

MCHCD INDIVIDUAL COVERAGE HRA

SUMMARY PLAN DESCRIPTION

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The Mendocino Coast Health Care District maintains the MCHCD Individual Coverage HRA. The terms of the Plan are contained in a lengthy, legally worded document. This Summary Plan Description is intended to acquaint you with the provisions of the Plan that apply to you by summarizing them in language that is easier to understand.

The format for the Summary is a series of questions and answers that cover such key areas as: when you become eligible; what benefits you may receive; and how your benefits are paid for. The Summary is merely intended to describe the Plan in a condensed fashion, not to change it or to add to it. Should the Plan and Summary be inconsistent in any way, the provisions of the Plan will overrule the Summary.

IDENTIFYING INFORMATION

1. Plan:

MCHCD Individual Coverage HRA

2. Employer/Plan Administrator:

Mendocino Coast Health Care District
775 River Drive
Fort Bragg, CA 95437
707 954-1849

3. Claims Administrator:

The Plan Administrator has retained P&A Administrative Services, Inc. to assist in Plan administration.

You may submit your claims online at P&A's website, www.padmin.com, by logging into your P&A Account or by using your smartphone.

Or you may mail your claims to P&A Administrative Services, Inc., 17 Court Street, Suite 500, Buffalo, NY 14202 or fax them to 716 855-7105.

4. Plan Year-End:

June 30

THE INDIVIDUAL COVERAGE HRA OVERVIEW

The Plan is intended to reimburse you for some of your medical expenses that are not paid by your insurance. The following is a list of some of the more commonly asked questions regarding your Plan.

EFFECTIVE DATE AND PLAN YEAR

WHAT IS THE EFFECTIVE DATE OF THE PLAN?

This Summary reflects the terms of the Plan as of October 1, 2020, the date the Plan started.

WHAT IS THE PLAN YEAR?

“Plan Year” refers to the accounting period that is used for purposes of maintaining the Plan's records, which normally will be the 12-month period beginning on July 1 and ending on the following June 30. However, the first Plan Year will be the period starting on October 1, 2020 and ending on June 30, 2021.

ELIGIBILITY AND PARTICIPATION

WHEN AM I ELIGIBLE FOR PLAN PARTICIPATION?

You become eligible for the Plan on the first day of the month after you have satisfied each of these requirements:

1. You are in a class of employee that is not eligible to enroll in a group major medical plan of the Employer; and
2. You provide proof that you have purchased your own individual major medical coverage (e.g., through a federal or state Health Care Exchange) which meets the requirements of the Affordable Care Act.

HOW DO I PROVIDE PROOF OF MY COVERAGE?

For your expenses during a particular Plan Year to be eligible for reimbursement, you must provide proof that you have coverage before the first day of that Plan Year. Proof can be in the form of documentation from a third party (e.g., your insurance company or from an Exchange where you made the purchase) or in the form of an Attestation that you sign.

Acceptable documentation includes an insurance card or Explanation of Benefits from your insurance company. An Attestation of coverage must state that you and your Spouse and/or Dependents are enrolled in individual medical coverage, the date the coverage started or will start and the name of your insurance company.

PLAN CONTRIBUTIONS

WHO PAYS FOR THE COST OF PLAN BENEFITS?

All benefits under the Plan are paid by the Employer. However, if you elect the COBRA or USERRA Continuation Coverage described below, you will be required to pay premiums to receive the coverage.

WHO PAYS FOR THE COST OF PLAN ADMINISTRATION?

The Employer pays the cost of Plan administration.

PLAN BENEFITS

WHAT BENEFITS MAY I RECEIVE UNDER THIS PLAN?

The purpose of the Plan is to reimburse you for a portion of your Eligible Expenses. An “Eligible Expense” is any expense for “medical care” (as defined in the Internal Revenue Code) that is not eligible for payment or reimbursement by any other health plan. This include the premiums you pay for your individual major medical coverage. “Eligible Expense” includes the cost of care for your Spouse or a Dependent who is enrolled with you in your individual major medical coverage.

