Number times reimbursable amount)
Example: Hospital out-patient surgery		100% max of $250.00 per occurrence	7/5/2024	$150.00
INPATIENT HOSPITAL ADMISSION		100% max of $1500.00 per occurrence		
HOSPITAL OUT-PATIENT SURGERY		100% max of $250.00 per occurrence		
HI-TECH IMAGING (MRI, PET SCAN, CT SCAN)		100% max of $100.00 per occurrence		

TOTAL CLAIM AMOUNT: $_____

This is to certify that I have incurred the expenses listed above that qualify for reimbursement under the City of Salem 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.

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