

**TOWN OF WINCHESTER
HEALTH REIMBURSEMENT ARRANGEMENT
REQUEST FORM**

Name		
Home Address	Address Change: Yes ___ No ___	
City	State	Zip
Phone Work: _____	Home/Cell: _____ Email: _____	

FILING INSTRUCTIONS

Please complete this form to request reimbursement for expenses incurred by you or your insured dependents. Reimbursement is limited to the copayments listed below. **In addition to this completed form, you must provide an itemized bill, a receipt, or other evidence of payment, and a copy of your HPHC Activity Summary.** Be sure to provide all information requested on this form. Incomplete forms will be returned to you. Mail or deliver your completed request to:

Anne Graglia Kostos
HR Dept.
Town of Winchester
71 Mt. Vernon St.
Winchester, MA 01890

HPHC ChoiceNet HMO and ChoiceNet PPO co-pays eligible for reimbursement after deductible has been paid:

Inpatient Hospitalization:	\$300. per admission
Outpatient Surgery:	\$150. per visit
Hi-tech Radiology Services: (CT scan, PET scan, MRI, and MRA)	\$100. per test
Emergency Room Visit:	\$100. per visit

PLEASE NOTE: Your plan year deductible must be met before you may apply for any reimbursement.

HEALTH REIMBURSEMENT ARRANGEMENT EXPENSES					
	Provider of Service (hospital or surgical facility)	Person Receiving Service	Dates of Service (Mo/Day/Yr.)	Amount of Expense Claimed	Nature of Expense: In-patient Hosp., Emergency Rm., etc.
1					
2					
3					
4					

I request payment from my health reimbursement account as indicated above for the expenses listed. To the best of my knowledge and belief, my statements in this reimbursement request are complete and true. I am claiming reimbursement only for eligible expenses incurred during the plan year and for my eligible dependents. I certify that these expenses have not previously been reimbursed under this or any other benefit plan, and will not be claimed as an income tax deduction. I authorize the Town to reimburse me the amount requested from the Health Reimbursement Arrangement Account.

Employee Signature _____ Date _____

TOWN OF WINCHESTER
MIDDLESEX COUNTY, MASSACHUSETTS



To: All Employees and Non-Medicare Covered Retirees participating in the Town of Winchester Health Plans

From: Richard Howard, Town Manager

Subject: **Healthcare Costs Eligible for Town Health Reimbursement**

Date: July 17, 2013

Dear Participant:

As you are aware, the Town's Health Insurance plans changed effective July 1, 2013 consistent with the agreement between the Town and the Public Employee Committee pursuant to legislative changes implemented as of that date. This change resulted in lower premium costs for both the Town and the members. Previously, when changes to the health plan were made which resulted in higher out of pocket costs to covered members, the Town provided a "Health Reimbursement Arrangement" (HRA) to assist with these charges.

Consistent with the changes, as of July 1, 2013, the Town is expanding the current HRA to allow members to be reimbursed for certain expenses under the new plan. The following information is being provided to help you understand what is reimbursable, and how to submit claims to the Town for payment.

Who is impacted by the changes as of July 1, 2013?

Any member who is covered under the Harvard Pilgrim ChoiceNet Best Buy HMO or ChoiceNet Best Buy PPO.

What member co-pays are eligible for reimbursement?

Several facility services will require the member to pay a copayment (part of the service cost you must pay after Harvard Pilgrim Health Care pays benefits under the plan) including the following:

In-patient hospital co-pay: up to \$300 per admission (note – some facilities will charge you \$700, but you will only be reimbursed \$300 per admission).

Out-patient surgery facility co-pay: \$150 per admission.

Hi-tech imaging including MRI, PET Scan or CAT Scan: \$100 per test

Emergency room visit co-pay: up to \$100 per visit.

Are there any other expenses members will incur as a result of the above services?

Yes, the new plans require members to pay a \$250 deductible (no more than \$750 for all family members combined) per person, and then the above co-pays apply. So, after you pay your deductible, these expenses will be reimbursed to you.

How will I know if I owe these co-pays? How will I know if I have satisfied my deductible? Is there a web site where I can find this information?

Harvard Pilgrim members will receive an Activity Summary (similar to the attached) that spells out this information. This document can be used to file for reimbursement of the above referenced copayments. A Health Reimbursement Arrangement Request Form must be completed and submitted, along with the expense documentation and proof of payment, to the Comptroller's Office, Town Hall. This form is available either on line at www.winchester.us (see link to Departments and Personnel Benefits), or at the Comptroller's Office, Town Hall.

Please note that you may also view your Activity Summary online by setting up a secure member account through HPHConnect at www.harvardpilgrim.org.

How long will this reimbursement last?

Based on an initial analysis and the PEC agreement, the Town is setting aside \$195,675 which should cover the anticipated reimbursements for the plan year.