At the time you first become a Participant in the Plan, your Employer will establish an HRA Account in your name. On the first day of every month coinciding with or after that date, your HRA Account will be credited with a certain number of “Benefit Dollars”. The amount of Benefits Dollars credited on a particular date will be determined by your Employer within its sole discretion. Unless and until the Employer decides to make a change, the contribution amount will be \$600.

Any Benefit Dollars that continue to be credited to your HRA Account after all your Eligible Expenses for a particular month have been reimbursed will be rolled forward and included in your HRA Account on the first day of the next month.

Understand that your “Account” exists for record-keeping purposes only and does not involve any actual segregation of funds for your benefit.

WHO IS A SPOUSE AND WHO IS A DEPENDENT?

Only the expenses of a Participant, a Participant’s Spouse or a Participant’s Dependent qualify are eligible for reimbursement.

Spouses

A person will be considered the Spouse of a Participant if the Spouse and Participant are married for purposes of federal tax law. Under federal tax law, a couple will be treated as married if they were married in a state where their marriage was legal under the law of that state at the time it occurred, irrespective of whether they continue to reside in that state or in another state where same-sex marriage is legal.

Relatives as Dependents

A Participant’s relative will be considered to be his or her Dependent if the Participant provided over half of the relative’s financial support for the calendar year. If the relative is a child, grandchild, brother, sister, niece or nephew of the Participant who is under age 19 (age 24 in the case of a full-time student), it is not necessary for the Participant to have provided over half of the relative’s support if the relative lived with the Participant for more than half of the calendar year and the relative did not provide more than one-half of his or her own support.

A special rule applies to the reimbursement of the health expenses of children of divorced parents. The child of divorced parents or legally separated parents is considered to be a Dependent of both parents if both parents together provide more than 50% of the child’s support and have custody of the child for more than half the year.

For purposes of this Plan, “Dependent” also includes any child of a Participant whose 27th birthday will not have occurred by the last day of the current calendar year, irrespective of whether the child satisfies any of the financial support or residency requirements referred to above in this section of the Summary.

Non-Relatives as Dependents

To qualify as a Dependent, a person who is not related to a Participant must:

1. receive over 50% of his or her financial support from the Participant for the calendar year;
2. have the same principal residence as the Participant for the entire calendar year; and
3. be a member of the Participant's household (which is not possible if their living together violates the law of the state where they live).

BENEFIT CLAIMS

HOW DO I OBTAIN BENEFITS?

You obtain reimbursement for an expense by providing the Claims Administrator with a fully completed claim form, an attestation of continuing individual health insurance coverage during the month of the expense and any supporting documentation specified by the claim form. The Claims Administrator will determine if the expense is reimbursable and will pay any benefits due to you under the Plan.

If your claim arises while you are receiving COBRA Continuation Coverage, your premium payments must be up-to-date (subject to a thirty-day grace period for late payment) to receive benefits.

To insure timely reimbursement, please submit your claims directly to the Claims Administrator.

WHAT ARE MY RIGHTS IF MY CLAIM FOR BENEFITS IS DENIED?

When a Claim is Denied

If your claim for benefits is denied, then you have the right to be notified of the denial and to appeal the denial, both within certain time limits.

As a general rule, you will receive notification of a claim denial within 30 days of the date you submitted your claim. However, the 30-day period may be extended for an additional 15 days due to circumstances beyond the Claim Administrator's control. This would be the case if, for example, you did not include enough information about a particular claim for the Claims Administrator to either allow or deny the claim.

The Claims Administrator will provide you with written notice if it becomes necessary to extend the 30-day period with regard to any claim that you file. The written notice will tell you the reason for the extension and when the Claims Administrator expects to make its decision. If the reason for the extension is that your claim was incomplete, you will also be notified of what additional information the Claims Administrator needs to allow or deny your claim, and you will be given 45 days after you receive the notice to provide the information during which time the claims submission deadline will be suspended.

