Gwinnett County Public Schools
Direct Reimbursement Plan
Dental Benefits

Summary Plan Description

Rev - 7/04
This is the official Summary Plan Description for the Gwinnett County Public Schools Direct Reimbursement Plan (the "Plan"). The Plan is a self-funded benefit plan that reimburses eligible employees and their eligible dependents or their provider for covered expenses. The Plan is available to the employees of Gwinnett County Public Schools (the "Company"), and its affiliates that participate in the Plan ("Participating Companies"). It does not involve an insurance company. Gwinnett County Public Schools is the Plan’s Administrator and Direct Reimbursement Benefit Plans is the Plan’s Claims Administrator.

If you elect to participate in the Plan, your pay will be reduced on a pre-tax basis (unless you state in writing to the Plan Administrator that you want your reduction to be on an after-tax basis) by the amount required to pay for the type of coverage you elected. You may elect to cover only yourself or you may elect to cover yourself and all of your dependents. As you incur expenses, you may submit claims for reimbursement or assign payment directly to your provider for these expenses. If your expenses are eligible for reimbursement under the terms of the Plan, you or your provider will receive a check for all or a portion of the reimbursable expenses (as payable under the Plan).

This Summary Plan Description will explain in more detail how the Plan works. However, if you have any questions concerning your benefits, ask your local Human Resources representative. Other people (like your co-workers, your supervisor or even your dentist) are not authorized to answer your questions about the Plan.

Gwinnett County Public Schools reserves the right to amend or terminate this Plan at any time. Nothing in this Summary Plan Description is intended to provide vested or nonchangeable benefits. Gwinnett County Public Schools can also change the benefits or contributions under the Plan or any other aspect of the Plan at any time and for any reason. The changes will apply to all covered persons, unless otherwise specified by Gwinnett County Public Schools. Generally, these amendments will not apply to expenses incurred prior to the date of enactment of the amendments.
Who Is Eligible?

All employees who have met the required waiting period and their eligible dependents may participate in the Plan. You are a full time employee if you routinely work at least 20 hours per week. Eligible dependents include your spouse and unmarried children under 19 years of age. Unmarried children between the ages of 19 and 26 may be included if they are full-time students. It is the employee's responsibility to provide proof of full-time student status.

An unmarried child with a mental or physical handicap or developmental disability, who can’t support himself/herself may stay eligible for dependent coverage beyond the Plan’s age limit if: (a) the condition started before he/she reached this Plan’s age limit; (b) he/she became covered by this Plan before he/she reached the age limit and stayed continuously covered until he/she reached such limit; and (c) he/she depends on you for most of his/her support and maintenance. To do this, it is the employee’s responsibility to send written proof that the child is handicapped and depends on you for most of his/her support and maintenance within 31 days from the date the child reaches the age limit. The employee may be asked for periodic proof that the child’s condition continues. The child’s coverage ends when yours does.

You can elect individual coverage (which only covers you), or you can elect family coverage (which covers you and all of your eligible dependents). However, if you are divorced or separated from your spouse, you may be required under the terms of a “Qualified Medical Child Support Order” to provide coverage under the Plan to any of your children named in such order. A Qualified Medical Child Support Order (“QMCSO”) is an order satisfying the requirements of ERISA and requiring a health (or dental) plan to recognize the child of a parent-employee as a plan participant. If the Plan Administrator receives a QMCSO for an employee who is not presently enrolled in the Plan, the employee will be enrolled in family coverage.

The Plan’s QMCSO procedures are available from the Plan Administrator upon request at no charge to you.

What Must I Pay For Coverage?

The coverage under this Plan is contributory, meaning the employee pays all or a portion of the cost.
How Do I Enroll For Coverage?

If you want to cover yourself or your dependents under the Plan, you must:

1. apply for the coverage on the proper form; and
2. agree in writing to make the required contributions.

Prior to the first day of each Plan Year (July 1 – June 30) the Company will provide an annual enrollment period during which you may elect to be covered under the Plan or, if you are already covered, to change the type of coverage (for example, from individual to family coverage).

The coverage that you elect during the annual enrollment period will become effective on July 1st following the annual enrollment period. If you become employed during the Plan Year and you elect coverage during a period other than the open enrollment period, your coverage will be effective on the first day of the month following completion of one month of employment in which you are regularly scheduled to work at least 20 hour per week.

