

**CAPITAL HEALTH SYSTEM  
EMPLOYEE WELFARE BENEFIT PLAN**

**VISION PROGRAM**

**SUMMARY PLAN DESCRIPTION**

**January 1, 2015**

## **A. INTRODUCTION**

This document constitutes a Summary Plan Description (“SPD”) which summarizes and explains the important provisions of the Vision Program sponsored by Capital Health System as in effect January 1, 2015. This SPD also provides information regarding administration of the Program as well as certain rights you have under federal laws governing employee welfare benefit programs.

The Vision Program is one of the benefits provided under the Capital Health System Employee Welfare Benefit Plan (the “Plan”). The Plan (and the component Vision Program) is not a contract of employment and does not guarantee continued employment. The various benefits under the Plan, including this Vision Program, are provided at the sole discretion of Capital Health System (“CHS”). CHS makes no promises to continue Plan benefits in the future and rights to future benefits will never vest. CHS reserves the right to amend, modify or terminate the Plan or any of the benefits thereunder at any time.

Affiliates of CHS may adopt the Plan with respect to one or more benefits thereunder including the Vision Program. You may obtain a list of all employers participating in the Plan upon written request to the Plan Administrator. The list is also available for inspection in the Human Resources office of CHS.

## **B. ELIGIBILITY**

You may enroll for coverage under the Vision Program if you are budgeted to work 20 or more hours a week. You begin to participate on the first day of the month following one month of active employment.

You may also cover your dependents under the Vision Program. Dependents include your legal spouse, your civil union spouse and your children under age twenty-six (26). Children include your biological children, adopted children, stepchildren and foster children. Coverage may continue past age 25 for a disabled child who is unable to earn a living because of a mental or physical disability that began prior to age 26 and who depends mainly on you for support and maintenance.

## **C. ENROLLMENT**

You may enroll in the Vision Program during an annual open enrollment period or during an initial period at the time of your hire. You are responsible for paying the full premium cost for the coverage you elect. You may pay for this coverage on a pre-tax basis as described under the section herein entitled “The Pre-Tax Advantage.”

## **D. BENEFITS**

The Vision Program is provided through EyeMed Vision Care (“EyeMed”). The benefits are insured and underwritten by Combined Insurance Company of America.

The Vision Program provides coverage for routine vision exams, as well as eyeglasses and contact lenses. Your cost for vision services (e.g., copayments) depends on whether you use

in-network providers who have contracted with EyeMed or out-of-network providers. If you use an in-network provider, you pay a stated amount and the provider bills the insurer for the remainder. If you use an out-of-network provider, you pay the full amount and then submit a claim for reimbursement. Set forth below is a Summary of Vision Care Services with your in-network cost and the out-of-network reimbursement amount.

### Summary of Vision Care Services

	Your In-Network Cost	Your Out-of-Network Reimbursement
<b>Exam</b>	\$10 co-pay	Up to \$30
Dilation as necessary	\$0	
Refraction	\$0	
<b>Retinal Imaging</b>	Up to \$39	N/A
<b>Exam Options – Contact Lenses</b>		
Standard Fit and Follow-Up	Up to \$55	N/A
Premium Fit and Follow-Up	90% of retail price	N/A
<b>Frames</b>	\$0 copay, plus 80% of balance over \$150	Up to \$75
<b>Standard Plastic Lenses</b>		
Single Vision	\$25 copay	Up to \$25
Bifocal	\$25 copay	Up to \$40
Trifocal	\$25 copay	Up to \$55
Lenticular	\$25 copay	Up to \$55
Standard Progressive	\$80 copay	Up to \$40
Premium Progressive	\$100 - \$125	Up to \$40
Tier 1	\$100	
Tier 2	\$110	
Tier 3	\$125	
Tier 4	\$80 copay, 80% of charge less \$120 Allowance	
<b>Standard Lens Options</b>		
UV coating	\$15	N/A
Tint (solid and gradient)	\$15	N/A
Standard scratch resistance	\$15	N/A
Standard polycarbonate – Adults	\$40	N/A
Standard polycarbonate – Kids Under 19	\$0	Up to \$28
Standard anti-reflective coating	\$45	N/A
Premium anti-reflective coating	\$57-68	
Tier 1	\$57	
Tier 2	\$68	
Tier 3	80% of retail	
Polarized	80% of retail price	N/A
Photocromatic / Transitions Plastic –	\$75	N/A
Other add-ons and services	80% of retail price	N/A