Any notification that you receive from the Claims Administrator denying a claim that you have submitted will include:

1. The reason for the denial;
2. A reference to the provision of the Plan on which the denial was based;

3. A description of any additional material or information that would be needed to approve your claim and an explanation of why it is needed;
4. A description of the Plan's internal and external review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA section 502(a) following a denial on review; and
5. If the Claims Administrator relied on an internal rule, guideline, protocol or similar criteria in making its determination, either a copy of the specific rule, guideline or protocol, or a statement that such rule, guideline, protocol or similar criterion was relied on in making the determination and that a copy of such rule, guideline, protocol or similar criterion will be provided to you free of charge upon request.

Appealing a Claim Denial

You have the right to an internal appeal and, if applicable, an external review to an independent review organization.

An internal appeal must be submitted to the Claims Administrator and must include the following information:

1. Your name and address;
2. a statement that you are disputing a denial of a claim or the Claims Administrator's act or omission;
3. The date of the Claims Administrator's notice denying your claim; and
4. The reasons for your disputing the Claims Administrator's denial of the claim or the Claims Administrator's act or omission.

You should also submit any documentation not previously provided that supports your claim.

Your internal appeal must be delivered to the Claims Administrator within 180 days after you receiving the denial notice or after the Claims Administrator's act or omission. Your internal appeal will be heard and decided by the Claims Administrator's Manager of Flex & Claims Administration.

If you do not file your internal appeal within this 180-day period, you lose your appeal rights.

Decision on Review

The Claims Administrator's Manager of Flex & Claims Administration will review and decide your appeal in a reasonable time not later than 60 days after he or she receives your request for review. The Claims Administrator's Manager of Flex & Claims Administration may, in his or her discretion, hold a hearing of 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. You will be informed of the identity of any medical expert consulted in connection with your appeal. 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 that will include:

1. The specific reason for the denial on review;
2. A reference to the provision of the Plan on which the denial was based;

3. A statement of your right to review, upon request and at no charge, relevant documents and other information;
4. If the Claims Administrator's Manager of Flex & Claims Administration relied on an internal rule, guideline, protocol or similar criteria in making its determination, either a copy of the specific rule, guideline or protocol, or a statement that such rule, guideline, protocol or similar criterion was relied on in making the determination and that a copy of such rule, guideline, protocol or similar criterion will be provided to you free of charge upon request; and
5. A statement of your right to bring an external appeal or a civil action under ERISA Section 502(a).

External Appeals

You have the right to an external review of an internal appeal that is denied unless the denial was based on a failure to meet the Plan's eligibility requirements.

The Claims Administrator's Manager of Flex & Claims Administration will advise you of the process for requesting an external review when your internal appeal is denied. It must be filed within 4 months after you were provided with his or her response to your internal appeal request, or you will lose your right to request it.

The external reviewer must notify you and the Claims Administrator of its decision within 45 days after it receives your external appeal request. The decision is binding on all parties unless other State or Federal law remedies are available.

UNDER WHAT CIRCUMSTANCES WILL I LOSE THE RIGHT TO SUBMIT CLAIMS?

You will lose eligibility for benefits if cease to be an eligible employee for any reason. When you lose eligibility:

1. No future expenses will not qualify for reimbursement under the Plan.
2. You will be permitted to submit claims for expenses you had in the current Plan Year before you lost eligibility.
3. Your remaining claims must be submitted within 180 days after you lost eligibility.

MAY I VOLUNTARILY GIVE UP MY RIGHTS TO RECEIVE BENEFITS?

Yes, you may. During the last month of any Plan Year or at the time you cease to be eligible for the Plan, you may elect to opt-out of the Plan, in which case you will be waiving your right to future reimbursement of eligible expenses. To exercise this right to opt-out of this Plan, please contact the Plan Administrator to obtain a form that may be used for this purpose.

CONTINUATION COVERAGE

WHAT HAPPENS IF I GO OUT ON FMLA LEAVE?

