JUDY M. MacDONALD
TREASURER AND COLLECTOR

Town of Middleborough
Office of the Treasurer and Collector
20 Centre Street, 3rd Floor
Middleborough, MA 02346-2270
email: jmcdnld@middleborough.com

TELEPHONE
(508) 946-2420
(508) 946-2421

FAX
(508) 947-5447

To: Employees of the Town of Middleborough

From: Judy M. MacDonald/ Treasurer & Collector

Date: August 28, 2017

Re: Health Care Reimbursements

Dear Employees,

The Town is implementing a **NEW POLICY** in which to submit your Health Care Reimbursements. Starting **NEXT QUARTER** (July 1, 2017 – September 30, 2017), you will be required to submit a Summary of Benefits ONLY, which can obtained by logging into your GIC Health Insurance Website. The Website for your plan can be found on the back of your insurance card.

The Summary of Benefits should be printed out for each month within the quarter AND for every member of your family. You are only to submit this form. We will no longer be accepting receipts.

This will streamline the process and it should be less confusion for everyone.

If you have any questions, please call Sue @508-946-2420 ext. 1127.

Town of Middleborough

NEW Co-Pay Health Reimbursement Form

Effective July 1, 2017

QUARTERLEY REIMBURSEMENTS WILL BE ACCEPTED UP UNTIL THE **SECOND WEEK** OF THE FOLLOWING MONTHS: **OCTOBER** (July 1-Sept 30) JANUARY (Oct 1-Dec 31) **APRIL** (Jan 1-March 31) AND **JULY** (April 1-June 30).

EMPLOYEE NAME:_____

HOME ADDRESS:_____

CITY, STATE AND ZIP:_____

DEPARTMENT/OFFICE:_____

Day Surgery: _____ @ $150.00 per visit = $_____
visits

MRI, CT, and PET Scans:_____ @ $75.00 per visit = $_____
scans

High Cost Hospitals:_____ @ $1,100.00 per admission = $_____
# of admissions

Low Cost Hospitals:_____ @ $75.00 or $300.00 per admission = $_____
# of admissions *(Tufts Spirit**$100.00 or $400.00)*

Specialists: _____ @ $30.00 or $60.00 per visit $_____
(Depends on Tier)

Emergency Room: _____ @ $50.00 per visit = $_____

Tier 2 Drugs: _____ @ $25.00 per prescription $_____

Tier 3 Drugs: _____ @ $90.00 per prescription $_____

Total Reimbursement: $_____

YOU MUST SUBMIT THE ORIGINAL RECEIPT WHICH SHOULD INCLUDE THE DOCTOR'S/HOSPITAL'S NAME AND ADDRESS, DATE OF SERVICE AND TOTAL AMOUNT PAID.

ANY REIMBURSEMENT REQUEST OF $300 OR ABOVE SHALL BE PROCESSED UPON RECEIPT.

DATE:_____ **WARRANT**_____

INVOICE: _____

ACCT. NO: 01.951.465201.0.0 **ACCT. NAME:** EMPLOYEE HEALTH INSURANCE MITIGATION FUND

VENDOR: _____ **VOUCHER**_____

AMOUNT: _____ **APPROVED BY:** _____

Appendix A

MITIGATION REIMBURSEMENTS FOR ACTIVE EMPLOYEE PLANS

	DAY SURGERY	MRI CT PET SCANS	HIGH COST HOSPITAL	LOWER COST HOSPITAL	***Tufts Spirit* *LOWER COST HOSPITAL*	SPECIALISTS	EMERGENCY ROOM	TIER 3 DRUGS MAIL ORDER	TIER 2 DRUGS MAIL ORDER
Co-Pay Effective 7/1/2016	$250.00	$100.00	$1,500.00	$275.00 or $500.00	***$300.00 or $700.00*	$30/$60/$90	$100.00	$165.00	$75.00
Reimbursement	$150.00	$75.00	$1,100.00	$75.00 or $300.00	***$100.00 or $400.00*	$0/30/60	$50.00	$90.00	$25.00
Cost to Employee	$100.00	$25.00	$400.00	$200.00	***300.00*	$30.00	$50.00	$75.00	$50.00