

**SOUTHCOAST MEDICAL GROUP, LLC  
HEALTH REIMBURSEMENT  
ARRANGEMENT (HRA) PLAN**

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**SUMMARY PLAN DESCRIPTION**

*Effective: January 1, 2010*

# SouthCoast Medical Group, LLC Healthcare Reimbursement Arrangement

## Summary Plan Description

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# **SouthCoast Medical Group, LLC Healthcare Reimbursement Arrangement Summary**

## **Plan Description Article I**

### **INTRODUCTION**

SouthCoast Medical Group, LLC, (the "Employer") sponsors the SouthCoast Medical Group, LLC Healthcare Reimbursement Arrangement for Eligible Employees. Under the federal tax law, the HRA Plan is known as a "Health Reimbursement Arrangement" or "HRA" plan.

The purpose of the HRA Plan is to reimburse Eligible Employees, up to certain limits, for their own Medical Care Expenses. Reimbursements for Medical Care Expenses paid by the HRA Plan generally are excludable from taxable income.

This Summary Plan Description (SPD) describes the basic features of the HRA Plan, how it operates, and how to get the maximum advantage from it. This Summary does not describe every detail of the HRA Plan and is not meant to interpret or change the provisions of your Plan. A copy of the Plan is on file at your Employer's office and may be read by you, your Beneficiaries, or your legal representatives at any reasonable time. In the event of any inconsistencies or conflict between the actual provisions of the HRA Plan Document and this Summary, the HRA Plan Document shall govern.

## Article II PARTICIPATION IN YOUR PLAN

### **How can I participate in the HRA Plan?**

Once an Employee has met the Plan's eligibility requirements, and provided that the procedures outlined under **How do I become a Participant and when is my Entry Date?** section are followed, the Eligible Employee may participate in the Plan.

### **What are the Eligibility Requirements to participate in the Plan?**

Employees who have been employed by the Employer for 90 consecutive calendar days, counting his or her Employment Commencement Date as the first such day, have enrolled in the Employer's HDHC Plan, and are employed by a participating Employer may participate in the Plan provided that the election procedures outlined under **How do I become a Participant and when is my Entry Date?** section are followed.

### **Are there any Employees who are not eligible to participate in the Plan?**

The following Employees are excluded from participating in the Plan:

- \* Employees covered by a collective bargaining agreement as to which retirement benefits were the subject of good faith bargaining, unless such agreement expressly provides for participation in the Plan
- \* Non-resident aliens with no US source of income
- \* "Leased employees" within the meaning of Section 414(n)
- \* Part-time employees who regularly work less than 32 hours per week
- \* Seasonal employees who regularly work less than 6 months per year
- \* Self-employed individuals, partners in a partnership, or more-than-2% shareholders in a Subchapter S corporation.

### **How do I become a Participant and when is my Entry Date?**

After you satisfy the eligibility requirements described under **What are the Eligibility Requirements to participate in the Plan?**, you will automatically be enrolled and become a Participant in the HRA Plan on the first day of the month coinciding with or following the date the eligibility requirements have been met.

Employees who actually participate in the HRA Plan are called "Participants." An Employee continues to participate in the HRA Plan until: (a) termination of the HRA Plan; or (b) the date on which the Participant ceases to be an Eligible Employee (because of retirement, termination of employment, layoff, reduction of hours, or any other reason).

However, for purposes of pre-taxing COBRA coverage for the HRA benefits, certain Employees may be able to continue eligibility in the HRA Plan for certain periods. See **What is Continuation Coverage and how does it work?**, and **What happens if my employment ends during the Plan Year or I lose eligibility for other reasons?** for information about how termination of participation affects your Benefits.

**What happens if my employment ends during the Plan Year or I lose eligibility for other reasons?** If you cease to be an Eligible Employee (for example, if you die, retire, or terminate employment), your participation in the HRA Plan will terminate unless you elect COBRA continuation coverage as described below. You will be reimbursed for any Medical Care Expenses incurred prior to your termination date, up to your account balance in the HRA account, provided that you comply with the reimbursement request procedures required under the HRA Plan (see **How will the HRA Plan work?** for more information on the reimbursement request process). Any unused portions will be unavailable after termination of employment.

