

---

**MAUA  
HEALTHCARE REIMBURSEMENT ACCOUNT PLAN  
SUMMARY PLAN DESCRIPTION**

---

## Plan Description

### Table of Contents

<b>Article</b>	<b>Section</b>	<b>Page</b>
<b>I</b>	INTRODUCTION TO YOUR PLAN	1
<b>II</b>	GENERAL INFORMATION	2
<b>III</b>	PARTICIPATION IN YOUR PLAN	4
<b>IV</b>	ADMINISTRATION OF YOUR PLAN	8
<b>V</b>	BENEFITS UNDER YOUR PLAN	10
<b>VI</b>	STATEMENT OF ERISA RIGHTS	11

---

## Article I

### INTRODUCTION TO YOUR PLAN

---

Your Employer offers this Healthcare Reimbursement Account Plan ("HRA Plan") as part of your employee benefits program. The purpose of the HRA Plan is to provide reimbursement for certain health care expenses not otherwise covered by any insurance or any other programs offered by the Employer. The Employer intends that this HRA Plan qualify as an accident and health plan under Section 105(e) of the Code, and that the nontaxable benefits provided under the HRA Plan be eligible for exclusion from Participants' income under Section 105(b) of the Code.

This HRA Plan is not a part of a Cafeteria Plan. The salary reduction, if any, withheld from your salary (wages) under a Cafeteria Plan is not used to fund this HRA Plan. If your Employer provides Cafeteria Plan credits, those credits cannot be used to increase your HRA Plan reimbursements.

This is not a "Salary (or wage) Reduction" plan. You are not paying for the cost of your benefits by electing to have your compensation reduced. The Employer is paying 100% of the benefits out of its general assets. The Employer will designate a maximum benefit that will be provided from the Employer's general assets for each enrolled Participant on an annual basis beginning the first day of any Plan Year or the first day of the month in which an Employee first enrolls in a Designated Group Health Plan. There is no segregated fund or trust established for this HRA Plan.

This Summary Plan Description is a brief description of the Plan and your rights, benefits and obligations under the Plan. This Plan Description is not meant to interpret, extend or change any provision contained in the Plan Document. The provisions of the MAUA Healthcare Reimbursement Account Plan can only be accurately understood by reading the Plan Document.

---

## Article II

### GENERAL INFORMATION

---

You may need the following information if you have any questions about your Plan.

#### 1. GENERAL PLAN INFORMATION

The name of this Plan is the MAUA Healthcare Reimbursement Account Plan ("HRA Plan").

Your Employer has included this Plan under Plan Number 505.

The provisions of this Plan became effective on March 1, 2007.

This Plan's records are maintained on a 12-month period known as the Plan Year. The Plan Year is from March 1<sup>st</sup> through February 28<sup>th</sup>.

Reimbursements under this HRA Plan are tax free and therefore governed by the Internal Revenue Service (IRS) Code. As a group health plan sponsored by your Employer, this HRA Plan is also subject to ERISA. Some of your basic rights under ERISA are described in this Summary Plan Description.

#### 2. EMPLOYER INFORMATION

The name, address and tax identification number of the Employer are:

Mid Atlantic Urology Associates, LLC  
d/b/a MAUA  
7500 Hanover Parkway  
Suite 206  
Greenbelt, MD 20770-2009

EIN Number (Tax ID): 43-2105237

#### 3. PLAN ADMINISTRATOR INFORMATION

The name, address and telephone number of your Plan Administrator is:

Mid Atlantic Urology Associates, LLC  
d/b/a MAUA  
7500 Hanover Parkway  
Suite 206  
Greenbelt, MD 20770-2009

Your Plan Administrator is responsible for the administration of your Plan. Should you need to see any records or have any questions regarding the Plan, contact the Plan Administrator.

The Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine at its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is eligible and entitled to receive any benefits under the Plan.

#### 4. BENEFITS COORDINATOR

Christie Wilhide has been named as the Plan's Benefits Coordinator. If you need additional information about the plan or the benefits offered, the Benefits Coordinator will be able to assist you.

#### 5. LEGAL REPRESENTATIVE

The following entity has been named your Plan's agent for service of legal process:

Mid Atlantic Urology Associates, LLC  
d/b/a MAUA  
7500 Hanover Parkway  
Suite 206  
Greenbelt, MD 20770-2009

Process may also be served on the Plan Administrator.