Can I Change My Election During The Year?

Your election to receive coverage under the Plan will remain in effect for the Plan Year (July 1 – June 30). If you are a new employee and elected coverage during a period other than the open enrollment period, your initial election will remain in effect from the date your election became effective until the following June 30th. If you do not complete a new election form for coverage during the next annual enrollment period, your election automatically will remain in effect for the next Plan Year.

You may change or revoke your election during the middle of a Plan Year only if you experience a "change in family status", and the change in coverage is on account of and consistent with the change in family status. Examples of changes in family status include: (1) your marriage, divorce or legal separation; (2) the birth or adoption of a child; (3) the death of a dependent; (4) a dependent who either becomes eligible for coverage or is no longer eligible; (5) a change in your spouse's employment; (6) a significant change in your or your spouse's health coverage attributable to your spouse's employment; (7) the receipt of a qualified medical child support order; (8) a “special enrollment period,” as required under the Internal Revenue Code; or (9) any other event deemed a change in family status by the Plan Administrator, in accordance with applicable law.
What Happens If I Don't Enroll When I First Become Eligible?

If you (or your dependents) do not enroll in the Plan when you (or your dependents) first become eligible to participate in the Plan, you may enroll yourself (or your dependents) during the annual enrollment period for the next Plan Year or a later Plan Year. If you (or your dependents) do not enroll in the Plan when you (or your dependents) first become eligible to participate, you (or your dependents) will be referred to as a "late entrant". (Late entrants are subject to reduced benefits under the Plan, as described below.)

What Amount Of Expenses Does The Plan Pay If I Am A Late Entrant?

If you (or your dependents) are late entrants, the amount of expenses that will be reimbursed is reduced for the first Plan Year in which you (or your dependents) participate in the Plan. After the first Plan Year during which you (or your dependents) participate as late entrants, you (or your dependents) will be eligible for standard plan benefits, assuming you (or your dependents) continue to participate in the Plan. If you (or your dependents) subsequently drop coverage during an annual enrollment period and then re-enroll during a following annual enrollment period, the amount of expenses that will be reimbursed is again reduced for the first Plan Year in which you (or your dependents) resume participation in the Plan. For each late entrant, the Plan will pay 50% of covered expenses incurred during the Plan Year. The maximum benefit per person for that Plan Year is $375 for the Basic Plan and $750 for the Premium Plan.

What Expenses Can I Get Reimbursed?

You will be reimbursed for all properly submitted expenses incurred by you or your covered dependents while you are covered under the Plan, except for those expenses discussed below that are not covered under the terms of the Plan. Covered expenses include treatment by any licensed provider.

Are There Any Expenses Not Covered?

You will not be reimbursed for the following expenses:

- Expenses incurred for injuries or conditions, which are payable through workers' compensation;
• Expenses incurred for services, which are covered by a governmental agency;
• Expenses incurred for services, which are covered by a company-sponsored medical plan;
• Expenses incurred for elective, cosmetic dentistry and/or expenses incurred for elective eye surgery, i.e., Radial Keratotomy, if applicable.

What Amount Of Expenses Does The Plan Pay?

Each person covered by the Plan, other than a late entrant, is eligible to be reimbursed for the percentage of his or her expenses in the amount indicated below. The Plan Year in which the treatment was provided is the year used to determine the reimbursement.

*The Plan will pay:*

<table>
<thead>
<tr>
<th></th>
<th>Basic Plan</th>
<th>Premium Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$75</td>
<td>None</td>
</tr>
<tr>
<td>Maximum Annual Benefit</td>
<td>$750</td>
<td>$1,500</td>
</tr>
<tr>
<td>Class I – Preventive Care (deductible waived)</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Orthodontia</td>
<td>Not Covered</td>
<td>50%</td>
</tr>
<tr>
<td>All other covered expenses</td>
<td>50%</td>
<td>60%</td>
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**Orthodontia Claims**

Payment for orthodontic treatment is made in installments. The first payment (downpayment) is payable on the date your braces are placed. The downpayment may be up to a maximum of 25% of the estimated total treatment charge and will be processed according to your schedule of benefits. The balance of the estimated total treatment charge is prorated and paid on a monthly basis during the anticipated duration of the treatment. It is the responsibility of the employee to provide proof of continuation of treatment in order to receive reimbursement.

