



7044 Hodgson Memorial Dr.
Savannah, GA 31406
Phone: 912-303-3523
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Low (\$1,500) Plan

**SouthCoast Medical Group
Health Reimbursement Arrangement**
(administered by SouthCoast Medical Group)

SouthCoast Medical Group is excited to roll out a Health Reimbursement Arrangement (HRA). This plan will be used in conjunction with your Medical Insurance Plan administered by Blue Cross Blue Shield of Georgia.

How does the HRA Account work?

HRA will reimburse the last \$1,500 of your \$3,000 In-Network Deductible.

Deductible

Employee responsibility	\$1,500.00
HRA reimbursement	<u>\$1,500.00</u>
Total Plan deductible	\$3,000.00

What expenses does the HRA Account reimburse?

The HRA account will reimburse you for your in-network medical expenses, such as office visits, labs, imaging procedures, and prescriptions.

How do I get reimbursed for my deductible expenses?

To receive reimbursement for deductible expenses, you must submit the BCBS Explanation of Benefits (EOB) document you receive showing your deductible expenses of more than \$1,500 and attach it with the completed HRA Reimbursement Form and send via e-mail, fax, or mail to:

Christina Burgdorf
7044 Hodgson Memorial Dr.
Savannah, GA 31406
Phone: 912-303-3523
Fax: 912-303-3596
E-mail: cburgdorf@southcoastmedical.com

NOTE: Before submitting the HEALTH REIMBURSEMENT ACCOUNT FORM, please verify the form is completed and the EOB is attached. Failure to do so may prolong your reimbursement.

Who do I contact if I have a HRA question?

Call Christina Burgdorf at 912-303-3523 or e-mail at cburgdorf@southcoastmedical.com.



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**Health Reimbursement Arrangement
 (Employer Funded)**

Reimbursement Claim Form

Page _____ of _____

Employee Name _____ Office Location _____

Phone # _____ E-mail _____

HRA BENEFIT

HRA plan will reimburse part of the employer sponsored medical plan in-network deductible only.
 Employee pays the first \$1,500 and HRA pays the next \$1,500 of the employer sponsored medical plan deductible.

***You must attach a copy of carrier's Explanation of Benefit for payment!**

Medical Expense Claims

Date Expense Incurred	Name of Service Provider	Person for Whom Expense Incurred	Net Amount	Pay Provider/ Insured
<p>→ Attach appropriate EOB(s) and submit with this claim form</p>			Total Amount of Expenses Submitted	\$

Read Carefully: The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Cafeteria Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state or city income tax on amounts paid from the Plan which relate to such expense.

 Employee's Signature

 Date