However, if you are rehired within 30 days or less during the same Plan Year and are eligible for the HRA Plan, then your HRA Account balance will be reinstated.

If you are rehired more than 30 days after you terminated employment, you will be treated as a new hire and must re-satisfy the eligibility requirements to rejoin the Plan.

If you cease to be an Eligible Employee for reasons other than termination of employment, such as a reduction of hours, then you must complete the waiting period described under **How do I participate in the HRA Plan?** before again becoming eligible to participate in the Plan.

**What is COBRA continuation coverage and how does it work? If I or my Spouse or Dependent has a COBRA Qualifying Event, can I continue to participate in the Plan?**

COBRA is a federal law that gives certain employees, spouses, and dependent children of employees the right to temporary continuation of their health care coverage under the Employer's major medical or other health insurance plan at group rates. If you, your Spouse, or your Dependent children incur an event known as a "Qualifying Event," and if such individual is covered under the HRA Plan when the Qualifying Event occurs, then the individual incurring the Qualifying Event will be entitled under COBRA (except in the case of certain small employers) to elect to continue his or her coverage under the HRA Plan if he or she pays the applicable premium for such coverage. "Qualifying Events" are certain types of events that would cause, except for the application of COBRA's rules, an individual to lose his or her health insurance coverage. A Qualifying Event includes the following events:

- \* Your termination from employment or reduction of hours;
- \* Your divorce or legal separation from your Spouse;
- \* Your becoming eligible to receive Medicare benefits;
- \* Your Dependent child's ceasing to qualify as a Dependent.

If the Qualifying Event is termination from employment, then the COBRA continuation coverage runs for a period of 18 months following the date that regular coverage ended. COBRA continuation coverage may be extended to 36 months if another Qualifying Event occurs during the initial 18-month period. You are responsible for informing the Plan Administrator of the second Qualifying Event within 60 days after the second Qualifying Event occurs. COBRA continuation coverage may also be extended to 29 months in the case of an individual, disabled within 60 days after the date the entitlement to COBRA continuation coverage initially arose and who continues to be disabled at the end of the 18 months. In all other cases to which COBRA applies, COBRA continuation coverage shall be for a period of 36 months.

**FMLA and USERRA Leaves of Absence**

If you go on a qualifying leave under the Family and Medical Leave Act of 1993 (FMLA) or Uniformed Services Employment and Reemployment Rights Act (USERRA), then to the extent required by the FMLA or USERRA, as applicable, the Employer will continue to maintain HRA Benefits on the same terms and conditions as if the Participant were still an active Eligible Employee.

**Non-FMLA and Non-USERRA Leaves of Absence**

If you go on a leave of absence that is not subject to the Family and Medical Leave Act of 1993 (FMLA) or Uniformed Services Employment and Reemployment Rights Act (USERRA), you will be treated as having terminated participation.

## Article III

### WHAT BENEFITS ARE PROVIDED UNDER THE PLAN

#### **What Benefits are offered under the HRA Plan?**

Once you become a Participant, the HRA Plan will maintain an "HRA Account" in your name to keep a record of the amounts available to you for the reimbursement of eligible Medical Care Expenses. Your HRA Account is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of the Employer), and it does not bear interest or accrue earnings of any kind. Benefits must first be reimbursed from any health insurance plan before any Benefits are payable from this Plan. In the event that an expense is eligible for reimbursement under both the HRA and a Health FSA, you must seek reimbursement from the Health FSA until that account balance has been exhausted before you can seek reimbursement from the HRA.