A one page “orthodontic questionnaire” must be completed by the orthodontist and submitted with the initial charges. This form is available from your Human Resources Representative, or by calling Direct Reimbursement Benefit Plans.
How Does The Plan Determine When a Service is Incurred?

The charge for service, supply, or treatment is considered incurred on the date the service is provided.

How Does The Plan Handle Expenses For Treatment In Process When Coverage Begins?

We will exclude from coverage all procedures, which began prior to the effective date of coverage with the exception of orthodontic care where we will allow expenses for monthly maintenance, incurred after the effective date. Expenses for any procedure performed on or after the effective date are covered even if it is a continuation of care begun before the effective date.

How Do I File My Claim?

When you incur expenses and you have not assigned benefits, you should obtain a written statement from your provider that describes the dates of service, the type of treatment and the charge. A request for claim payment should be made on claim forms that are obtained from the Human Resources Department. Properly completed claim forms should be sent directly to the Claims Administrator (the address for the Claims Administrator is at the end of this Summary Plan Description) within a reasonable period following occurrence of the treatment or expense.

If you have assigned benefits to your provider, he or she will submit the claim on your behalf. The provider must submit an employer provided claim form indicating benefits have been assigned and a statement of services rendered. Any amounts due the provider which have not been paid under this plan are the responsibility of the employee.

All claims for expenses must be submitted no later than 6 months after the end of the Plan Year in which the expenses were incurred. The Company reserves the right to verify all reimbursement requests. A fraudulent claim is grounds for termination of benefits and other disciplinary actions (including termination of employment) determined within the discretion of the Company.
What Do I Do If My Claims Are Denied?

If your claim is denied (all or in part), you will be informed of the reason(s) for denial, and you may initiate a review of the claim by contacting the Plan Administrator for further instructions. Under the review procedure, you or your duly authorized representative have the right to: (a) request the review by making written application to the Plan Administrator, no later than 60 days after the claim denial, (b) review pertinent Plan documents, and (c) submit issues and comments in writing in support of the claim. You will be notified in writing of the results of the claim review and the reason for any denial no later than 60 days following receipt of the properly completed request for review, unless it is necessary to seek additional information, in which case the determination will be made within 120 days. Any requests for review not responded to within this period shall be deemed denied.

When Does My Coverage End?

Your coverage, as well as that of your dependents, ends on the earliest of the following dates, subject to your right to elect COBRA coverage:

- The date this Plan terminates or is amended to exclude you or your dependents from the class of employees or dependents, as applicable, eligible for coverage;
- The date you are no longer in an eligible class of employees or, with respect to a dependent’s coverage, the date the dependent is no longer an eligible dependent;
- The last day of your employment;
- The date of your death; or
- The date you fail timely to pay employee-required contributions;
- The date you withdraw from the Plan.
- If you take a leave of absence pursuant to the Family and Medical Leave Act, (“FMLA”), your elected coverage will be continued by the Company for the authorized period of leave. You will have the option of paying for your coverage while on leave or upon return to active employment.

Any expenses that you incur during your period of coverage will be eligible for reimbursement, subject to the terms of the Plan.
What Are My Rights Under COBRA?

COBRA continuation of Plan benefits is available to those individuals who, for a variety of reasons, would normally lose coverage. Individuals who wish to continue coverage must elect to do so within certain time limits and must pay the entire cost of coverage plus an administrative charge on a regular timely basis.

Who Is Eligible For COBRA

You and your dependents ("Qualified Beneficiaries") are eligible for COBRA continuation coverage if you and your dependents are actually covered under the Plan at the time of your “qualifying event,” as described below. In addition, a child born to or adopted by an individual covered under COBRA is also considered a Qualified Beneficiary.

A “qualifying event” includes your termination of employment or reduction of hours of employment with the Company or a Participating Company. This excludes your discharge due to gross misconduct. The Plan Administrator will determine what constitutes gross misconduct. Bankruptcy of the Company is also considered a qualifying event.