The Family Medical Leave Act ("FMLA") entitles certain employees to take unpaid leaves of absence totaling twelve weeks per year for specified personal or family health and child care needs. Your coverage under the Plan during any FMLA leave will continue at no cost to you. However, you will lose coverage (subject to your right to elect COBRA Continuation Coverage) if you fail to return to work at the end of the leave or if you give earlier notice of your intention not to return from the leave.

WHAT HAPPENS IF I TAKE MILITARY LEAVE?

If you take a leave of absence from the Employer in connection with duty in the uniformed services, the Plan will continue to cover you on the same basis as an active employee (except for expenses directly related to the military service, e.g., combat-related injuries) if the period of the leave is expected to be less than thirty one days. For leaves of a longer duration, you may elect to continue coverage in the plan at your own expense for up to twenty-four months. The "uniformed services" are the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training or full-time National Guard duty, the commissioned corps of the Public Health Service and any other category of persons designated by the President of the United States in time of war or emergency.

MAY I CONTINUE MY PARTICIPATION IN THE PLAN IF I BECOME INELIGIBLE (BECAUSE, FOR EXAMPLE, MY EMPLOYMENT TERMINATES?)

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), allows certain individuals to continue their health plan coverage at their own expense when that coverage otherwise would end. The purpose of this section of the Summary is to **explain the COBRA rules that could allow you to continue your coverage under this Plan after you would otherwise lose eligibility.**

COBRA Coverage

COBRA coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." After a qualifying event, COBRA coverage must be offered to each person who is a "qualified beneficiary." You and your Spouse and Dependents, if any, all could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event.

If you elect COBRA coverage, you will receive the same coverage as active employees who have coverage under the Plan. You will also have the same rights that active employees have, including open enrollment and special enrollment rights.

As an employee, you will have a qualifying event if:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than your gross misconduct.

Your Spouse will have a qualifying event if:

1. You die;
2. Your hours of employment are reduced;
3. Your employment ends for any reason other than gross misconduct;
4. You become enrolled in Medicare (Part A, Part B or both); or
5. The two of you become divorced or legally separated.

Your Dependent will have a qualifying event if:

1. You die;

2. Your hours of employment are reduced;
3. Your employment ends for any reason other than gross misconduct;
4. You become enrolled in Medicare (Part A, Part B or both);
5. You and your Spouse become divorced or legally separated; or
6. He or she stops being eligible for coverage under the Plan as a "Dependent".

Notifying the Plan Administrator of Qualifying Events

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been timely notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee or enrollment of the employee in Medicare (Part A, Part B or both), the Employer must notify the Plan Administrator of the qualifying event within 30 days after the event occurs.

When the qualifying event is divorce, legal separation or your child's loss of eligibility for coverage as a Dependent, you must notify the Plan Administrator in writing within 60 days after the qualifying event occurs. Failure to do so will result in a loss of eligibility for COBRA continuation coverage.

How to Provide Notice

Any notice that you provide regarding COBRA continuation coverage must be in writing. Notice of a qualifying event must include the name of the Plan, the name and address of the employee covered by the Plan, and the name and address of any qualified beneficiary. Your notice must also specify the qualifying event and the date it happened. If the qualifying event is divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation.

The Plan's form titled, "Notice of Qualifying Event", should be used to notify the Plan Administrator of a qualifying event. A copy of this form can be obtained from the Plan Administrator.

You must mail your notice to the Plan Administrator unless you are otherwise instructed by the Plan Administrator. If mailed, your notice must be postmarked no later than the last day of the 60-day notice period.

See the information below regarding how the occurrence of a second qualifying event may affect the length of COBRA continuation coverage that is available. Any notice that you provide of a second qualifying event must include the same type of information that was included in your notice of the first qualifying event. The Plan's form titled, "Notice of Second Qualifying Event", should be used to notify the Plan Administrator of a second qualifying event. A copy of this form can be obtained from the Plan Administrator. Your notice must be mailed within 60 days after the second qualifying event occurs.