<b>Contact Lenses*</b> Conventional	\$0 copay, plus 85% of balance over \$150	Up to \$120
Disposable	\$0 copay, plus 100% of balance over \$150	Up to \$120
Medically necessary	\$0 (paid in full by Plan)	Up to \$210
<b>LASIK or PRK from US Laser Network</b>	85% of retail price or 95% of promotional price Whichever is lesser	N/A
<b>Frequency - based on Calendar Year</b>		
Exam	Once every 12 months	Once every 12 months
Lenses or Contact Lenses	Once every 12 months	Once every 12 months
Frames	Once every 12 months	Once every 12 months

\* For prescription contact lenses for only one eye, the Plan will pay one-half of the amount payable for contact lenses for both eyes.

**NOTE:** Benefit and Frame allowances provide no remaining balance for future use within the same Benefit Frequency.

### Medically Necessary Contact Lenses

The Plan provides coverage for medically necessary contact lenses when one of the following conditions exists:

- **Anisometropia** of 3D in meridian powers
- **High Ametropia** exceeding –10D or +10D in meridian powers
- **Keratoconus** where the member’s vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses
- **Vision Improvement** for members whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses

The benefit may not be expanded for other eye conditions even if you or your providers deem contact lenses necessary for other eye conditions or visual improvement.

### Additional Discounts

Under the Plan, you may receive benefits for eyeglass frames, eyeglass lenses or contact lenses as outlined on the Summary of Vision Care Services. In addition, EyeMed provides an in-network discount on products and services once your in-network benefits for the applicable benefit period have been used. The in-network discounts are as follows:

- 40% off a complete pair of eyeglasses (including prescription sunglasses)
- 15% off conventional contact lenses
- 20% off items not covered by the Plan at network providers

These in-network discounts may not be combined with any other discounts or promotional offers. Discounts do not apply to EyeMed Provider's professional services, disposable contact lenses or certain brand name vision materials in which the manufacturer imposes a no-discount practice or policy.

Pursuant to Maryland and Texas law, discounts may not be available at all network providers. Prior to your appointment, you should confirm with your provider that discounts are offered.

### **Retinal Imaging Benefit**

Retinal imaging has been provided as an additional discount to your vision plan. Retinal imaging is a diagnostic tool that provides high-resolution, permanent digital records of your inner eye. Please consult with your Provider to determine if you are a candidate for retinal imaging.

### **Savings on Laser Vision Correction**

EyeMed Vision Care, in connection with the U.S. Laser Network, owned and operated by LCA Vision, offers discounts to you for LASIK and PRK. You receive a discount when using a network provider in the U.S. Laser Network. The U.S. Laser Network offers many locations nationwide. For additional information or to locate a network provider, visit [www.eyemedlasik.com](http://www.eyemedlasik.com) or call **1-877-5LASER6**.

After you have located a U.S. Laser Network provider, you should contact the provider, identify yourself as an EyeMed member and schedule a consultation to determine if you are a good candidate for laser vision correction. If you are a good candidate and schedule treatment, you must call the U.S. Laser Network again at **1-877-5LASER6** to activate the discount.

At the time treatment is scheduled, you will be responsible for an initial refundable deposit to the U.S. Laser Network. Upon receipt of the deposit, and prior to treatment, the U.S. Laser Network will issue an authorization number to your provider. Once you receive treatment, the deposit will be deducted from the total cost of the treatment. On the day of treatment, you must pay or arrange to pay the remaining balance of the fee. Should you decide against the treatment, the deposit will be refunded.