Before the start of each Plan Year, the Employer will determine a maximum annual amount that may be credited during that Plan Year to the HRA Account of each Participant in the HRA Plan. At the beginning of each Plan Year that you are a Participant, your HRA Account will be credited with \$1,500.00 for employee-only coverage, and \$3000 for family coverage. For example, if the maximum annual amount is determined by the Employer to be \$1,200 for the Plan Year and credited on an annual basis, your account will be credited with \$1200 at the beginning of the plan year in which you are a Participant. Your HRA Account will be reduced by any amount paid to you, or for your benefit, for eligible Medical Care Expenses. The amount available for reimbursement of Medical Care Expenses as of any given date will be the total amount credited to your HRA Account as of such date, reduced by any prior reimbursements made to you as of that date.

After the end of the Plan Year, the unused amount, if any, in your HRA Account will be forfeited.

#### **How will the HRA Plan work?**

The HRA Plan will reimburse you for eligible Medical Care Expenses to the extent that you have a positive balance in your HRA Account. The following procedure should be followed:

- \* You must submit a claim to the Plan Administrator and provide any additional information requested by the Plan Administrator;
- \* A request for payment must relate to Medical Care Expenses incurred by during the time you were a Participant under this Plan;
- \* A request for payment must be submitted within 90 days following the close of the Plan Year in which the Medical Care Expense was incurred;

Claims must be submitted in writing. The Plan Administrator may require that Participants submit claims on a form provided by the Plan Administrator. The claim must set forth:

- \* The individual(s) on whose behalf the Medical Care Expenses were incurred;
- \* The nature and date of the Medical Care Expenses so incurred;
- \* The amount of the requested reimbursement; and
- \* A statement that such Medical Care Expenses have not otherwise been reimbursed and are not reimbursable through any other source, and that Health FSA coverage, if any, for such Medical Care Expenses has been exhausted.

Each claim must be accompanied by bills, invoices, or other statements from an independent third party (e.g., a hospital, physician, or pharmacy) showing that the Medical Care Expenses have been incurred and showing the amounts of such Medical Care Expenses, along with any additional documentation that the Plan Administrator may request.

If the Employer implements an electronic payment card program (debit card, credit card, or similar method) to pay expenses from the HRA, some expenses may be validated at the time the expense is incurred (like co-pays for medical care). For other expenses, the card payment is only conditional and you will still have to submit supporting documents.

**Are there any limitations on Benefits available under the HRA Plan?**

Below are the benefit coverage options, and their respective exclusions, available under the HRA Plan:

**(a) Limited-Purpose HRA Coverage Option.**

Only reimburses expenses not covered by insurance for medical care, as defined in Code section 213(d), provided, however, that such expense is for:

- \* In-Network deductible expenses to the extent that they exceed the minimum HSA guidelines

**When must the Medical Care Expenses be incurred for the HRA?**

For Medical Care Expenses to be reimbursed to you from your HRA Account for the Plan Year, they must have been incurred during that Plan Year. The Plan Year for the HRA is a 12-month period beginning on January 1st and ending on December 31st.

A Medical Care Expense is incurred when the service that causes the expense is provided, not when the expense was paid. If you have paid for the expense but the services have not yet been rendered, then the expense has not been incurred. For example, if you prepay on the first day of the month for medical care that will be given during the rest of the month, the expense is not incurred until the end of that month (and cannot be reimbursed until after the end of that month). You may not be reimbursed for any expenses arising before the HRA Plan became effective, before your Enrollment Form became effective, for any expense incurred after the close of the Plan or after a separation from service (except for Continuation Coverage, as described under **What is "Continuation Coverage" and how does it work?**).

**Will I pay any administrative costs under the HRA Plan?**

No. The cost of the plan includes administrative expenses and is paid entirely by the Employer.

**Are my Benefits taxable?**

The HRA Plan is intended to meet certain requirements of existing federal tax laws, under which the Benefits that you receive under the HRA Plan generally are not taxable to you. However, the Employer cannot guarantee the tax treatment to any given Participant, since individual circumstances may produce differing results. If there is any doubt, you should consult your own tax adviser.

**How long will the HRA Plan remain in effect?**

Although the Employer expects to maintain the HRA Plan indefinitely, it has the right to amend or terminate all or any part of the HRA Plan at any time for any reason. It is also possible that future changes in state or federal tax laws may require that the HRA Plan be amended accordingly.

