City of Vancouver
Kaiser Permanente HMO Plan
Summary Plan Description Supplement

This is an important notice concerning your benefits under the City of Vancouver's **Kaiser Permanente HMO Plan** (the "Plan"). This Summary Plan Description Supplement contains important information regarding the Plan and should be kept with your other Plan materials. If this Summary Plan Description Supplement contains information that conflicts with other materials you have received regarding the Plan, the terms of this Summary Plan Description Supplement will control. The other plan materials that, together with this Summary Plan Description Supplement, constitute the Plan's Summary Plan Description, are: Kaiser Permanente Certificates entitled *Washington Medical A Guide to Your Kaiser Permanente Medical Benefits*; Benefit Summaries; a statement of Kaiser Permanente's policy for protecting the confidentiality of health information; a statement of the cost of premiums to the group; a medical directory that includes a list of primary care and specialty care providers, medical offices and plan hospitals and information on Kaiser Permanente care, procedures requiring prior authorization and how to learn the qualifications of Kaiser Permanente providers; an explanation about Kaiser Permanente mental health services, titled *Q & A About Kaiser Permanente Mental Health Services*; a description of *Member and Patient Rights and Responsibilities* and any other materials referred to in the service agreement under which the group is covered. All such information or materials will be provided automatically or upon request, free of charge.

Plan Name: City of Vancouver Kaiser Permanente HMO Plan.

Plan Sponsor:

City of Vancouver
P.O. Box 1995
Vancouver, Washington 98668-1995
Telephone number: 360-619-1017

Employer Identification Number: 93-6001288.

Agent for Legal Process: The plan sponsor named above.

Type of Plan: Group Health Plan.

Plan Year: The Plan's fiscal year is the 12-month period from January 1 to December 31.

Plan Administrator:

City of Vancouver
P.O. Box 1995
Vancouver, Washington 98668-1995

Funding Medium and Type of Plan Administration: This plan is fully insured. Benefits are provided under a group insurance contract entered into between The City of Vancouver and Kaiser Permanente. Claims for benefits are sent to Kaiser Permanente. Kaiser Permanente, not The City of Vancouver, is responsible for paying claims.

Collective Bargaining Agreements: There are Collective Bargaining Agreements affecting this Plan. Those Collective Bargaining Agreements are available for examination, and copies may be obtained by written request to the plan administrator.

Eligibility: The rules on eligibility are stated in the other written plan materials, which are considered to be part of this disclosure.

Description of Benefits: The benefits provided are described in the other written plan materials, which are considered to be part of this disclosure.

Cessation of Benefits: The circumstances which can lead to disqualification, ineligibility, or denial, loss, forfeiture or suspension of benefits are described in the other written materials, which are considered to be part of this disclosure.

Contributions: The source of contributions will be employer and employee contributions as calculated by the employer.

COBRA CONTINUATION RIGHTS

A federal law, commonly known as "COBRA," requires that employees and members of their families have the opportunity to obtain extended health coverage (called "continuation coverage") under the Plan at group rates in certain instances when a loss of coverage otherwise would occur. Group health plan coverage includes medical, dental, vision, prescription drug and other coverage providing medical benefits. There is no continuation right under COBRA for life insurance, disability coverage, or any other non-health benefit. The continuation rights described in this section apply only to the following benefits under the Plan: Medical and prescription drug benefits.

All of the health coverage provided under the Plan is considered provided by a single plan, even if provided by different carriers or under different funding arrangements. In this section, the word "Plan" refers only to health coverage provided under the Plan and the word "participant" refers to any employee or former employee who is covered under the Plan because of his or her employment or because he or she has elected and maintained COBRA coverage.

The Plan provides no rights to continue coverage beyond what is required by applicable law. Nothing in this section or elsewhere in any Plan materials should be read as providing for any greater right to continue coverage under the Plan than that required by law.

When Does Continuation Coverage Become Available?

Participant

If you are a participant in the Plan, you will have the right to choose continuation coverage under the Plan if one of the following events occurs and, under the terms of the Plan, the event would cause loss of your coverage under the Plan:

(1) Your hours of employment with The City of Vancouver are reduced.

(2) Your employment with The City of Vancouver is terminated for reasons other than gross misconduct on your part.