You are responsible for scheduling any required follow-up visits with the U.S. Laser network provider to ensure the best results from your laser vision correction procedure.

### **Mail Order Contact Lens Replacement Program**

You can save money by ordering replacement contact lenses at competitive prices through [www.eyemedcontacts.com](http://www.eyemedcontacts.com). The contacts will be delivered directly to your home. Your plan allowance and discounts do not apply to this service.

## **E. EXCLUSIONS**

No benefits will be paid for services or materials connected with or charges arising from:

1. orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
2. medical and/or surgical treatment of the eye, eyes or supporting structures;

3. Any vision examination, or any corrective eyewear required by the Company as a condition of employment, safety eyewear;
4. services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
5. plano (non-prescription) lenses;
6. non-prescription sunglasses;
7. two pair of glasses in lieu of bifocals;
8. services or materials provided by any other group benefit plan providing vision care;
9. services rendered after the date an insured person ceases to be covered under the vision program, except when vision materials ordered before coverage ended are delivered, and the services rendered to the insured person are within 31 days from the date of such order; and
10. lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when vision materials would next become available.

This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit the insurer from providing insurance, including, but not limited to, the payment of claims.

## **F. PROVIDERS**

As noted above, you may use either an in-network provider or an out-of-network provider.

### **Using In-Network Providers**

EyeMed's network of providers includes private practitioners, as well as the nation's premier retailers, LensCrafters®, Sears Optical, Target Optical, JCPenney Optical and most Pearle Vision locations. To locate EyeMed Vision Care providers near you, visit [www.eyemed.com](http://www.eyemed.com) and choose the Insight Network. You may also call EyeMed's Customer Care Center at 1-866-800-5457. EyeMed's Customer Care Center can be reached Monday through Saturday 7:30 am to 11:00 pm EST and Sunday 11:00 am to 8:00 EST.

When making an appointment with the provider of your choice, identify yourself as an EyeMed member and provide your name and the name of your organization or Plan number, located on the front of your ID card. Confirm the provider is an in-network provider for the Network. While your ID card is not necessary to receive services, it is helpful to present your EyeMed Vision Care ID card to identify your membership in the Plan.

When you receive services at a participating EyeMed Network Provider, the provider will file your claim. You will have to pay the cost of any services or eyewear that exceeds any

allowances, and any applicable co-payments. You will also owe state tax, if applicable, and the cost of non-covered expenses (for example, vision perception training).

### **Using Out-of-Network Providers**

If you receive services from an out-of-network Provider, you will pay for the full cost at the point of service. You will be reimbursed up to the maximums as outlined in the Summary of Vision Care Services. To receive your out-of-network reimbursement, complete and sign an out-of-network claim form, attach your itemized receipts and send to First American Administrators, Inc., (“FAA”), a wholly-owned subsidiary of EyeMed Vision Care:

FAA/EyeMed Vision Care, LLC.  
Attn: OON Claims  
P.O. Box 8504  
Mason, OH 45040-7111

For your convenience, a FAA/EyeMed out-of-network claim form is available at [www.eyemed.com](http://www.eyemed.com) or by calling EyeMed’s Customer Care Center at **1-866-800-5457**.

### **G. THE PRE-TAX ADVANTAGE**

As noted earlier, you may reduce your gross earnings by the amount you are required to pay each month for the vision coverage you elect. You will be taxed for federal income tax purposes (and in most states) only on the remaining amount of your gross earnings and not on the amounts used to pay for these benefits. The pre-tax contributions made for the benefits are not subject to Social Security taxes. Therefore, your Social Security benefits may be reduced if you elect these benefits, rather than taxable compensation. Generally, the reduction is a small one. However, the impact varies from case to case and cannot be predicted by CHS.

In return for this pre-tax advantage, the law provides that your election must be irrevocable for the year. You may make mid-year changes only in response to and consistent with certain events as described below. Any amounts not expended for benefits during the year will be forfeited.