In addition to the above events, your spouse and dependent children are eligible for COBRA continuation coverage if they are actually covered under the Plan at the time of any of the following qualifying events:

- Your divorce or legal separation;
- Your death; or
- Your becoming entitled to benefits under Medicare.

In addition to the above events, your dependent children will be eligible for COBRA continuation coverage if they are actually covered under the Plan at the time they lose coverage under the Plan due to loss of dependent status.

What Notice Do I Have To Give For COBRA To Take Effect?

The Plan Administrator has no way of knowing when you are divorced or when a dependent child loses eligibility. Therefore, it is your responsibility and the responsibility of affected dependents to notify the Plan Administrator within 60 days of a divorce, legal separation or loss of a child’s dependent status under the Plan. If this notice is not received within 60 days, the dependent will permanently lose eligibility for COBRA continuation coverage.
How Long Does COBRA Coverage Last?

COBRA continuation coverage may extend for 18 months in the case of your termination of employment or reduction of hours, and otherwise for 36 months, provided that a covered dependent lost coverage under the Plan as a result of the qualifying event. If coverage under the Plan continues beyond the occurrence of a qualifying event, the 18 or 36-month period will not begin until loss of coverage. The 18-month period may be extended if a second qualifying event causing loss of coverage (for example, death, divorce or legal separation) occurs during that period. Coverage will never last more than 36 months from the date of the original qualifying event (i.e., the date you terminated employment with a participating company or your hours were reduced). However, if you (the covered employee) separate from service or reduce your hours less than 18 months after the date you became entitled to Medicare, then the coverage for your dependents may be extended to a maximum of 36 months from the date you became entitled to benefits under Medicare.

What Are My Rights Under COBRA If I Am Disabled?

Qualified Beneficiaries deemed disabled for Social Security purposes (and their covered family members) can extend coverage up to 29 months if:

- The Qualified Beneficiary is determined, under the Social Security Act, to have been disabled within 60 days of the date COBRA coverage commenced for the Qualified Beneficiary;
- The determination of disability is made before the end of the initial 18-month continuation period; and
- A copy of the disability award is provided to the Plan Administrator within 60 days of the date of determination and before the end of the 18-month continuation period.

In the case of COBRA continuation coverage that is extended beyond the 18-month continuation period due to a Qualified Beneficiary’s disability, COBRA continuation coverage will terminate on the first day of the month that begins more than 30 days after it is determined that the Qualified Beneficiary is no longer disabled, unless coverage is terminated earlier for any of the reasons described below for the termination of COBRA coverage.
Can COBRA Coverage Terminate Earlier Than Described Above?

Yes, although COBRA will generally continue for either the 18-, 29-, or 36-month period described above, it can be terminated earlier for any of the following reasons.

- The Qualified Beneficiary fails to pay the premium in a timely manner, defined initially as within 45 days of the date of the election and thereafter within 30 days of each due date;
- The Qualified Beneficiary becomes covered under another group plan (unless the Qualified Beneficiary is subject to pre-existing condition exclusions under that plan);
- The Qualified Beneficiary becomes entitled to Medicare benefits. However, your covered dependents may still continue their coverage if you become eligible for Medicare; or
- The Plan is terminated in its entirety and neither the Company nor its affiliates maintain any type of group plan.

If COBRA coverage terminates, it cannot be reinstated.

How Do I Elect COBRA Coverage?

Qualified Beneficiaries will be notified in writing of their eligibility for COBRA continuation coverage and of the election procedures. In order to obtain COBRA continuation coverage, Qualified Beneficiaries must follow all instructions sent with the notice of eligibility. Generally, Qualified Beneficiaries will have 60 days from the date of notice to elect COBRA coverage. During this 60-day election period, the Qualified Beneficiaries must decide if they intend to continue their coverage by agreeing to pay the premiums on a monthly basis.

How Do I Pay For COBRA Coverage?