Participant's Spouse

If you are covered by the Plan as the spouse of a participant, you will have the right to choose continuation coverage under the Plan if one of the following events occurs and, under the terms of the Plan, the event would cause loss of your coverage under the Plan:

(1) Your spouse dies.

(2) Your spouse's employment with The City of Vancouver terminates (for reasons other than his or her gross misconduct) or your spouse's hours of employment with The City of Vancouver are reduced.

(3) You are divorced or legally separated from your spouse.

Participant's Dependent Child

If you are covered by the Plan as a dependent child of a participant, you will have the right to choose continuation coverage under the Plan if you lose coverage under the Plan for any of the following reasons:

(1) Your parent who is the participant dies.

(2) Your parent who is the participant is terminated (for reasons other than his or her gross misconduct) or such parent's hours of employment with The City of Vancouver are reduced.

(3) Your parents divorce or obtain a legal separation.

(4) You cease to be a "dependent child" eligible for coverage under the Plan.

Loss or Reduction in Anticipation of a Qualifying Event

Because continuation coverage rights apply only if one of the events listed above will cause a coverage loss, individuals who do not have coverage under the Plan on the day before one of those events occurs generally have no rights to continuation coverage under the Plan. If, however, an individual's coverage under the Plan is eliminated or reduced in anticipation that one of those events would occur, that individual may have continuation coverage rights even if not covered under the Plan on the day before such an event.

This may occur, for example, if a participant drops a dependent's coverage in anticipation of a divorce or legal separation. In that case, if the Plan Administrator was properly notified of the later divorce or legal separation, the dependent whose coverage was dropped may be entitled to obtain continuation coverage starting on the date of the divorce or legal separation. If you believe that this rule might apply to you, it is important to alert the Plan Administrator promptly. If you fail to alert the Plan Administrator that certain qualifying events have occurred, you will lose any right you would otherwise have to continuation coverage under the Plan. Once appropriately notified, the Plan Administrator will make a determination of whether coverage was lost due to anticipation of a qualifying event taking into account the specific facts and circumstances of the loss of coverage situation.

No Coverage In Effect Due to Violation of Law

Federal regulations provide for COBRA rights if coverage was terminated or withheld in violation of applicable law and that is the reason coverage is not in effect under the Plan on the day before one of the listed events. The Plan makes every effort to comply with all applicable laws, and it is doubtful you would ever have any reason to believe that coverage had been terminated or withheld in violation of law. Nonetheless, if you believe that this rule might apply to you, it is important to alert the plan administrator so that a determination can be made and continuation coverage offered if appropriate.

Who Has the Responsibility of Providing Notice of Various COBRA Events?

Under COBRA, the participant or a family member must inform The City of Vancouver of a divorce, legal separation, or a child losing dependent status under the Plan. The notice must be given within 60 days after the later of the event or the date the Plan says coverage will end because of the event. If notice is not provided within that 60-day period, continuation coverage will not be available as a result of that event. Also, any claims paid by the Plan after the date coverage should have ended must be refunded to the Plan. The City of Vancouver has the responsibility to notify Kaiser Permanente of the employee's death, termination of employment or reduction in hours.

When The City of Vancouver (i) is notified of a divorce, legal separation, or loss of dependent status, or (ii) determines that a participant has died, terminated employment, or had a reduction in hours, The City of Vancouver will in turn determine whether you will suffer a loss of coverage because of the event. If so, you will be notified of your continuation coverage rights, but only to the extent that The City of Vancouver has been notified in writing of the correct mailing address.

Electing COBRA Coverage

In the remainder of this section, the word "you" refers to an individual who has an independent right to elect COBRA coverage, as described above.

You do not have to show that you are insurable to choose continuation coverage, and you can elect continuation coverage even if you are covered by another group health plan or Medicare prior to the election date.

As directed in the notice regarding continuation coverage rights, you must notify The City of Vancouver in writing if you want continuation coverage. You may elect COBRA coverage under the Plan for all family members having COBRA rights, and any such family member or a legally authorized third party may elect COBRA coverage on your behalf. You and each other family member who has COBRA rights also has an independent right to elect continuation coverage under the Plan even if other family members do not obtain COBRA coverage. The election must be made on the proper form, as specified in the notice of COBRA coverage rights, within 60 days of the later of the date of The City of Vancouver's notice or the date the Plan says you would lose coverage because of one of the events described above. The postmark date on the envelope in which the election with respect to your coverage is sent will be deemed the date of your election.