See the information below regarding how a determination by the Social Security Administration that a qualified beneficiary is disabled may affect the length of COBRA continuation coverage that is available. Any notice of disability that you provide must include the name of the disabled qualified beneficiary, the date when the qualified beneficiary became disabled and the date the Social Security Administration made its determination that he or she is disabled. Your notice of disability must include a copy of the Social Security Administration's determination.

The Plan's form titled, "Notice of Disability Determination", should be used to notify the Plan Administrator of a disability determination. A copy of this form can be obtained from the Plan Administrator. Your notice must be mailed within 60 days after the Social Security Administration makes its determination and before the end of the first 18 months of COBRA continuation coverage.

Electing COBRA Coverage

Once the Plan Administrator receives timely notice that a qualifying event has occurred, COBRA coverage will be offered to each of the qualified beneficiaries. COBRA coverage will begin on the date that Plan coverage would otherwise have been lost.

Each qualified beneficiary has an independent right to elect COBRA coverage. For example, you and your Spouse may elect coverage separately. Also, you or your Spouse may elect coverage for your minor children.

A qualified beneficiary must elect coverage in writing within 60 days after it is offered, using the Plan's election form and following the procedures specified on the election form. Your election form must be provided to the Plan Administrator at the address indicated on the form. If you mail your form, it must be postmarked no later than the last day of the 60-day election period.

Even if you first reject COBRA coverage, you may change your mind and elect the coverage before the end of the 60-day election period.

Length of COBRA Coverage

When the qualifying event is your death, your enrollment in Medicare (Part A, Part B or both), your divorce or legal separation or your Dependent losing eligibility as a Dependent, COBRA coverage lasts for up to 36 months. When the qualifying event is the end of your employment or a reduction in your work hours and you became entitled to Medicare benefits less than 18 months before that qualifying event, COBRA coverage for other family members lasts until 36 months after the date of Medicare entitlement. Otherwise, when the qualifying event is the end of your employment or reduction in your work hours, COBRA coverage generally lasts for up to 18 months. There are three ways in which this 18-month period of COBRA coverage can be extended.

Second qualifying event extension of 18-month period of COBRA coverage

An 18-month extension of coverage will be available to other family members if a second qualifying event occurs during the first 18 months of their continuation coverage. The maximum amount of total COBRA coverage available when a second qualifying event occurs is 36 months. Such second qualifying events include your death, your divorce, your enrollment in Medicare or a child losing status as a Dependent.

If a second qualifying event occurs, you must notify the Plan Administrator in writing within 60 days to obtain the extension.

Medicare extension for Spouse and Dependents

If your employment ends or your work hours are reduced within 18 months after you become entitled to Medicare, the maximum coverage period for your Spouse and Dependents will end three years from the date you enrolled in Medicare.

Disability extension of 18-month period of COBRA coverage

An 11-month extension of coverage may be available if you or another family member receiving COBRA is disabled. For the extension to be available, the Social Security Administration ("SSA") must determine that the family member was disabled during the first 60 days of COBRA coverage, and you must notify the Plan Administrator of that fact in writing within 60 days after the SSA's determination and before the end of the first 18 months of continuation coverage. If the disability extension is available, it will apply to the COBRA coverage of all family members, not just the disabled family member.

You must notify the Plan Administrator within 30 days if the SSA determines that the family member has

stopped being disabled at any time before the extension coverage period ends. COBRA coverage for all qualified beneficiaries will terminate when this occurs. The plan reserves the right to retroactively cancel COBRA coverage and to require reimbursement of all benefits paid after the first day of the month that is more than 30 days after the SSA's determination that the qualified beneficiary is no longer disabled.

Termination of COBRA Coverage before the End of the Maximum Coverage Period

Your COBRA coverage may be terminated before the end of the maximum period if (1) you fail to make any premium on time; (2) you become covered under another group health plan; (3) you enroll in Medicare; or (4) the Employer ceases to provide any coverage under the Plan.