Payments for COBRA continuation coverage are payable monthly to the Plan Administrator and are due by the first of each month. COBRA continuation coverage will terminate if payments (other than the first payment) have not been received within 30 days of the first of each month. The first payment for COBRA continuation coverage is due within 45 days after you make your election to receive COBRA continuation coverage and the election is received by the Plan Administrator. If the payment is not made within the 45 days for the first payment, COBRA continuation coverage will terminate. The Plan Administrator is not required to send you payment reminders or overdue notices.
HOW PROTECTED HEALTH INFORMATION
ABOUT YOU MAY BE USED AND DISCLOSED
AND HOW YOU CAN OBTAIN ACCESS TO THIS
INFORMATION

To persons enrolled in the Gwinnett County Public Schools’ Health Plan, as administered by Direct Reimbursement Benefit Plans:

The Plan is required by law to maintain the privacy of protected health information and to provide covered individuals with notice of its legal duties and privacy practices with respect to protected health information. However, the Plan is permitted to use and disclose this information under the circumstances described in this notice.

The Plan is required to abide by the terms of this notice until it is amended. The Plan reserves the right to change the terms of this notice and to make the new notice provisions effective for all protected health information that it maintains. All individuals covered under the Plan will receive a revised notice within 60 days of a material revision to the notice.

In order for the Gwinnett County Public Schools’ Health Plan to pay for your covered protected health expenses, the Plan and those administering the Plan must create or receive certain protected health information about you. This information may involve:

Payment activities such as billing and collection activities, eligibility determinations, adjudication of claims, pre-certification and utilization review, and coordination of benefits, or Health care operation activities such as quality assessment, case management, subrogation or business management and general administrative activities, or Treatment activities by your health care provider, such as providing information about other treatments you have received.

By your enrolling in the plan, you have agreed to allow the Plan and its administrators to create or use your protected health information in order to perform these duties without your express authorization. The Plan may also disclose protected health information about you without your authorization to business associates of the plan, such as actuaries who price the cost of coverage, the claims administrator who pays the claims or other professionals who perform services on behalf of the Plan. All disclosures made by the Plan of protected health information for purposes of payment or health care
operation activities shall be the minimum necessary to accomplish the intended purpose of the disclosure, and any business associate who receives the information must agree to keep it confidential.

The Plan may be required to make available to the Department of Health and Human Services all books and records regarding the health information of covered persons if this information is requested for audit purposes. You will not have to authorize this disclosure.

The Plan may disclose information about your medical records to a medical professional treating you. No authorization is necessary for this disclosure.

The law requires the Plan to make certain disclosures. These include disclosures:

As necessary to comply with workers’ compensation or other similar programs. As necessary for courts and law enforcement agencies. Disclosures to a law enforcement agency may occur if required by law (such as the occurrence of certain types of wounds) or if required by a court order or other legal process. The Plan may also disclose protected health information: for the purpose of identifying or locating a suspect, witness, fugitive or missing person; about a crime victim, if the victim agrees or emergency circumstances require disclosure without consent; about a person who has died if the nature of the death suggests that it may be the result of criminal conduct; or if there is evidence to suggest that a crime occurred on the premises.
As necessary for public health research and disclosure, including reporting of communicable diseases to the applicable authorities (who may contact exposed individuals) and workforce protected health investigations.
As necessary to a health oversight agency for oversight activities authorized by law. However, this will generally not include an investigation of a particular individual unless it involves receipt of health care, public health benefits or public benefits contingent on the individual’s health.
As necessary if disclosure is required by another law.

The Plan may also be permitted or required to disclose protected health information without your authorization under the following circumstances:

If authorized by law, to the proper authorities for purposes of reporting child abuse or domestic violence. Subject to certain restrictions, the Plan may also report this information to social services, but must generally inform the victim of the abuse that it is making the disclosure.
To people working for or with the Food and Drug Administration, these disclosures may be necessary:

• to report adverse events with respect to food or dietary supplements, product defects (including use or labeling defects), or biological product deviations; for product tracking; to enable product recalls, repairs or replacements; or to conduct post marketing surveillance.
Upon your death:
- to a coroner, funeral director or to tissue or organ services, as necessary to permit them to perform their functions.

Under certain circumstances:
- for research purposes.
- to prevent or lessen a serious threat to the health or safety of a person or the public.
- If authorized by law, in connection with military matters or matters of national security and intelligence.

In addition, the Plan’s administrators may disclose protected health information to the Plan Sponsor, Gwinnett County Public Schools, under the following conditions:

Gwinnett County Public Schools may not use any such information for employment-related decisions.
Gwinnett County Public Schools may receive such information as the Plan documents allow.
You have the right to inspect the Plan documents allowing disclosures.