If your COBRA coverage election is not made during the applicable election period, your group health insurance coverage will end as of the date determined by Plan terms, and you will have no right to obtain COBRA coverage. Likewise, in order for COBRA coverage under the Plan to become effective, payment for COBRA coverage from the date on which the Plan says your coverage should have ended must be brought current within 45 days after your election date. The postmark date on the envelope in which payment for your coverage is sent is deemed the date of your payment. If required payments are made during this 45-day period, COBRA coverage will be effective retroactive to the date coverage under the Plan ended. Thereafter, COBRA coverage will only remain in effect so long as timely payments for that coverage continue.

What Type of Coverage Can Be Elected?

If COBRA coverage is elected and paid for, it will be identical to the coverage provided under the Plan to similarly-situated participants or family members, as of the time coverage is being provided. This means that if the coverage for similarly-situated participants or family members is modified, your COBRA coverage will be modified in the same manner.

If your COBRA coverage under the Plan is associated with a service area (as with HMO coverage, for instance) and you move out of the service area, you may have an opportunity to elect other coverage. If you notify The City of Vancouver of the change, you will have an opportunity to enroll in any other coverage option(s) that The City of Vancouver makes available to its employees that can provide coverage in the new location.

Once your COBRA coverage becomes effective, you will have the same rights to enroll dependents and change elections with respect to the Plan as applies to similarly-situated active employees. Except in the case of a participant's new child, as described below, however, no dependents added to continuation coverage will have any independent rights to continuation coverage, and their coverage will end at the same time as that of the individual who enrolled them.

Notices You Must Give While Continuation Coverage is in Effect

A child born to, adopted by, or placed for adoption with, a participant during a period of continuation coverage may be eligible for coverage as a qualified beneficiary to the same extent as other family members having COBRA rights. You or another family member must notify The City of Vancouver within 90 days of a child's birth to, adoption by, or placement for adoption with, the participant during a period of continuation coverage. Coverage for the new child may be elected (and the child's independent right to COBRA coverage preserved) only if the City of Vancouver is notified of the child's birth, adoption or placement within 90 days.

Additionally, as detailed below, the maximum period of continuation coverage may be extended in some situations, but the participant or a family member usually must notify the Plan Administrator in order for such an extension to apply. If a qualified beneficiary qualifies for the disability extension described in the next section, the participant or a family member also must notify the Plan Administrator within 30 days after the date that it is determined that such person is no longer disabled. Your notice will be considered "sent" on the day it is mailed as evidenced by the postmark that appears on the envelope.

How Long Does Continuation Coverage Last?

If continuation coverage is not elected for you, your group health coverage under the Plan will end in accordance with Plan terms. Until you elect continuation coverage, your coverage under the Plan will be terminated, subject to retroactive reinstatement following receipt of your election and timely payment.

Your continuation coverage period generally will be 36 months from the date of the event triggering the right to continuation coverage. If the triggering event was a participant's

termination of employment or reduction in hours of employment, however, the continuation coverage period generally is 18 months.

This 18-month coverage period will be extended in three situations.

1. Family members of a participant who became entitled to Medicare during the 18 months before the participant terminated employment or reduced hours will have a maximum continuation period that ends 36 months after the date of the participant's Medicare entitlement.
2. The 18-month maximum period of COBRA coverage may be extended to 29 months if the Social Security Administration determines that you (or a family member who is entitled to COBRA coverage because of the same event) were disabled at any time during the first 60 days of COBRA coverage. For this extension to be available, you or a family member must notify the Plan Administrator within 60 days of the date of the Social Security Administration determination and within the 18-month period.
3. The maximum continuation period is extended from 18 or 29 months to three years if, while COBRA coverage is in effect, one of several events occurs. The events that can result in this extension for family members who are entitled to COBRA coverage are: the participant's death, divorce, legal separation or Medicare entitlement. For a dependent child entitled to and receiving COBRA coverage, ceasing to meet dependent eligibility requirements under the Plan will result in this extension.

In no case will the total COBRA coverage period be more than 36 months, and in no case will the total COBRA coverage period for a participant be more than 18 months (29 months in the case of disability, as provided above). For a child born to, adopted by, or placed for adoption with, a participant during continuation coverage, these periods are measured from the date of the event that triggered the continuation coverage in effect at the time of birth, adoption, or placement. In no event is the coverage period for such a child based on the date of birth, adoption, or placement.