#### 6. MISCELLANEOUS PROVISIONS

**Termination and Amendment of Plan** The Employer expects to maintain the HRA Plan indefinitely as an employee benefit. However, the Employer has the right, in its sole discretion, to terminate the Plan or to modify or amend any provision of the Plan at any time.

Participants in this HRA Plan will receive no reimbursements after a HRA Plan termination or a partial HRA Plan termination affecting them, except with respect to covered events giving rise to benefits and occurring prior to the date of HRA Plan termination or partial termination and except as otherwise expressly provided in this Plan Description, or provided in writing by the Employer.

**No Continued Employment** No provisions of the HRA Plan or this Plan Description shall give any employee any rights of continued employment with the Employer or shall in any way prohibit changes in the terms of employment of any Employee covered by the HRA Plan.

**Non-Assignment Of Benefits** Except as may be required pursuant to a "Qualified Medical Child Support Order" which provides for HRA Plan coverage for an alternate recipient, or other applicable law, no Participant or beneficiary may transfer, assign or pledge any HRA Plan benefits.

**Excess Payments** Upon any benefit payment made in error under the Plan, the Employer will inform you that you are required to repay the amount that has been paid under this Plan in error. This includes and is not limited to amounts over the annual maximum benefit allocation, amounts for services that are determined not to be Qualified Expenses, or when you do not provide adequate documentation to substantiate a paid claim upon request. The Employer may take reasonable steps to recoup such an amount including withholding the amount from future salary or wages, and reducing the amount of future benefit reimbursements by the amount paid in error.

---

## Article III

### PARTICIPATION IN YOUR PLAN

---

In order to be eligible for this HRA Plan you must be enrolled in and remain covered under a "Designated Group Health Plan". If you are enrolled under any other health insurance option then you will not be eligible under this HRA Plan. Any event that terminates your coverage under a "Designated Group Health Plan" option will automatically terminate coverage under this HRA Plan. Your Employer reserves the right to change the plans that are considered Designated Group Health Plan(s) at its discretion.

Employees who fail to meet the requirements for enrollment in the Designated Group Health Plan are not eligible to enroll in this Plan. In addition, the following persons are excluded from participating in this Plan:

- Employees who are non-resident aliens and receive no earned income from the employer which constitutes income from sources within the United States.
- Employees who are self-employed individuals as described in section 401(c) of the Internal Revenue Code including sole proprietors, or partners in a partnership.

If you become eligible under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for coverage by an Accident or Health Benefit available under the Plan you shall be allowed to participate in the Plan, so long as you comply with the provisions set out in HIPAA.

#### ENROLLMENT

You will automatically become a Participant in this Plan upon successful enrollment in the Designated Group Health Plan. There are no separate enrollment forms or requirements for this Plan.

Generally, you are not allowed to change the terms of your enrollment during a Plan Year for the Designated Group Health Plan or this Plan. There are, however, a few exceptions to this rule. Your coverage under this Plan will change on the same date and in the same manner as allowed under the Designated Group Health Plan. You should consult with the Designated Group Health Plan or your Benefits Coordinator for details regarding the events that occur that will allow you to change your elections.

Events that typically allow a change in enrollment include a change in the Employee's legal marital status (events that change an Employee's legal marital status include marriage; death of spouse; divorce; legal separation; and annulment); the adoption, birth, or death of a child or other Dependent of the Employee or the Employee's Spouse; the emancipation or coming of age of a child of the Employee so that the child is no longer eligible as a Dependent under the Plan; the employment of the Employee or Employee's Spouse; change in the Employee's residence; the Employee beginning or ending adoption proceedings, or; Medicare or Medicaid entitlement.

#### TERMINATION OF PARTICIPATION

A Participant will no longer be enrolled as a Participant in this HRA Plan on the earlier of:

- (1) the day the Participant ceases to be covered under the Designated Group Health Plan; or,
- (2) the date this Plan terminates.

**Military Leave.** If you go on a leave of absence because of military service, you may continue coverage under this Plan as required by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). You will be required to pay for coverage in an amount allowed under USERRA. This extension of coverage will end on the earlier of: (1) the last day of the 24-month period beginning on the date your absence begins; or (2) the day after the date on which you fail to apply for or return to a position of employment with the Employer. Your Employer can provide additional information if necessary.