You may change your election during the year **only if** you meet the circumstances set forth below. You are permitted to make election changes for certain “qualified status changes” provided you notify the Plan Administrator within **31 days** of the event and timely submit your election change form.

The events that constitute a “change in status” include the following:

- Events that change your legal marital status, including marriage, death of spouse, divorce, legal separation, and annulment.
- Events that change your number of dependents, including birth, death, adoption, and placement for adoption.

- Events that change your employment status or the employment status of your spouse or dependents that affect your eligibility for benefits, including a termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence or a change in work site.
- Events that cause your dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstances.
- A change in your place of residence, the place of residence of your spouse or dependent that affect eligibility for benefits under the plan.

*General Consistency Rules:* You may only make an election change pursuant to a change in status if your requested election change is consistent with that change in status. The Plan Administrator has sole discretion to determine whether a requested change is consistent with the change in status. Your election change will be consistent with the change in status only if the change is on account of and corresponds with a change in status *that affects eligibility for vision coverage under the Plan*. A change in status that affects eligibility includes a change in status that results in an increase or decrease in the number of an employee's family members or dependents who may benefit from vision coverage under the Plan.

*Please note, it is possible to experience a "change in status" event, but not have the change affect eligibility for vision coverage under the Plan. In such case, you will not be able to make a change in your elections.*

In addition, if there is a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody, including a Qualified Medical Child Support Order, *see* Section L, that requires a change in accident or health coverage for your child who qualifies as your dependent, you or the Plan Administrator may make an election change to add or drop coverage consistent with the terms and scope of the order.

## **H. CESSATION OF PARTICIPATION**

Your participation in the Vision Program will end on the last day of the month in which your employment terminates or, if earlier, on the first day of the month for which you fail to make any required contributions. Coverage of a dependent ends when he or she ceases to be an eligible dependent, when your coverage ends or when required contributions are not paid. All coverage ends if CHS cancels the Vision Program or terminates the Plan.

You may, however, have the right in certain instances to choose COBRA continuation coverage as described below.

## **I. YOUR RIGHTS UNDER COBRA**

You have a right to choose continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA") for yourself and your covered family members if you lose vision coverage under the Plan because of a reduction in your hours of employment



or the termination of your employment (for reasons other than gross misconduct on your part). (A child who is born to or placed for adoption with a participant during a period of COBRA coverage is also considered a covered family member.)

If you are the spouse of an employee covered by this Plan, you have the right to choose COBRA continuation coverage for yourself and your covered family members if you lose vision coverage under the Plan for any of the following four reasons, known as “qualifying events”:

- the death of your spouse;
- a termination of your spouse’s employment (for reasons other than gross misconduct) or reduction in your spouse’s hours of employment;
- divorce or legal separation from your spouse; or
- entitlement of your spouse to Medicare.

A “dependent child” covered by this Plan has the right to continue coverage under COBRA if vision coverage under the Plan ends because of any of the following five qualifying events:

- death of a parent who is employed by CHS;
- termination of a parent’s employment (for reasons other than gross misconduct) or reduction in a parent’s hours of employment with the Employer;
- divorce or legal separation of a parent employed by CHS;
- entitlement to benefits under Medicare of a parent employed by CHS; or
- ineligibility for vision coverage as a dependent child under this Plan.

Please note that an event is a qualifying event only if it results in loss of coverage. You or a family member or legal representative must inform the Plan Administrator within 60 days of the date of a divorce, legal separation, or loss of a dependent child status. If the Plan Administrator is not notified within 60 days, you will lose the right to continue coverage.

When the Plan Administrator is notified on a timely basis that a qualifying event has occurred, you will be notified that you have the right to choose COBRA continuation coverage. You have 60 days from the later of the date you are notified about COBRA or the date of loss of your coverage to inform the Plan Administrator that you want to continue your coverage. If you do not choose COBRA continuation coverage, your group vision coverage under this Plan will END.