Are There Any Circumstances In Which COBRA Coverage May Be Cut Short?

Your continuation coverage may be cut short for *any* of the following reasons:

(1) After electing COBRA, you first become covered under any other group health plan (as an employee or otherwise) that does not contain any exclusion or limitation for any preexisting condition that applies to you (taking into account prior creditable coverage when required by federal law).

(2) After electing COBRA, you first become entitled to Medicare benefits.

(3) The premium for your continuation coverage is not paid within 30 days of the due date.

(4) Neither The City of Vancouver (nor any of its affiliates) provides any group health coverage to any employee.

(5) You became entitled to a 29-month maximum coverage period due to your own or a family member's disability, and there has been a final Social Security Administration determination that the disabled individual has ceased to be disabled.

(6) Occurrence of any event that permits termination of coverage under the Plan for an individual covered other than pursuant to COBRA (submitting fraudulent claims, for example).

How Much Does COBRA Continuation Coverage Cost?

In general, you must pay 102 percent of the Plan premium in order to obtain and continue COBRA coverage. If the maximum COBRA coverage period is extended from 18 months to 29 months due to an individual's disability, the required payment for the family coverage unit that includes the disabled individual is 150 percent of the premium for the 19th and succeeding months. Special rules apply in some situations so that the higher premium does not apply during the disability extension. Please contact the plan administrator if you have questions concerning this premium, at the telephone number or address noted above.

What Happens When Continuation Coverage Ends?

If you continue coverage for the full 18-month, 29-month, or three-year maximum continuation coverage period, you must be given the option of enrollment under a conversion health plan otherwise generally available under the Plan. You will receive notice of this option during the 180 days before the end of your maximum continuation coverage period.

SPECIAL RULES ON FMLA LEAVES OF ABSENCE

The City of Vancouver is subject to the Family and Medical Leave Act of 1993 (FMLA), and, when allowing leaves protected under the FMLA, The City of Vancouver allows participants to continue group health plan coverage at regular contribution levels while on the leave. Beginning an FMLA leave is *not* an event which qualifies you for continuation coverage (beginning a non-FMLA leave may be a COBRA qualifying event, however). If one of the events listed earlier in this section occurs during an FMLA leave, however, and, under the terms of the Plan, it normally would result in loss of coverage, then the normal rules described above concerning COBRA coverage would apply. In addition, if a participant who takes an FMLA leave does not return at the end of that leave, the last day of that leave may be treated as a reduction in hours for purposes of determining whether continuation coverage rights apply.

SPECIAL RULES ON HEALTH FLEXIBLE SPENDING ACCOUNTS

If you are enrolled in the health flexible spending account and experience a COBRA qualifying event, you cannot elect continuation coverage under the Health FSA unless, as of the day before your COBRA qualifying event, the participant's contributions to the Health FSA for the year exceed claims for the year. In addition, any COBRA coverage under the Health FSA will extend only until the end of the plan year in which the event occurred, and will not be subject to extension under any circumstances.

SPECIAL RULES CONCERNING RETIREES' COVERAGE

For those receiving coverage from The City of Vancouver as a retiree or the dependent of a retiree, The City of Vancouver's filing for Chapter 11 reorganization can create COBRA rights if it causes a loss of coverage. Different maximum coverage periods and conditions for coverage than those described in this section would apply to retirees and their dependents obtaining continuation coverage in that event.

WHO TO CONTACT WITH QUESTIONS ABOUT CONTINUATION COVERAGE

If you have any questions about COBRA, please contact The City of Vancouver Human Resources Department at 360-619-1017. If your marital status changes, a child loses dependent status, you or a family member changes address, or other changes occur, please notify the Human Resources Department at the address shown above. It is particularly important that you inform The City of Vancouver at the address shown above of a divorce, legal separation, or dependent child losing eligibility because notice of these events is necessary to protect any rights to continuation coverage. A form is available from the Human Resources Department for you to use to provide these notices

CLAIMS PROCEDURE

Information and guidance regarding claims, complaints, grievances and appeals procedures is provided in the other written plan materials which are considered to be part of this disclosure. The procedures governing claims for benefits include:

- Procedures for obtaining preauthorizations, approvals, or utilization review decisions in the case of group health plan services or benefits; filing claim forms; notifications of benefit determinations; and review of denied claims in the case of any plan; and
- Applicable time limits and remedies available under the plan for the redress of claims which are denied in whole or in part.