## **CONTINUING PLAN PARTICIPATION UNDER COBRA**

Under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, ("COBRA"), made applicable to governmental entities under the Public Health Services Act, any Participant, Spouse or Dependent eligible for continuation coverage shall be allowed to continue to participate in this HRA Plan, so long as such Participant, Spouse or Dependent complies with the provisions set out below. The COBRA HRA Plan monthly premium will be 1/12 of the average annual cost for the Employer to maintain this HRA Plan for similarly situated Employees, multiplied by 102%. The COBRA eligible Participant must also elect to continue coverage under the Designated Group Health Plan offered by the Employer. When a qualifying terminating event occurs a Participant will receive a notice that provides detail regarding COBRA coverage.

When you, your covered spouse or your covered dependent experience a qualifying event, you will be sent a notification explaining your rights to elect COBRA continuation coverage. The Employer will provide this notification no later than 44 days from the date of the loss of coverage. You or a covered spouse or covered dependent have the responsibility to notify your Employer of your desire to continue coverage within sixty days from the later of the date of notification or loss of coverage. Keep in mind, Qualified Beneficiaries who elect continuation coverage are responsible for premiums back to the date termination from the plan would have occurred.

If you or a covered dependent experience a qualifying event and do not receive a qualifying event notification in a timely fashion, you are requested to contact the Benefits Coordinator immediately. Even if you elect not to continue coverage, it is vital you have the information necessary to make an informed decision.

Your Employer will know when certain qualifying events (i.e. reduced work hours, employment termination and death of an employee) occur. You and your spouse or covered dependents will be responsible for notifying the Benefits Coordinator in writing of a divorce, legal separation, Medicare entitlement or when a dependent loses his/her "dependent status". You have sixty days from the date of the event to notify our office of these qualifying events. If you do not notify the Benefits Coordinator in writing within the 60 day period, COBRA continuation cannot be offered.

Listed below are qualifying events for which you and/or your covered dependents are able to continue coverage under COBRA. As shown, the maximum continuation coverage time frame depends upon the qualifying event experienced. To be considered a Qualified Beneficiary, you or your dependent must have been enrolled on the HRA Plan on the day prior to the qualifying event. One exception to this rule is when a child is born to (or placed for adoption with) an employee during the COBRA continuation period. These children will receive all the rights of a Qualified Beneficiary throughout the COBRA continuation period.

### **Qualifying Events That Yield a Maximum of Eighteen Months' Coverage (Experienced by the Employee)**

- (1) Termination of employment (for reason other than "gross misconduct");
- (2) Reduction of employee's work hours.

### **Qualifying Events That Yield a Maximum of Thirty-six Months' Coverage (Experienced by a Covered Dependent)**

- (1) Death of the employee;
- (2) Divorce or legal separation;
- (3) Employee is entitled to Medicare but dependents are not;
- (4) Dependent child who no longer meets the plan's definition of a "dependent."

Under the Family and Medical Leave Act of 1993 (FMLA), you have the right to take up to 12 weeks of unpaid leave to care for themselves or a relative. If you elect to take this leave and later notify the Employer that you will not be returning, you have the ability to continue your coverage for eighteen months from the date benefits are terminated on account of your failure to return to work. (FMLA does not apply to all organizations and can differ between states. Please contact the Benefits Coordinator for further information on FMLA.)

If you experience a qualifying event that entitles you and your covered dependents to less than thirty-six months of continuation coverage (including the disability extension described above) and during your period of continuation coverage your covered dependents experience a second (or "multiple") qualifying event, the period of continuation coverage for your covered dependents may be extended under COBRA from eighteen months (or twenty-nine months if disabled) to thirty-six months. The maximum continuation period is thirty-six months regardless of how many qualifying events your covered dependents experience. It is the responsibility of you or your covered dependents to notify our office within sixty days of the multiple qualifying event. Employees who experience a reduction in work hours followed by termination of employment shall only be eligible for eighteen months of continuation coverage under COBRA.

**When Notice Is Required.** When certain events occur that affect your eligibility under your employer sponsored group health plan, or that affect your covered spouse and dependents coverage, you, your spouse or covered dependent must notify us of the event, in writing, in order to be offered COBRA Continuation. Any person covered under the group health plan that becomes eligible for COBRA continuation coverage is called a "Qualified Beneficiary". The events that require notice are:

- (1) the occurrence of a qualifying event that is a divorce or legal separation of a covered employee from his or her spouse, or a dependent who loses eligibility under the plan;
- (2) the occurrence of a second qualifying event after a person has become enrolled in COBRA continuation coverage, this only applies when the maximum COBRA continuation term available for the person is 18 or 29 months;
- (3) a Qualified Beneficiary has been determined by the Social Security Administration to be disabled at any time during the first 60 days of continuation coverage; and
- (4) a Qualified Beneficiary has subsequently been determined by the Social Security Administration to no longer be disabled.