## Article IV CLAIMS

### PROCEDURE

#### **What happens if my claim for benefits is denied?**

If (a) a claim for reimbursement under the HRA Plan is wholly or partially denied, or (b) you are denied a benefit under the HRA due to an issue germane to your coverage under the HRA Plan (for example, a determination of a Change in Status; or eligibility and participation matters under the HRA Plan document), then the claims procedure described below will apply. If your claim is denied in whole or in part, you will be notified in writing by the Plan Administrator within 30 days after the date the Plan Administrator received your claim. (This time period may be extended for an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Plan Administrator is expected to be made. Where a claim is incomplete, the extension notice will also specifically describe the required information, will allow you 45 days from receipt of the notice in which to provide the specified information and will have the effect of suspending the time for a decision on your claim until the specified information is provided.)

Notification of a denied claim will set out:

- \* a specific reason or reasons for the denial;
- \* the specific Plan provision on which the denial is based;
- \* a description of any additional material or information necessary for you to validate the claim and an explanation of why such material or information is necessary;
- \* appropriate information on the steps to be taken if you wish to appeal the Plan Administrator's decision, including your right to submit written comments and have them considered, your right to review (upon request and at no charge) relevant documents and other information, and your right to file suit under ERISA (where applicable) with respect to any adverse determination after appeal of your claim.

#### *Appeals*

If your claim is denied in whole or part, then you (or your authorized representative) may request review upon written application to the "Appeals Committee". Your appeal must be made in writing within 180 days after your receipt of the notice that the claim was denied. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that you feel your claim should not have been denied. It should include any additional facts and/or documents that you feel support your claim. You will have the opportunity to ask additional questions and make written comments, and you may review (upon request and at no charge) documents and other information relevant to your appeal.

#### *Decision on Review*

Your appeal will be reviewed and decided by the Committee or other entity designated in the Plan in a reasonable time not later than 60 days after the Committee receives your request for review. The Committee may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with your appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of a medical expert consulted in connection with your appeal will be provided.

If the decision on review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

- \* the specific reason(s) for the decision on review;
- \* the specific Plan provision(s) on which the decision is based;
- \* a statement of your right to review (upon request and at no charge) relevant documents and other information;

- \* if an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, then a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; and
- \* a statement of your right to bring suit under ERISA § 502(a) (where applicable).

*Duty of Beneficiary/Third Party Recoveries*

Any Beneficiary under the Plan that receives a payment, whether by lawsuit, settlement, or otherwise, from third parties for costs associated with sickness or injury resulting from the acts or omissions of another person or party must reimburse the Plan to the extent the Beneficiary has received payments from the Plan for such sickness or injury. The Plan has a first lien upon any such recovery. Any recovery by the Plan Administrator from such payments is subject to a deduction for reasonable attorney fees and court costs incurred by the Beneficiaries in securing the third-party payments, and shall be prorated, to reflect that portion of the total recovery reimbursed to the Plan Administrator for the benefits it had paid from the Plan. However, the Plan's share of the recovery will not be reduced because the Beneficiary has not received the full damages claimed, unless the Plan Administrator agrees in writing to such a reduction.

The Plan further requires covered Beneficiaries promptly advise the Plan Administrator of third-party claims and to execute any assignments, liens, or other documents the Plan Administrator requests. The Plan may withhold Benefits until such documents are received.

*Subrogation/Acts of Third Parties*

The Plan Administrator, on behalf of the Plan, has the right to recover any payments made to Beneficiaries, whether by lawsuit, settlement, or otherwise, by third parties for costs associated with sickness or injury resulting from the acts or omissions of another person or party. The Plan has a first lien upon any such recovery. Any recovery by the Plan Administrator from such payments is subject to a deduction for reasonable attorney fees and court costs incurred by the Beneficiaries in securing the third-party payments, and shall be prorated, to reflect that portion of the total recovery reimbursed to the Plan Administrator for the benefits it had paid from the Plan. However, the Plan's share of the recovery will not be reduced because the Beneficiary has not received the full damages claimed, unless the Plan Administrator agrees in writing to such a reduction.