FOREIGN LANGUAGE SATEMENT

This Summary Plan Description Supplement and the other written plan materials contain a summary in English of your plan rights and benefits under the Kaiser Permanente HMO Plan. If you have difficulty understanding any part of this Summary Plan Description Supplement, the insurer's certificate, or other Plan materials, you may call the Plan Administrator's office at 360-619-1017 for assistance.

MATERNITY OR NEWBORN COVERAGE

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

SPECIAL RIGHTS FOLLOWING MASTECTOMY

A group health plan generally must, under federal law, make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of mastectomy.

Our Plan complies with these requirements. Benefits for these items generally are comparable to those provided under our Plan for similar types of medical services and supplies. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by consultation between the attending physician and the patient. Our Plan neither imposes penalties (for example, reducing or limiting reimbursements) nor provides incentives to induce attending providers to provide care inconsistent with these requirements.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

This plan will cover individuals deemed to be alternative recipients under a qualified medical child support order (QMCSO). A QMCSO is a court judgment, decree or order, or a state administrative order that the force and effect of law, that is typically issued as part of a divorce or as part of a state child support order processing, and that requires health plan coverage for an alternative recipient. An alternative recipient is a child of a participant who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. The effective date for a child added to the plan under a QMCSO is the date specified in the court order, or, if none, the date of the court order. The plan has detailed procedures for determining whether an order qualifies as a QMCSO. You may obtain a copy of such procedures from the Plan Sponsor/Administrator without charge.

HIPAA SPECIAL ENROLLMENT RIGHTS

(This section does not affect life insurance, disability coverage, or any other non-health benefit.) If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in our plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth adoption, or placement for adoption.

You and Your Dependents Can No Longer be Excluded Due to Health Status

No plan Discrimination: A plan that is subject to HIPAA cannot discriminate on the basis of health factors. A plan cannot impose evidence of insurability or underwriting requirements, or otherwise determine eligibility for health coverage on the basis of an individual's health status. The law prohibits discrimination among similarly situated plan participants and their dependents (including late enrollees) based on health status or health claims experience.

This statement describes general plan rules. In the event of a conflict, the provisions of the formal plan document will control.

RIGHT OF SUBROGATION

This information is described in the other written plan materials, which are considered to be part of this disclosure.

DISCRETIONARY AUTHORITY

The Plan Administrator has discretion to allocate and delegate its responsibilities under the Plan, and to designate other persons to carry out any of its responsibilities under the Plan. These delegations may include, for example, delegating claims administration duties to an insurer or claims administrator. The Plan Administrator (and any person to whom the Plan Administrator has allocated or delegated its responsibilities under the Plan, acting within the scope of that allocation or delegation) shall perform its duties in its sole discretion and shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator (and any person to whom the Plan Administrator has allocated or delegated its responsibilities under the Plan, acting within the scope of that allocation or delegation) shall have full discretion to interpret Plan provisions, and to make determinations (including factual determinations) in carrying out Plan provisions, which interpretations and determinations shall be made by the Plan Administrator in its sole discretion. Any construction of the terms of the Plan, and any determination that is adopted by the Plan Administrator (or any person to whom the Plan Administrator has allocated or delegated its responsibilities under the Plan, acting within the scope of that allocation or delegation) and for which there is a rational basis shall be final and legally binding on all parties.

Any interpretation of the Plan or other action of the Plan Administrator (and any person to whom the Plan Administrator has allocated or delegated its responsibilities under the Plan, acting within the scope of that allocation or delegation) shall be subject to review only if such interpretation or other action is without rational basis. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review and shall be entitled to the maximum deference permitted by law.

ERISA RIGHTS

As a participant in the Kaiser Permanente HMO Plan 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

Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and Collective Bargaining Agreements.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements. The 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.

Continue Group Health Plan Coverage: Continue 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 Supplement and the documents governing the Plan concerning the rules governing your COBRA continuation coverage rights.

Reduction or Elimination of Exclusionary Periods of Coverage for Preexisting Conditions Under Your Group Health Plan, if Any, 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, and 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 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, your union, 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 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 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 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.

ASSISTANCE WITH YOUR QUESTIONS

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 in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.