Generally, if you choose to continue your coverage, you may be charged up to 102 percent of the full cost to the Plan for your coverage. You will be required to pay your first premium payment within 45 days from the date you choose to continue your coverage. If you lose vision coverage under the Plan due to a reduction in the hours of the participant’s employment or the termination of the participant’s employment, you may continue your coverage for 18 months. However, the 18-month coverage period for covered spouses and dependent children may be extended to 36 months if another qualifying event (death, divorce or

legal separation, Medicare entitlement, or ineligibility for dependent coverage) occurs during the initial 18-month period. For all other qualifying events, you may continue your coverage for 36 months. You or a family member or legal representative must inform the Plan Administrator if you believe that you, your covered spouse or covered dependent are entitled to extend the period of your continuation coverage.

*COBRA Extension for Disabled Individuals:* If you are eligible for 18 months of COBRA continuation coverage, coverage may be extended for up to an additional 11 months if you are (or a covered family member is) determined to be disabled under the rules for Social Security benefits on or within 60 days of the date of your termination of employment or reduction in hours of employment. You may be charged up to 150 percent of the cost of the coverage for the 19th through the 29th month of coverage. To extend coverage, you must notify the Plan Administrator of a determination of disability within 60 days after the date the determination is made and before the end of the first 18 months of COBRA coverage.

Your COBRA continuation coverage may end earlier for any of the following reasons:

- CHS no longer provides group health benefits coverage to any of its employees;
- the premium for your continuation coverage is not timely paid;
- you become covered under another group health plan that does not contain any exclusion or limitation with respect to a pre-existing condition that you have and that would apply to deny you coverage;
- you become entitled to Medicare; or
- coverage is extended for up to 29 months due to a disability and there has been a final determination that the disabled individual is no longer disabled. (You must notify the Plan Administrator within 30 days of the date of any final determination that disability has ended.)

## **J. CLAIMS & CLAIMS APPEALS**

### **Time Frames for Processing Claims**

First American Administrators, Inc., a third-party administrator and wholly owned subsidiary of EyeMed (“hereinafter “FAA”) will decide claims within the time permitted by applicable state law, but generally no longer than 30 days after receipt. If FAA needs additional time to decide a claim, it will send you a written notice of the extension, which will not exceed 15 days. If FAA needs additional information from you in order to decide the claim, FAA will send you a written notice explaining the information needed. You will have 45 days to provide the information to FAA. If your claim is denied, in whole or in part, FAA will inform you of the denial in writing.

### **Time Frames for Appealing Claims**

If your claim is denied, in whole or in part, you may appeal. The appeal must be in writing and received by FAA within 180 days of your notice of the denial. If you do not receive

an EOB within 30 days of submission of your claim, you may submit an appeal within 180 days after this 30-day period has expired. Your appeal will be decided within 60 days after receipt. Your written letter of appeal should include the following:

- The applicable claim number or a copy of the FAA denial information or Explanation of Benefits, if applicable.
- The item of your vision coverage that the member feels was misinterpreted or inaccurately applied.
- Additional information from the member's eye care provider that will assist FAA in completing its review of the member's appeal, such as documents, records, questions or comments.

You may authorize someone else to file and pursue a complaint or appeal on your behalf. If you do so, you must notify FAA/EyeMed Vision Care in writing of your choice of an authorized representative. Your notice must include the representative's name, address, phone number, and a statement indicating the extent to which he or she is authorized to pursue the complaint and/or appeal on your behalf. A consent form that you may use for this purpose will be provided to you upon request

The appeal should be mailed or faxed to the following address:

FAA/EyeMed Vision Care, LLC  
Attn: Quality Assurance Dept.  
4000 Luxottica Place  
Mason, OH 45040  
Fax: 1-513-492-3259

FAA/EyeMed will review your appeal for benefits and notify you in writing of its decision. You must exhaust this claims and appeals procedure before filing a civil action under section 502(a)(1)(B) of ERISA.