## Article V STATEMENT OF ERISA RIGHTS

### **What are my ERISA Rights?**

The HRA Plan is an ERISA welfare benefit plan under the Employee Retirement Income Security Act of 1974 (ERISA) and is governed by ERISA.

**Your Rights.** As a participant in the HRA Plan, you may be entitled to certain rights and protections under ERISA. ERISA provides that all participants shall be entitled to:

- \* Examine, without charge, at the Plan Administrator's office and at other specified locations (such as worksites) all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;
- \* Obtain, upon written request to the Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies); and
- \* Receive a summary of the HRA Plan's annual financial report, if any. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

**Fiduciary Obligations.** In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefits plan. The people who operate your HRA Plan, called "fiduciaries" of the HRA Plan, have a duty to do so prudently and in the interest of the HRA Plan Participants and beneficiaries.

**No Discrimination.** No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

**Right to Review.** If your claim for a benefit is denied or ignored in whole or in part, you must receive a written explanation of the reason for the denial, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

**Enforcing Your Rights.** Under ERISA, there are steps that you can take to enforce these rights. For instance, if you request a copy of plan documents or the latest annual report (if any) from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive them, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, then you may file suit in a state or federal court (but only if you have first filed your claim under the plan's claims procedures and, if applicable, filed a timely appeal of any denial of your claim). If it should happen that plan fiduciaries misuse the HRA Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

**Assistance With Your Questions.** If you have any questions about your plan, you should contact the HRA Plan Administrator. If you have any questions about this statement or about your rights under ERISA or HIPAA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You

may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

**HIPAA Privacy Rights - Use and Disclosure of Protected Health Information.** Except for certain permitted uses and disclosures, the Privacy Rule issued by the federal government prohibits the HRA Plan from using or disclosing certain health information about you that is created or received by the HRA Plan without your written authorization. For additional information about your privacy rights, please either refer to the HRA Plan's Privacy Notice or contact the HRA Plan's Privacy Official:

SouthCoast Medical Group, LLC  
PO Box 15849  
Savannah, GA 31416  
(912) 303-3552

If you wish to authorize the HRA Plan to use or disclose your PHI in a manner that is not otherwise permitted, you must submit a signed and completed authorization form to the HRA Plan. You may request a copy of the authorization form from Human Resources.

**Permitted Uses and Disclosures.** The HRA Plan is permitted under the Privacy Rule to use or disclose your PHI without your authorization only for purposes related to:

- \* Health care treatment;
- \* Payment for health care;
- \* Health care operations; and
- \* Other specifically permitted exceptions, such as disclosures to assist disaster relief, disclosures to lessen serious health or safety threats, or disclosures to business associates.

For a complete list of permitted exceptions, please refer to the HRA Plan's Privacy Notice or contact the HRA Plan's Privacy Official.

**Disclosures to the Employer.** After the Employer has certified to the HRA Plan that it is in compliance with the Privacy Rule, the HRA Plan may disclose PHI to the Employer without your authorization to the extent that the PHI is necessary for the Employer to perform HRA Plan administration functions. The HRA Plan may not disclose any more PHI to the Employer than is necessary for the Employer to fulfill its administration functions, and the HRA Plan may not disclose PHI to the Employer for purposes of any employment-related actions or in connection with any other employee benefit provided by the Employer.