**Where the Notice is Sent.** The written notice must be mailed or otherwise delivered to the Benefits Coordinator.

**When Notice is Due.** Each Employee or Qualified Beneficiary who lost coverage due to a qualifying event listed above under numbers 1 or 2 must deliver the notice 60 days from the later of (1) The date on which the relevant qualifying event occurs; (2) The date on which the Qualified Beneficiary loses (or would lose) coverage under the plan as a result of the qualifying event; or (3) The date on which the Qualified Beneficiary is informed, through the furnishing of the plan's Plan Description or the General Notice, of their responsibility to provide the notice and these procedures for providing the notice.

A Social Security Determination of Disability must be delivered within 60 days after the later of: (1) The date of the disability determination by the Social Security Administration; (2) The date on which a qualifying event occurs; (3) The date on which the Qualified Beneficiary loses (or would lose) coverage under the plan as a result of the qualifying event; or (4) The date on which the Qualified Beneficiary is informed, through the furnishing of the plan description or the General Notice, of both the responsibility to provide the notice and the plan's procedures for providing such notice to the administrator. In addition, the notice of a Social Security Determination of Disability must be delivered before the end of the 18 month COBRA continuation period. If the Social Security Administration determines that a COBRA Participant is no longer disabled, that Determination must be delivered within 30 days of the later of: (1) the date of the final determination by the Social Security Administration that the Qualified Beneficiary is no longer disabled; or (2) The date on which the Qualified Beneficiary is informed, through the furnishing of the plan's plan description or the General Notice of both the responsibility to provide the notice and the plan's procedures for providing such notice to the administrator.

**What The Notice Must Contain.** Your written notice must contain at least the name of the person(s) that will be losing coverage, the event that will cause the loss of coverage (referred to as a qualifying event) and the date the qualifying event actually occurs. You should also provide, along with the letter, documentation of the event that occurred, such as a photocopy of a divorce order or legal separation order showing the date the divorce or legal separation began. If you have any question about what type of documentation is required, you should contact the Benefits Coordinator at the address provided in this notice. The Benefits Coordinator may develop and make available a form which may be required to be completed to provide adequate notice.

**Trade Act of 2002.** The Trade Act of 2002 expands the benefits available to workers displaced by import competition or shifts of production to other countries. It offers qualified workers a tax credit of up to 65% of COBRA health insurance premiums for both them and their family. The law also creates a second "election period" for individuals not electing COBRA coverage upon their loss of employment if they are within the six months immediately after their group health plan coverage ended. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at [www.doleta.gov/tradeact/2002act\\_index.asp](http://www.doleta.gov/tradeact/2002act_index.asp).

## **HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)**

The scope of HIPAA is to eliminate barriers for individuals (mainly people with pre-existing medical conditions that would have difficulty obtaining immediate coverage) who lose coverage and want to find some form of replacement plan. The law limits a plan's "pre-existing condition limitation time frame" to twelve months for newly enrolling individuals and provides credit for prior medical coverage, including COBRA continuation coverage. When you terminate from a group medical plan, you will receive a Certificate of Coverage that illustrates your prior coverage. This certificate should be shown to a new employer to receive one month credit for every month of prior coverage. Keep in mind that if there is a break in coverage greater than sixty-three days, the new employer does not have to provide any prior coverage credit.

In addition, if you elect COBRA and keep your coverage for the maximum continuation period available to you, you may be eligible for coverage under an individual plan (through an insurer of your choice) on a guaranteed issue basis without any pre-existing condition limitations.

## **THE FAMILY AND MEDICAL LEAVE ACT**

The Family and Medical Leave Act ('the FMLA') requires employers with 50 or more employees to provide unpaid leave for eligible employees at the time of the birth or adoption of a child or at the time of a serious health condition affecting the employee or a family member.

If you are on an unpaid leave under the FMLA rules, you may continue to participate in the plan, as long as you continue your coverage under the Designated Group Health Plan.

If a Participant's coverage under the Plan ceased while on FMLA leave, the Participant will be entitled to resume coverage upon return from leave on the same participation basis in effect prior to the leave, or as otherwise required under the FMLA. The Participant will be entitled to elect reinstatement in the Plan at the coverage level that was in effect before the FMLA leave.

---

## **Article IV**

### **ADMINISTRATION OF YOUR PLAN**

---

The Plan Administrator is responsible for the administration of your HRA Plan. The duties of the Plan Administrator include determining who is eligible to participate, interpreting laws and regulations and how they apply to your Plan and whether or not certain expenses should be allowed under the Plan.