### **Complaint Procedure**

If you are dissatisfied with an EyeMed Provider's quality of care, services, materials or facility or with EyeMed's Plan administration, you should first call EyeMed Customer Care Center at **1-866-800-5457** to request resolution. The EyeMed Customer Care Center will make every effort to resolve your matter informally.

If you are not satisfied with the resolution from the Customer Care Center service representative, you may file a formal complaint with EyeMed's Quality Assurance Department at the address noted above. You may also include written comments or supporting documentation.

The EyeMed Quality Assurance Department will resolve your complaint within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after EyeMed's receipt of your complaint. Upon final resolution, EyeMed will notify you in writing of its decision.

**K. QUALIFIED MEDICAL CHILD SUPPORT ORDERS (“QMCSOs”)**

The plan is required to provide health benefits in accordance with the applicable provisions of any “qualified medical child support order” (“QMCSO”) as required under ERISA. In general, the term qualified medical child support order means a “medical child support order” which requires the plan to provide a child of a participant with health coverage under the plan where the child would not otherwise be covered; for example, if the child would lose coverage as a result of a parent’s divorce. A medical child support order is a judgment, decree, or other (including approval of a settlement agreement) issued by a court of competent jurisdiction. It also includes a National Medical Support Notice that meets the requirements of the regulations of the Department of Labor set forth at 29 CFR §2590.609-2. Under a QMCSO, the plan can be ordered to enroll the child in any available health care expense coverage option and deduct the applicable cost from the participant’s wages. Accordingly, the Plan Administrator has the right to make any necessary changes to the participant’s medical coverage elections in order to provide the child(ren) with the coverage required by the QMCSO, and to authorize on the participant’s behalf the payment of any additional premium costs from the participant’s wages. The Plan Administrator has established procedures for qualifying medical support orders. Participants and beneficiaries may obtain, without charge, a copy of the plan’s QMCSO procedures from the Plan Administrator.

**L. BASIC FACTS**

<i>Plan Name:</i>	Capital Health System Employee Welfare Benefit Plan. The Vision Program is included as a benefit under this Plan.
<i>Plan Number:</i>	510
<i>Plan Year:</i>	January 1 – December 31
<i>Plan Sponsor/Employer:</i>	Capital Health System 750 Brunswick Avenue Trenton, NJ 08638 (609) 394-6000
<i>Sponsor’s Employer Identification Number:</i>	22-3548695
<i>Plan Administrator:</i>	Vice President Human Resources Capital Health System 2997 Princeton Pike Lawrenceville, NJ 08648
<i>Service of Legal Process:</i>	General Counsel Capital Health System 750 Brunswick Avenue Trenton, NJ 08638

<b><i>Plan Type:</i></b>	The Plan is an employee welfare benefit plan established under section 3(1) of the Employee Retirement Security Act of 1974, as amended (“ERISA”) and the Department of Labor Regulations thereunder.
<b><i>Plan Funding:</i></b>	The vision benefits offered under the Plan are provided through insurance. Certain discounts are provided by EyeMed.
<b><i>Type of Administration:</i></b>	The vision benefits are paid by the insurer and are administered by EyeMed and the insurer.

## **M. ERISA STATEMENT**

As a participant in the Capital Health System Employee Welfare Benefit Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants are entitled to:

### **Receive Information About Your Plan and Benefits**

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, all documents governing the plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) that is 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 all documents governing the operation of the plan, including insurance contracts and the latest annual report (Form 5500 Series), and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Receive a copy of the procedures used by the plan for determining a qualified medical child support order (QMCSO).

### **Continue Group Health Plan Coverage**

- Continue health care coverage for yourself, spouse and/or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and 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.

- Reduction or elimination of exclusionary periods of coverage for pre-existing 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.

### **Prudent Action by Plan Fiduciaries**

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The 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 welfare benefit or exercising your rights under ERISA.

### **Enforce Your Rights**

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain 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 materials 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 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 status of a medical child support order, you may file suit in a 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.

### **Information and Answers**

If you have any questions about your 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 with 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
- 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.