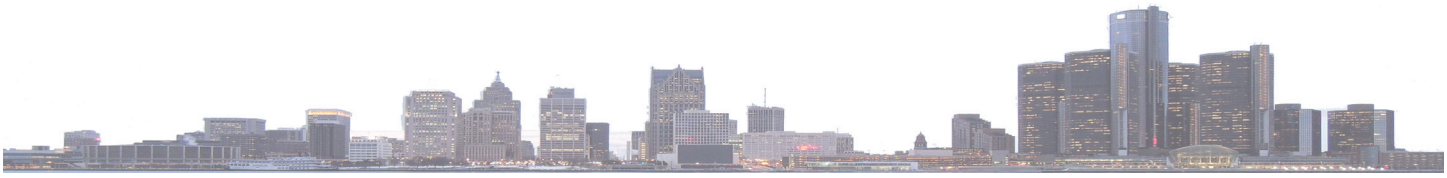

City of Detroit General Retiree Healthcare Trust

Health Reimbursement (HRA) Claim Form - 2026

Instructions: To receive benefits from your HRA account, you must complete **ONE FORM** per patient, along with the following information:

PLEASE NOTE: The minimum amount that can be reimbursed must total $25.00 per submission. You MUST allow up to 10 business days for reimbursement. All reimbursements for claims will be made payable to the member.

Retiree's Name:_____ Retiree's SS# or Alternate ID: _____

Address:_____ Phone Number: _____

Patient Name:_____ Relationship: _____

RECURRING PREMIUM REIMBURSEMENT – JANUARY TO DECEMBER 2026

(MEDICARE PART B OR MONTHLY MEDICAL INSURANCE PREMIUMS ONLY)

Reimbursement for:	**Information Required:**
Medicare Part B	Statement from SSA showing monthly Part B amount
Medical Insurance Premium	Statement from Provider showing monthly premium amount

Providers Name **Amount of Claim**

_____

_____

STANDARD REIMBURSEMENT

Reimbursement for:	**Information Required:**
Medical Co-payments	Copy of your Explanation of Benefits Form (EOB). **Balance due statements are not acceptable.**
Dental	A copy of your EOB. **Balance due statements are not acceptable. Orthodontic services will be paid for after services are rendered.**
Vision Services	Copy of a detailed invoice listing the services rendered and the charge for each.
Prescription Payment or Co-Payment	A copy of the drug label stub or a printout from your pharmacy. **Cash register receipts are not acceptable.**

Type of Service (Medical, Dental, Vision, RX, Premium)	**Providers Name**	**Date of Service**	**Amount of Claim**
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____

By signing this form, I understand that benefits shall be paid in accordance with the City of Detroit General Retiree Healthcare Trust. (See the reverse side of this form for a brief description of covered benefits).

Retiree's Signature:_____ Date: _____

P.O. Box 4955 ◆ Troy, MI 48099-4955
Phone 248·641·4913 ◆ Facsimile 248·813·9898 ◆ Toll Free 844·563·8911
www.ourbenefitoffice.com/mydetroitretireebenefits

STANDARD REIMBURSEMENT *(continued from other side)*

Reimbursement for:	**Information Required:**
Medical Co-payments	Copy of your Explanation of Benefits Form (EOB). **Balance due statements are not acceptable.**
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Type of Service (Medical, Dental, Vision, RX, Premium)	**Providers Name**	**Date of Service**	**Amount of Claim**

How will my (HRA) be Funded?

At the first of each month, your HRA will automatically be credited with the amounts indicated below based on the categories outlined.

Non- Medicare Retiree Retired Prior to 1/1/2015	**Amount**
Non-Medicare Eligible (Pre-65)	**$140.00**
Non-Medicare Eligible Spouse w/< $75k Household Income on Public Exchange	**$140.00**
Non-Medicare Eligible w/< $75k Household Income on Public Exchange	**$190.00**
Non-Medicare Eligible Duty Disabled	**$315.00**
Non-Medicare-eligible Surviving Spouse married to retiree at time of retirement	**$140.00**

Medicare Retiree Retired Prior to 1/1/2015	**Amount**
Medicare Eligible (65+ or disabled) who have elected to opt-out of the medical plans offered by the Trust	**$130.00**
Medicare-eligible Surviving Spouse married to retiree at time of retirement	**$130.00**

Is there a time limit to file for HRA Benefits?

Yes, HRA Claims must be filed by March 31st of the year following the Plan Year in which the expense was incurred.

Where do I send my HRA reimbursement requests?

Send these requests to:

City of Detroit General Retiree Healthcare Trust P.O. Box 4955
Troy, Michigan 48099-4955

Fax: (248) 876-4355

Email: CityofDetroitGeneralHRAclaims@benesys.com