To the extent that your PHI is disclosed to the Employer, the Employer will:

- \* not use or further disclose PHI other than as permitted or required by the official HRA Plan document or as required by law;
- \* ensure that any agents to whom the Employer provides PHI (or certain Electronic Protected Health Information (EPHI)) received from the HRA Plan agree to the same restrictions and conditions that apply to the Employer with respect to PHI;
- \* not use or disclose PHI for employment-related actions and decisions unless authorized by you;
- \* not use or disclose PHI in connection with any other benefit provided by the Employer unless authorized by you;
- \* report to the HRA Plan's Privacy Officer any misuse or improper disclosure of PHI;
- \* make PHI available to you in accordance with the requirements of the Privacy Rule;
- \* make PHI available to you for amendment and incorporate any amendments to PHI in accordance with the requirements of the Privacy Rule;
- \* make available to you the information required to provide an accounting of disclosures in accordance with the requirements of the Privacy Rule;
- \* make internal practices, books, and records relating to the Employer's use and disclosure of PHI available to the Secretary of Health and Human Services for the purposes of determining the HRA Plan's compliance with HIPAA; and
- \* if feasible, return or destroy all PHI received from the HRA Plan that the Employer still maintains in any form, and retain no copies of the PHI, when the PHI is no longer needed for the purpose for which the disclosure was made (or if return or destruction is not feasible, limit further uses and

disclosures to those purposes that make the return or destruction infeasible).

The Employer may only disclose your PHI (or certain EPHI) to the following employees and may only do so to the extent that the employees perform HRA Plan administration functions:

- \* The Privacy Official;
- \* Employees in the Employer's Human Resources Department;
- \* Employees in the Employer's Office of General Counsel; and
- \* Any other class of employees designated in writing by the Privacy Official.

If an employee does not comply with the requirements of the Privacy Rule, then the Employer may apply appropriate sanctions to the employee in order to ensure compliance with the Privacy Rule. If you become aware of any inappropriate use or improper disclosure of PHI, contact the Privacy Official immediately.

## **Article VI GENERAL INFORMATION**

### **General Plan Information**

- \* Name: SouthCoast Medical Group, LLC Healthcare Reimbursement Arrangement
- \* Plan Number: 502
- \* Effective Date: January 1, 2010
- \* Plan Year: January 1st to December 31st . Your Plan's records are maintained on this 12-month period of time
- \* Type of Plan: Welfare Plan
- \* Your plan shall be governed by the Laws of the State of Georgia

### **Employer/Plan Sponsor Information**

- \* Name and Address: SouthCoast Medical Group, LLC  
PO Box 15849  
Savannah, GA 31416  
(912) 303-3552
- \* Federal Employer Tax Identification Number (EIN): 58-2194871

### **Plan Administrator Information**

Name, address, and business telephone number:

SouthCoast Medical Group, LLC  
PO Box 15849  
Savannah, GA 31416

Attention: Plan Administrator  
(912) 303-3552

The Plan Administrator appoints the Plan Administrator to keep the records for the Plan and to be responsible for the administration of the Plan. However, the Appeals Committee acts on behalf of the Plan Administrator with respect to appeals. The Plan Administrator will answer any questions that you may have about our Plan. You may contact the Plan Administrator at the above address for any further information about the Plan.

### **Funding and Type of Plan Administration**

The HRA is a group health plan and is self-funded by the Employer.

All of the amounts payable under this Plan may be paid from the general assets of the Employer.

Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets, it may hire an unrelated third-party paying agent to make Benefit payments on its behalf.

### **Named Fiduciary**

The named fiduciary for the HRA Component is:

Your Human Resource Rep

**Agent for Service of Legal Process**

The name and address of the Plan's agent for service of legal process is:

SouthCoast Medical Group, LLC  
PO Box 15849  
Savannah, GA 31416  
(912) 303-3552

**Newborns' and Mothers' Health Protection Act of 1996 (NMPHA)**

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or to less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

**Qualified Medical Child Support Order**

The HRA will provide benefits as required by any qualified medical child support order (QMCSO), as defined in ERISA § 609(a). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

**USERRA**

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). More information about coverage under USERRA is available from the Plan Administrator.

**Women's Health and Cancer Rights Act of 1998 (WHCRA)**

The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy. This law applies generally both to persons covered under group health plans and persons with individual health insurance coverage. But WHCRA does NOT require health plans or issuers to pay for mastectomies. If a group health plan or health insurance issuer chooses to cover mastectomies, then the plan or issuer is generally subject to WHCRA requirements.