Other uses and disclosures of your protected health information will be made only with your written authorization and you may revoke the authorization at any time, upon request.

You have the right:

- To request restrictions on certain uses and disclosures of your protected health information.
  The Plan does not have to agree with a requested restriction, but if the Plan does agree, then the Plan will abide by that restriction.
- To receive your own confidential health information by alternative means or at alternative locations, if receipt of the information in the usual manner could endanger you.
  You should contact Gwinnett County Public Schools’ Privacy Officer to request the alternative delivery. You must include a statement that disclosure of the information in the usual manner could endanger you.
- To inspect and copy your own health information, but exceptions apply to certain types of information. If you request to see or copy your own health information from Gwinnett County Public Schools’ Privacy Officer and one of these exceptions apply, you will be given more information at that time, including the circumstances under which you may challenge the exception.
- To amend your own health information when that information is incorrect.
- To obtain an accounting of any disclosure of your confidential health information, other than disclosures for purposes of payment, health care
operations or treatment, or disclosures made in accordance with your written authorization.

- To obtain a paper copy of this notice upon request.

In each case, you must make your request to the Privacy Officer, in writing. Depending upon the nature of the request, you will be given more information at that time, including any exceptions to the rules that may apply to your case.

Individuals may complain to the Plan Sponsor and/or to the Secretary of Health and Human Services if they believe their privacy rights have been violated. If you wish to file such a complaint, please contact Gwinnett County Public Schools' Privacy Officer as shown below and you will be given information on how to proceed. You will not be retaliated against by the Plan, its administrators, or the Plan Sponsor for the complaint. The Department of Health and Human Services may be contacted in Washington, DC or listings may be found in local telephone directories.

For further information contact the Gwinnett County Public Schools' Privacy Officer.

You may also contact Direct Reimbursement Benefit Plans' Privacy Officer, Cassie Gross, at 1-888-745-3274.
Information Required By The Employee Retirement Income Security Act Of 1974, As Amended ("ERISA")

Name Of Plan:

Gwinnett County Public Schools
Direct Reimbursement Plan

Type Of Plan:

Welfare Benefit Plan

Plan Document:

This Summary Plan Description also constitutes the Plan document for Gwinnett County Public Schools Direct Reimbursement Plan.

Plan Year:

July 1 – June 30

Plan Sponsor/Plan Administrator:

Gwinnett County Public Schools is the principal employer that maintains the Plan and also is the Plan Administrator of the Plan.

The address of Gwinnett County Public Schools is:
610 West Crogan Street
Lawrenceville, GA 30046

The telephone number of Gwinnett County Public Schools is:
770-995-6392

The Plan Administrator has the exclusive power and discretionary authority to interpret the Plan. The Plan Administrator is the “Named Fiduciary” under ERISA.
Plan Funding:

Company and Employee contributions cover the cost of the Plan. Company contributions and any Employee pre-tax contributions withheld by way of payroll deduction are held by the Company and used to pay Plan benefits. All Employee contributions to the Plan shall be withheld from the Employee’s paycheck on a pre-tax basis unless the Employee requests, in writing to the Plan Administrator, that the required contributions be withheld on an after-tax basis. **Any after-tax Employee contributions may be held in trust by the trustee.** The amount of all such contributions is actuarially determined where necessary.

**Employer Identification Number:**

58-6000254

**Plan Number:**

501

**Agent For Receiving Service Of Legal Documents:**

In the event of legal action involving the Plan, legal papers may be served upon: **Gwinnett County Public Schools**

**Claims Administrator:**

Claims for benefits under the Plan will be processed by Direct Reimbursement Benefit Plans. The Claims Administrator’s address is:

Direct Reimbursement Benefit Plans  
P.O. Box 71549  
Newnan, GA 30271  
678-762-8842
ERISA RIGHTS

As a participant in the Gwinnett County Public Schools Employee Benefit Plan you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that all plan participants shall be entitled to:

✔ 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 collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor.

✔ Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

✔ Receive a summary of the plan’s annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

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. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim.

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 case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in 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.

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, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.