

City of Newburyport

Section 105 Healthcare Reimbursement Plan

Request Form- Plan Year July 1, 2022- June 30, 2023

Employee Name:		
Social Security Number:	Daytime Phone Number:	
Email:	New Email:	Yes or No
This form must be accompanied by a prescription record reflecting the amount you have paid for RX or the claim cannot be processed. You may be asked to provide other types of acceptable proof of claim documents. See Summary Plan Description for Complete Explanation of Benefit.		

Covered Expenses

Employees and Retirees

For employees or retirees enrolled in BCBS Network Blue New England \$500 Deductible, Network Blue Select \$500 Deductible, Blue Care Elect \$500 Deductible or the Medex 2 Plan

Individual or family Coverage: After each enrolled participant has paid the first \$300.00 of prescription costs (RX) this plan will reimburse additional RX expenses thereafter so long as there are available funds. See your Summary Plan Description for full details based upon which health plan you are enrolled in.

Under 'cost' enter the amount that you expect to be reimbursed based upon what the EOB says is your responsibility.		
Date of Service	Expense Type	Cost
		\$
		\$
		\$
	TOTAL:	\$

I certify that the following reimbursement submissions are for expenses incurred for my spouse, my eligible dependents or myself. I will not claim credit for these expenses on my individual income tax returns and I will not receive payment from any other source for any of these expenses.

Signature

Date

Mail or Fax to: **ADVANCED BENEFIT STRATEGIES**

Attn: Section 105 Administration

30 Mill Street Unionville, CT 06085

Fax (860) 673-2207

Tel (877) 732-8125