You must notify the Plan Administrator in writing within 30 days, if, after electing COBRA coverage, you or another family member becomes covered under another group health plan or enrolls in Medicare Part A or B. The Plan reserves the right to retroactively cancel COBRA coverage and to require reimbursement of all benefits paid after the date of commencement of other group health plan coverage or Medicare entitlement.

Cost of COBRA coverage

The amount that you may be required to pay may not exceed 102% of the cost to the Plan of providing your coverage (150% during any disability extension).

Payment for COBRA coverage-First payment

If you elect COBRA coverage, you do not have to send any payment with your election form. Your first payment will be due within 45 days after the date of your election (This is the date your election form is post-marked, if mailed). If you do not make your first payment for COBRA coverage within 45 days, you will lose all of your rights to COBRA coverage.

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated through the month before you make your first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact the Plan Administrator to confirm the correct amount of your first payment.

Payment for COBRA coverage- Periodic payments

After you make your first payment for COBRA coverage, you will be required to pay for each subsequent month of coverage. These payments are due on the first day of each month of coverage. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. The Plan will notify you of the payments due for these coverage periods. A notice is only a reminder to you to pay. It is not a bill. You must make your payment by the due date or within the grace period (discussed below) whether or not you receive a notice.

Grace periods for periodic payments

Although monthly payments are due on the dates shown above, you will be given a grace period of 30 days to make each payment. Your COBRA coverage will be provided for each coverage period so long as payment for that coverage period is made before the end of the grace period for that payment. However, if you make a monthly payment later than its due date but during its grace period, your coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If You Have Questions

If you have questions about your COBRA coverage, you should contact the Plan Administrator, or you may contact the nearest Regional or Employer Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and Employer EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

To protect your rights, you should notify the Plan Administrator if you change your address. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

MISCELLANEOUS

WHAT HAPPENS IF MY EXPENSES ARE ELIGIBLE FOR REIMBURSEMENT UNDER A CAFETERIA PLAN OF THE EMPLOYER?

If you have an expense that is an eligible expense under a cafeteria plan as well as under this Plan, the expense must be reimbursed by this Plan to the extent that you are eligible for reimbursement of expenses under this Plan.

CAN MY EMPLOYER TERMINATE OR CHANGE THE PLAN?

Although the Employer presently anticipates the Plan continuing indefinitely, it has the right to amend or terminate the Plan at any time.

WHAT OTHER RULES APPLY TO MY PARTICIPATION?

MATERNITY BENEFITS

Under federal law, group health plans (including this Plan) and health insurance issuers may not restrict benefits for any hospital length of stay in connection with childbirth for the mother and newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a caesarean section, or require that authorization be obtained from the plan or the insurance issuer for prescribing a length of stay not in excess of these periods.

YOUR ERISA RIGHTS

As a Participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

- a. 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.
- b. obtain, upon written request to the Plan 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.
- c. receive a summary of the 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.

COBRA Rights

d. continue your health care coverage for yourself, Spouse or dependents if there is a loss of coverage under the 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 plan on the rules governing your COBRA continuation coverage rights.

Prudent Action by Plan Fiduciaries

e. In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plan. These people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. 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.

Enforce Your Rights

f. If your claim for a 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.

g. 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 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 that 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 medical child support order, you may file suit in federal court. If it should happen that the 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.

Assistance with Your Questions

h. If you have any questions about the plan, you should contact the Plan administrator. If you have any questions about this statement or your rights under ERISA, 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.

THIS SUMMARY IS NOT MEANT TO INTERPRET, EXTEND OR CHANGE THE PLAN IN ANY WAY. IN CASE OF A CONFLICT BETWEEN THIS SUMMARY AND THE ACTUAL PROVISIONS OF THE PLAN, THE PROVISIONS OF THE PLAN WILL ALWAYS GOVERN YOUR RIGHTS AND BENEFITS.