420 WASHINGTON STREET ♦ SUITE LL8 BRAINTREE MA 02184 ♦ (781) 848-9848

Town of Norton

Health Reimbursement Plan (HRA)

July 1, 2020 to June 30, 2021

Following negotiations between the Town of Norton and the Norton Public Employee Committee (PEC) it was agreed that, effective July 1, 2016, the Town would offer a Health Reimbursement Plan (HRA) to its' employees and non-Medicare retirees on the following health plans:

Blue Cross Blue Shield Network Blue New England $250. Deductible Plan and

Blue Cross Blue Shield Blue Care Elect $250. Deductible Plan

To mitigate the impact on subscribers of the deductible and co-pays in those plans, the Town and the PEC have agreed that the Town will sponsor a Health Reimbursement Plan for the reimbursement of the following:

50% of the Deductible (the deductible is $250. per individual/$750. per family)

50% of the Inpatient Hospital Co-pay: (the co-pay for Tier 1 hospitals is $300. and for other hospitals is $700.)

50% of the Outpatient/Day Surgery Co-pay (this co-pay is $150.)

The mitigation arrangement applied to the July 1, 2016 – June 30, 2017 plan year as well as the following three plan years (through June 30, 2020).

Once you have incurred an eligible expense submit a copy of the **Claim Summary/Explanation of Benefits** from your provider or Blue Cross Blue Shield that shows both the date and description of the expense and the deductible amount or co-pay that you paid, along **with a claim form**, to Cafeteria Plan Advisors, Inc.

All payments will be made directly to the participant. All eligible expenses must be incurred within the plan year (July 1 – June 30) and submitted no later than ***60 days*** after the plan year ends. As the Administrator for this Plan, should you have any questions please contact us at:

Cafeteria Plan Advisors, Inc.
420 Washington Street, Suite 100
Braintree MA 02184
Phone: (781) 848-9848 Fax: (781) 848-8477 Email: info@cpa125.com

HRA
CLAIM FORM

HRA Plan Year: July 1, 2020 - June 30, 2021

Employer: **Town of Norton – HRA**

Employee:_____SSN: xxx-xx-_____

Street:_____City: _____

State:_____Zip:_____ Phone: _____

Email: _____

Reimbursements for Eligible Participants in the Town plans:	**Start/End Dates of Service**	**Deductible or Co-pay Total**	**50% of Total (Amount to be Reimbursed)**
Plan Year Deductible *$250 Individual (plan reimburses up to $125)* *$750 Family (plan reimburses up to $375)*	-		
In-Patient Hospital Admission Co-pay *$300 Tier 1 (plan reimburses up to $150)* *$700 Outside Tier 1 (plan reimburses up to $350)*	-		
Outpatient Surgical Co-pay *$150 (plan reimburses up to $75)*	-		
Total			**$**

- All claims ***require*** a copy of the Explanation of Benefits/Claim Detail from Blue Cross Blue Shield showing both the date and description of the services and the deductible amount or co-pay
- Claims must be submitted no later than 60 days after the plan year (July 1 - June 30) ends

This is to certify that I have incurred the expenses listed above and have not been reimbursed by my Flexible Spending Program and that these expenses qualify for reimbursement under the Town's Plan. I hereby request reimbursement for these expenses.

Participant's Signature:_____Date: _____

Mail to:		**Fax to:**		**Scan and Email PDF file to:**
Cafeteria Plan Advisors, Inc 420 Washington St. Suite 100 Braintree, MA 02184	**OR**	781-848-8477	**OR**	Info@cpa125.com