After becoming a participant in the HRA Plan, file all change requests with the Benefits Coordinator and requests for reimbursement with the Service Provider. The Employer has the final determine, in accordance with the various laws that apply to HRA Plans, whether or not to grant your requests.

#### **FUNDING – MAXIMUM REIMBURSEMENT AMOUNTS**

Employees enrolled in a Designated Group Health Plan will be eligible to receive reimbursements from the general assets of the Employer for Qualified Expenses incurred in a Plan Year or the remaining portion of a Plan Year in which they are enrolled. The amounts stated below are available on the first day of the applicable Plan Year, or first day of coverage for a late enrollee.

Upon enrollment in the Designated Group Health Plan, Employees with Employee only coverage or Employee coverage and coverage for any additional dependent will be eligible to receive \$1000.00 in reimbursements per Plan Year after the Employee pays the first \$200 of the deductible. This amount is available on each day of the Plan Year in which an Employee is enrolled.

#### **NO CARRY OVER OF BALANCE**

There is no carry over of any unused benefit from one Plan Year to another. If there is a balance remaining in your annual allocation at the end of the Plan Year, the balance is forfeited to the Employer. No cash outs are allowed.

#### **FORFEITURES**

If your participation in the HRA Plan ends, perhaps because you terminate employment, your period of coverage ends on the day of the terminating event, such as the day you terminate employment. Any expenses incurred after that date are ineligible for reimbursement. If you have not incurred Qualified Expenses equal to the amounts allocated on your behalf under this HRA Plan before that date, you forfeit the unused amount.

You must submit all claims for reimbursement before the end of a 90 day period that begins on the day of your termination from the plan. Claims submitted after that 90 day period will not be considered for reimbursement.

All forfeited amounts become the property of the Employer. The Employer can use forfeited amounts for the payment of administrative expenses under this HRA Plan, or to assign to future allocations that are not dependent on a Participants prior reimbursement experience.

#### **CLAIMS FOR REIMBURSEMENT**

Reimbursement shall only be made under this HRA Plan on the basis of Qualified Expenses incurred by the Participant, the Participant's Spouse or the Participant's Dependents, as presented to the Service Provider on a written form specified by the Benefits Coordinator and as evidenced by a written statement from a third party that a Qualified Expense has been incurred. The Employer shall have the final

determination regarding what are and what are not Qualified Expenses subject to reimbursement. To make the determination that a Qualified Expense subject to reimbursement has been incurred, the Employer requires that the Explanation of Benefits issued by the carrier that administers the Designated Group Health Plan be submitted with each claim.

In the event of the death of the Participant prior to the payment of any claims, payment shall be made in the following priority: 1) Executor of the Estate of the deceased Participant, 2) Spouse, 3) Family member held responsible for payment of deceased's health care bills, 4) Spouse of dependent with COBRA continuation rights.

### **ORDER OF BENEFITS REGARDING THE MEDICAL REIMBURSEMENT PLAN (FSA)**

If you elect to participate in the Medical Reimbursement Plan offered by the Employer and also participate in this HRA Plan, your claims will be submitted and reimbursed under this HRA Plan first, and will only be reimbursed from the Medical Reimbursement Plan when the expense, or part of the expense submitted cannot be reimbursed under this HRA Plan.

### **CLAIMS AND DENIALS**

When you submit a claim for reimbursement under this Plan, the Service Provider will notify you of an adverse benefit determination no later than 30 days after receipt of the claim. This period may be extended one time for up to 15 days, provided that the extension is necessary due to matters beyond the control of the Service Provider and the Service Provider notifies you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you will be allowed at least 45 days from receipt of the notice within which to provide the specified information.

The denial notice you receive will state the reason(s) for the denial and refer to the Plan provision or section of the Internal Revenue Code upon which was relied in making the decision to deny the claim. The denial notice will include a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary. It will describe the review procedures and the time limits applicable to such procedures. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the notice will include the specific rule, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request.

Your authorized representative can act on your behalf in pursuing a benefit claim or appeal of an adverse benefit determination. The Employer has established reasonable procedures for determining whether an individual has been authorized to act on your behalf. There are no fees charged to appeal a denial of a claim for reimbursement. You must first file an appeal within the time limits stated below, with the Plan Administrator, in order to bring a lawsuit in federal court for an item that can be appealed under this Plan.

After the claim has been denied, you will be allowed an opportunity to appeal. If requested in writing, and within 180 days of the claim denial, the Employer will give you a full and fair review within 60 days of the request for review of the denied claim. The Benefits Coordinator will notify you in writing of the final decision. The decision to deny reimbursement will be reviewed in a manner that does not afford deference to the initial denial and will be conducted by an appropriate named fiduciary of the plan who is neither the individual who made the denial nor the subordinate of such individual. You will have the opportunity to submit written comments, documents, records, and other information relating to the claim. You can request, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim. The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, regardless to whether the information was submitted or considered in the initial denial.

---

## Article V

### BENEFITS UNDER YOUR PLAN

---

#### INTRODUCTION

Benefits under this HRA Plan shall take the form of tax free reimbursements for Qualified Expenses incurred by you, your Spouse or your Dependents that are incurred during the period in which you are enrolled under this HRA Plan. Benefits are provided from the Employer's general assets. You are entitled to benefits under this HRA Plan up to the amount that has been allocated by the Employer on your behalf.

#### REIMBURSEMENT FOR QUALIFIED EXPENSES

This HRA Plan will only provide reimbursements for Qualified Expenses. Qualified Expenses are medical expenses incurred during a Plan Year by a Participant, the Participant's Spouse or the Participant's Dependents while the Participant is covered under this HRA Plan. Medical expenses are only reimbursable to the extent allowed as a deduction by the IRS. For purposes of the Plan, an expense is incurred on the date when the underlying services giving rise to the medical expenses are performed and not on the date that the services are billed by the service-provider or paid by the Participant.

Qualified Expenses are limited to the actual amount spent by the Participant that is applied towards the medical and prescription deductibles due under the terms of a Designated Group Health Plan. All other charges or expenses are excluded from this definition. Claims must be submitted within 90 days from the end of a Plan Year or the end of participation in the Plan. Claims that are submitted after this time limit will not be considered Qualified Expenses.

#### BENEFITS DUE TO A MEDICAL CHILD SUPPORT ORDER

The HRA, under certain circumstances, will provide benefits for your child, even if you do not have custody of your child or the child is not claimed on your taxes your dependent. Those circumstances must be established through a Qualified Medical Child Support Order (QMCSO). A QMCSO is a decree or order issued by a court that obligates you to provide health benefits for your child. If you incur this type of obligation as a result of a court ordered medical child support order, you must inform the Benefits Coordinator. The Benefits Coordinator can provide you with a copy of the Qualified Medical Child Support Order Procedure. This procedure explains the rules that the Benefits Coordinator must follow to properly handle a QMCSO. The Benefits Coordinator will determine if a medical child support order is a Qualified Medical Child Support Order in accordance with the provisions of the Procedure, the Plan Document. If a medical child support order is found to be a QMCSO, the Plan may be obligated to provide coverage or benefits to the child under any medical benefit offered to you under the Plan.

---

## Article VI

### STATEMENT OF ERISA RIGHTS

---

As a Participant in any Plan that is subject to Employee Retirement Income Security Act of 1974 (ERISA), you are entitled to certain rights and protections under ERISA. In general, the welfare benefit plans sponsored by your Employer such as but not limited to the HRA Plan are subject to ERISA.

ERISA provides that you are entitled to:

#### **RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS**

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the ERISA Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) 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 Plan Administrator, copies of documents governing the operation of the ERISA Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the ERISA Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

A complete list of the employers and employee organizations sponsoring this Plan may be obtained by participants and beneficiaries upon written request to the Plan Administrator. Participants and beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular employer or employee organization is a sponsor of the Plan and, if the employer or employee organization is a Plan Sponsor, the Plan Sponsor's address.

#### **CONTINUE GROUP HEALTH PLAN COVERAGE**

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the ERISA Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage.

Review this Summary Plan Description and the documents governing the ERISA Plan on the rules governing your COBRA continuation coverage rights.

#### **RECEIVE CREDIT AGAINST PRE-EXISTING CONDITIONS LIMITATIONS**

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

## **PRUDENT ACTIONS BY PLAN FIDUCIARIES**

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of an ERISA Plan. The people who operate an ERISA plan, called "fiduciaries" have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.

## **ENFORCE YOUR RIGHTS**

If your claim for an ERISA Plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the ERISA 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 the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the 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.

You must first file an appeal within the time limits stated in Part IV, with the Plan Administrator, in order to bring a lawsuit in federal court for an item that can be appealed under this Plan.

## **ASSISTANCE WITH YOUR QUESTIONS**

If you have any questions about your ERISA Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or contact 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. f